Continuity in Primary and Community Care in Midwifery

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Original Article

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Abstract:

Aim: To identify factors that influence the implementation of the midwife-led model of continuous care and to find out the interest of Czech and Slovak midwives and women in such care.
Design: Quantitative research
Methodology: Research conducted using a standardized questionnaire method from September 2022 to January 2023. The selection of respondents was deliberate, 320 Czech and 131 Slovak midwives and 521 Czech and 162 Slovak women. The data were evaluated in Excel statistics.
Results: Midwives in both countries consider the lack of support from the state and health insurance companies, inadequate legislation and the negative attitude of gynaecologists to be significant obstacles. In both the Czech and Slovak Republics, women have a comparable interest in community care, while Czech midwives with up to 20 years of experience showed more interest.
Conclusion: The vision for changing the status quo is to de-

velop a model of continuity in midwifery, strengthen the political environment, and support the integration of community midwives into the health care system that women are interested in.

Introduction

Continuity of care is a concept that is based on primary care. It involves care over time by the same provider for a specific person rather than for an entire population (Bradford et al, 2022). It is considered to be one of the main attributes of quality of care within health care services. The continuity model in the community includes the delivery of counselling, antenatal, postpartum care to women and families, individual education and the participation of a midwife at the birth that the woman has chosen (Michel-Schuldt et al, 2020). This form of complex care of the woman and child faces many challenges in providing services. It requires a degree of flexibility, travel needs, legislative adjustments in training, professional competencies and integration of maternity services into the health care system. Despite evidence and positive policy developments that enable continuity of care in midwifery, organisational changes are slow or absent in many countries (Renfrew et al, 2014). In the Czech Republic (the CR) and the Slovak Republic (the SR), continuous primary and community care provided by midwives is delivered on a limited scale. There has been a significant reduction in the number of visits to pregnant women and mothers after childbirth by midwives, although the length of hospital stay has been reduced from 7.3 days to 3.6 days in the Czech Republic and 4.0 days in the Slovak Republic, and the number of hospital beds has decreased from 10.9 to 4.4 thousand in the Czech Republic and from 5.4 to 2.4 thousand in the Slovak Republic. (Health Yearbooks of the Czech Republic and Slovakia for the period 1991-2020) There are several reasons that explain this problem. These include a lack of understanding of how midwifery models work, how they can be implemented in different situations, the low status of midwives in relation to doctors and their dominance. Midwifery is often not considered an autonomous profession (Sandall, et al, 2001; P. ten Hoope-Bender et al, 2016). In both countries, the position of midwives in the community care system is not defined in an exact way. The services provided by midwives are covered to a small extent by health insurance. In the Czech Republic there are 194 registered independent workplaces where midwives independently provide continuous care, but the procedures must be indicated by a gynaecologist. In Slovakia, licensed midwives, of which there are ten, can provide specific health care during pregnancy and after childbirth, without a doctor's indication, for those pregnant women who are insured with the health insurance company UNION. Women who are pregnant for the first time have little idea of what midwives can do in independent practice. Their main source of information comes from their own experience of midwifery during childbirth. To improve the coordination of primary and secondary care, which is largely ignored, and the services of midwives in the community, which are not very visible, often remain silenced, there is a need to increase multidisciplinary training, revise the system of financial reimbursement for maternity services provided, and improve the promotion of the role and services led by midwives (Zadoroznyj et al, 2000; Schölmerich et al, 2014). Despite the barriers and obstacles, the midwife-led model of continuous care is associated with lower rates of interventions during labour, analgesia, episiotomy, amniotomy. Women report higher levels of satisfaction with care, feeling safer, less stressed, more respected (Walsh 2021; Sandall 2013; Forster et al 2016). The continuity of care helps to develop a trusting relationship with the mother and family, improves communication, and increases efficiency and accountability for services provided. This enables the midwife to identify problems, behavioural changes and needs of the mother and baby early during community or home visits (Bowers et al, 2015).

Aim: The aim of the study was to identify factors that influence the implementation of

midwife-led community-based continuous care and the interest of midwives and women in this form of care in the Czech and Slovak Republics.

