リトリート・国際母子(第100回)
合同カンファレンス
“助産力を考える”

NCGM

日時:2012年2月15(水)18時00分～20時00分
場所:国際医療協力研修センター5階大会議室
講演:

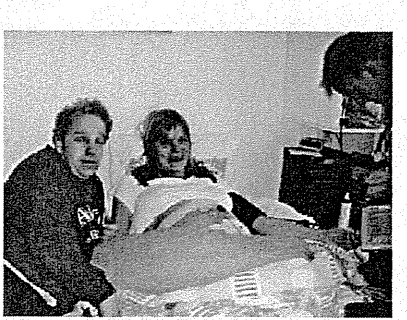
1)**Transforming Maternity Care**
Dr. Carol Sakala, PhD, MSPH
(Director of Programs Childbirth Connection)

2)**The maternity system in Amsterdam Area, Netherlands**
Ms. M.W. Sanders-Bootsma
(Coordinator, home-monitoring high risk pregnancies,
The Academic Medical Centre, Amsterdam)

わが国でも「院内助産」(病院内であっても正常分娩は基本的に助産師だけで取り扱うシステム)が普及しつつあります。国際医療研究センター病院産科でも、4月から助産師外来が発足します。今回は、医師主導分娩が主体の米国と、助産師が広く活躍しているオランダから講師をお招きして、自然なお産のあり方などについてディスカッションします。Sakala博士には、「EBMに基づいた助産ケア」について、Sanders-Bootsmaさんには、アムステルダム大学で行われているユニークな試みである「ハイリスク妊婦のホームモニタリング(在宅ケア)」など、オランダの周産期ケアについてお話を伺います。

ボストンにてSakala博士(左端)と

バースセンター



ホームモニタリング

文責:箕浦茂樹(中央検査部長、国際母子TFリーダー)

NCGM

NCGM Retreat & MCH Joint Conference

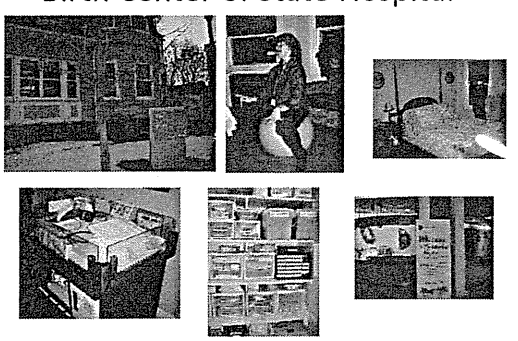
Lecture

1) **Transforming Maternity Care**
Dr. Carol Sakala, PhD, MSPH
(Director of Programs Childbirth Connection)

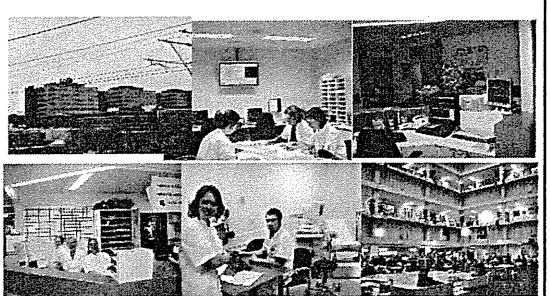
2) **The maternity system in Amsterdam Area, Netherlands**
Ms. Marian W. Sanders
(Coordinator, home-monitoring high risk pregnancies, The Academic Medical Centre, Amsterdam)

Beth Israel Deaconess Medical Center

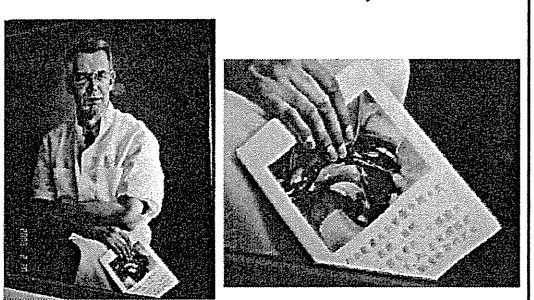
Birth Center of State Hospital



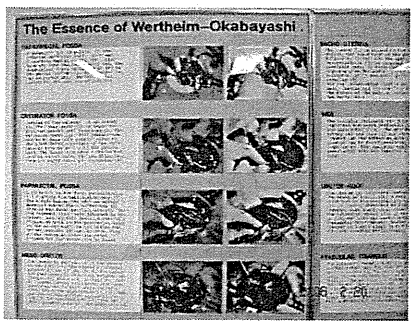
Academic Medical Center, AMC



AMC and Prof. Okabayashi

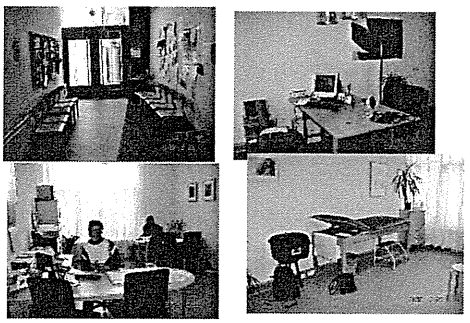


Wertheim-Okabayashi operation for cancer of uterine cervix



Home monitoring of high risk pregnancy

Midwifery care



Key Words

- Evidence based maternity care
- Humanized care
- Safety and comfort

Transforming Maternity Care by Improving the Health Care Delivery System

National Center for Global Health and Medicine

Tokyo

15 February, 2012

Carol Sakala, PhD, MSPH
Director of Programs
Childbirth Connection

Transforming Maternity Care Project

- This model could be adapted for other countries
- This model could be adapted for other clinical areas

Childbirth Connection

- National non-profit organization in New York City
- Since 1918, working to improve maternity care quality on behalf of women and families
- Mission is to improve the quality of maternity care through consumer engagement and health system transformation

Learn more: http://www.childbirthconnection.org/pdfs/90-year-timeline.pdf

Challenges for U.S. Maternity Care

World Health Organisation reports many countries performing better on

- maternal mortality
- stillbirth
- early neonatal mortality
- neonatal mortality
- postneonatal mortality
- infant mortality

Source: World Health Report 2005 at http://www.who.int/whr/2005/whr2