Methodology: we conducted the study from September 2022 to January 2023.We used a questionnaire method to collect empirical data in two language versions: in Czech and Slovak for midwives and women. The items in the questionnaire assessed sociodemographic indicators: place of practice, age, education, experience, and parity for women. We used the Likert scale to assess the respondents' opinions and barriers to continuous community care. We analyzed legislation, financial evaluation, time flexibility, counseling, accompanying mothers during childbirth, and gynecologists' attitudes towards midwifery services. For women, we analyzed awareness and satisfaction with midwifery services. We purposively sampled the respondents in the research population, where the criterion for midwives was the implementation of midwifery practice and willingness to complete the questionnaire, and for women the criterion was willingness to complete the questionnaire and age more than 18 years. 320 (8% of the total number of 3700 midwives) Czech and 131 (7% of the total number of 1800 mid-

Table 1 Provision of primary and community care (PCC) in midwifery in the Czech Republic

Provision of PCC	abs.p.	rel.p.	length of practice			
			up to 5yrs.	6-20 yrs.	21-35	36 and more
PCC is provided as a private practice	98	30,6%	19	38	26	15
PCC is provided as an occupation	102	31,9%	23	32	35	12
I don't provide PCC, but I'm interested	75	23,4%	43	15	12	5
I don't provide PCC and I'm not interested	45	14,1%	8	19	15	3
Czech midwives in total	320		93	104	88	35
		100%	29,1%	32,5%	27,5%	10,9%

Table 2 Provision of primary and community care (PCC) in midwifery in the Slovak Republic

Provision of PCC	abs.p.	rel.p.	length of practice			
			up to 5yrs.	6-20 yrs.	21-35	36 and more
PCC is provided as a private practice	10	7,6%	0	2	6	2
PCC is provided as an occupation	68	51,9%	21	24	15	8
I don't provide PCC, but I'm interested	36	27,5%	21	12	2	1
I don't provide PCC and I'm not interested	17	13,0%	9	2	4	2
Slovak midwives in total	131		51	40	27	13
		100%	39,0%	30,5%	20,6%	9,9%

wives) Slovak midwives participated in the research survey. The second sample consisted of 521 women from the Czech Republic and 162 women from Slovakia. The questionnaires were distributed through professional organizations in Slovakia Slovak Chamber of Nurses and Midwives, in the Czech Republic Czech Chamber of Midwives, and for women through women's organizations.

Data analysis

Data collection was conducted electronically via the internet platform "Survio", which fully ensures anonymity and protection of respondents' personal data in accordance with the Declaration of Helsinki. The collected data were evaluated by descriptive and inferential statistics using Microsoft Excel 2010. For descriptive statistics, we calculated absolute frequencies (f) and relative frequencies (%), arithmetic mean (AM) values, standard deviations (SD), median (Mdn), minimum (min) and maximum (max) values. Statistical tests were performed at the significance level $\alpha = 0.05$ ($^*p < 0.05$) using the Chisquare test ($\chi 2$). To test the population mean, we used the Z test statistic.

Results

In the group of midwives, the greatest number of midwives with a bachelor's degree in midwifery were represented, 210 (65.6%) in the Czech Republic, 88 (67.2%) in Slovakia, 104 (32.5%) with 6 to 20 years of work experience in the Czech Republic and 51 (39.0%) with 5 years of work experience in Slovakia. In the female population, second births were the most represented, with 241 (46.3%) in the Czech female population and 67 (41.3%) in the Slovak female population. The age structure was most represented between 31 and 40 years, with 284 (54.5%) in the Czech female population and 88 (54.3%) in the Slovak female population. In Table 1 and Table 2, we present the provision of primary and community care in midwifery in both countries in relation to the length of experience.

In the Czech Republic, 98 (31%) midwives have an independent private practice and in the Slovak Republic only 10 (8%) respondents have an independent private practice. Midwives most often provide the above care if they are employed. Czech midwives mainly provide individual counselling 94(48%), courses for

Table 3 Czech and Slovak midwives - Interest in providing primary and community care

Primary and community care	ČR n=320		SR n=131	
	abs.p.	rel.p.	abs.p.	rel.p.
a) is provided as an independent full-time private practice	29	9,1%	1	0,7%
b) is provided as a part-time private practice while working in a hospital, clinic or school	69	21,5%	9	6,9%
a+b) is provided as an independent private practice	98	30,6%	10	7,6%
c) is provided as a full-time employee	71	22,2%	63	48,1%
d) is provided as a part-time employee	31	9,7%	5	3,8%
c+d) is provided as an employee	102	31,9%	68	51,9%
e) is NOT provided but I consider providing it if the legislative and financial conditions are modified	75	23,4%	36	27,5%
f) is not provided and I don´t consider providing it	45	14,1%	17	13,0%
a-f) in total	320	100%	131	100%

pregnant women 80 (41%), continuous care 71(36%), antenatal care 62 (31%) and visiting service 57 (29%). Slovak midwives reported similar items when providing care: providing individual counselling 51 (39%), continuous care 49 (37%), courses for pregnant women 27(21%) and care during delivery in the maternity ward 24 (18%). However, Czech midwives are more interested in primary and community care compared to Slovak midwives, as shown by the result of the test statistic $Z = 2.78$. Statistically significant difference $p = 0.00535$, $p < 0.05$ was confirmed. 95% CI confidence interval ranges <0.0135; 0.0777> . Both groups of respondent midwives are mainly not interested in physiological home birth in CR 100 (76%) compared to SR 125 (63%), in physiological home birth in maternity house in CR 80 (61%) compared to SR 70 (35%), and in exercise for pregnant or postpartum women in CR 49 (37%) compared to SR 86 (44%). Midwives are not interested in these activities regardless of years of clinical practice. Similarly, women reported the least interest in midwife-led home births. This was 106 (20.4%) in CR and 37 (22.8%) female respondents in SR. Younger Czech midwives with up to 20 years of experience are more interested in providing primary and community care than older Czech midwives with 21 years of experience. The result of the test statistic $Z = 4.7945$. Confi-

Table 4 Barriers - midwives in the Czech Republic

Barrier	Female respondents' answer		Rating scale				
	abs.p.	rel.p.	None	Rather small	medium	Rather large	large
inadequate legislation	237		3	11	74	138	94
		74,1%	0,9%	3,5%	23,1%	43,1%	29,4%
insufficient support from the state, health insurance companies	253		3	11	49	140	117
		79,1%	0,9%	3,5%	15,3%	43,7%	36,6%
negative attitude of gynaecologists	209		6	32	91	118	73
		65,3%	1,9%	10,0%	28,4%	36,9%	22,8%
insufficient education	99		26	82	116	72	24
		30,9%	8,1%	25,6%	36,3%	22,5%	7,5%
external barriers	798		38	136	330	468	308
		62,3%	3,0%	10,6%	25,8%	36,5%	24,1%
lack of interest of midwifes	62		11	86	137	70	16
		19,4%	3,5%	26,8%	42,8%	21,9%	5,0%
financial uncertainty	143		7	49	107	112	45
		44,7%	2,2%	15,3%	33,4%	35,0%	14,1%
greater responsibility	101		7	56	130	82	45
		31,6%	2,2%	17,5%	40,6%	25,6%	14,1%
inconsistency of midwives	123		7	73	108	99	33
		38,4%	2,2%	22,8%	33,8%	30,9%	10,3%
internal barriers	429		32	64	482	363	139
		33,5%	2,5%	20,6%	37,6%	28,4%	10,9%

dence interval 95% CI ranges <0.0509; 0.1213>. The same result was shown for respondents in the Slovak Republic, where younger midwives are more interested in providing the above care, test statistic result Z = 5.724, 95% confidence interval CI ranging <0.1154; 0.2355>. Based on the results, we found that women mostly would be interested in community midwifery services, 270 (51.8%) in CR and 94 (58%) in SR. Only 58 (11.1%) women in the Czech Republic and 21 (13.0%) women in the Slovak Republic would not be interested in the services of midwives. Most women in the Czech Republic would be interested in counselling for physiological pregnancy by a midwife 351 (67.4%), and in exercise for pregnant and postpartum women 279 (53.5%). In Slovakia, women expressed interest in postnatal visit service 110(67.9%), in birth guidance by a midwife in a healthcare facility 85 (52.5%). The results of the study show that women in CR are more interested in the activity, however, midwives in CR show the lowest level of interest in the activity, which is exercise for pregnant or postpartum women. Respondents rated which barriers and obstacles affect the delivery of primary and community care provided by midwives. Overall, Czech midwives reported external barriers 798 (62%) more often than internal barriers 429 (33.5%), compared to Slovak midwives who rated external barriers also as more significant 302 (58%) than internal barriers 222 (42%). Those midwives from the Czech Republic who provide primary and community care as private practice rated external barriers (legislation, state support, health insurance companies, negative attitude of gynaecologists, lack of education) 254(64.5%) as stronger compared to internal barriers 117(29.8%). Table 4 provides an overview.

Discussion

Studies point in particular to the lack of standardisation of primary and community midwifery, a precisely defined scope of practice, and criteria for practical training in community midwifery qualification and specialisation (Renfrew et al, 2014; de Jonge et al, 2015). As a result of the change in the specific role of community midwives, there is an inaccuracy within the definition of continuous community care, not reflecting the changes in the scope of practice that current community midwifery requires. Sherratt (2013) cites the problem that education is mostly based on theory and lacks real and relevant practical experience. Full mastery of the competencies needed to assist a woman during pregnancy, birth and the six months of labour can only be gained through a reasonable amount of experience in the clinical area under the supervision of experienced community midwives and doctors. The difficulty in educating midwives for community care is to provide practice in a community environment that meets the needs of pregnant women. Pregnant women are not always satisfied with the professional support they receive from midwives during the care they are offered because the support does not match their actual needs. Therefore, the services provided by midwives should be based on the interest of women and not only on the interest of midwives. Because a positive birth experience can have the effect of boosting a woman's confidence, improving the bond between her baby, the preference for the way of the next birth. In contrast, women who experience inadequate support before becoming pregnant are at greater risk of negative birth experiences, are more likely to experience fear of childbirth in subsequent pregnancies, which may lead to requests for caesarean sections in future births (Bäckström et al, 2022; Hendrych-Lorenz, 2019). The International Confederation of Midwives and the WHO (2017, 2006) have highlighted the difficulties in providing primary and community care in midwifery in many countries around the world, particularly in terms of legislation, creating an environment for practice, education, monitoring and evaluation of midwives' work. However, the strategies recommended by international organisations have been met with resistance from many national governments due to the increase in care provided by gynaecologists (Vermeulen et al, 2019). Barriers at the macro level, inequitable models of financing between doctors and midwives result in interpersonal conflicts at the micro level. Therefore, most of the barriers to the development of primary and community care come from less favourable rela-

tionships between midwives and gynaecologists. In some situations, midwives may actually pose a certain threat to the obstetrician-gynaecologist, which in many countries is mainly based on the model of payment for procedures, the scope of midwives' competence, and the possible competition for participation in childbirth. Models of financing contribute to the exclusion of midwives from primary community care, discourage collaboration and encourage competition (Munro et al, 2013; Darling et al, 2023). Schölmerich (2014) highlights the need for improving coordination and interprofessional communication in the continuum of information shared not only between midwife and obstetrician, but also between primary and secondary care. The key barriers to interprofessional collaboration are reported to be strong hierarchical structures, fragmentation of care, lack of respect, trust and lack of clarity about responsibilities and authority. Midwives perceive their work environment as stressful with a high risk of conflict. Professional dissonance, caused by inconsistencies in communication, coordination mechanisms and professional ethics, is considered a central cause of tension (Smith, 2015; Aquino et al, 2016; McFarland et al, 2020; Hansson et al. 2022). The heterogeneous professional basic understanding of childbirth, its redefinition into a disease that requires specialist care that can only be provided in hospitals, has caused a loss of autonomy for midwives. Evidence shows that health systems that lack midwives have higher rates of unnecessary interventions, higher economic costs and inequalities in care provision. These aspects can reinforce feelings of demarcation between professional groups of midwives and doctors and inhibit a common vision of care (Reiger, 2008; Reiger et al, 2009; de Jonge et al, 2015; Behruzi et al, 2017; McFarland et al, 2020). In order to implement midwifery care that is focused on women and their families, it would be constructive to adopt a statement of the value of this care, supported by groups of providers, health policy makers and health insurers (Fontein-Kuipers et al, 2018). Both women and midwives today face the challenges of a prevailing care delivery system characterized by a lack of 'person' time, limited space for decision-making, hierarchical and medicalized care, and weaknesses in practical community-based midwifery education that override the core competencies of midwives (Lohmann et al, 2018). A limit to the paper is the lower number of responses from midwives and women respondents in both countries, which was due to reluctance to answer the questions. The online questionnaire website was viewed by 976 midwives in CR, 320 (32.8%) completed valid questionnaires, in CR 131(51.6%) of 254 midwives completed the questionnaire. In the second set from CR, 1292 women viewed the questionnaire and 521 (40.3%) completed the questionnaire, in CR 162 (32.0%) of 507 women completed the questionnaire.

Conclusion

Based on the results obtained, we conclude that there is a need to modify the primary community care system based on the actual needs of women and to provide conditions for functional, comprehensive and accessible midwifery services. Educations, regulation through legislation, licensing and effective management of the midwifery workforce are important dimensions of health policy that require attention. The vision is that primary care in a community midwifery setting, close to the woman and her family, can be provided by a community midwife, providing a seamless transition to other continuing care with a multidisciplinary approach when needed.

Conflict of interest

The authors declare no conflict of interest.

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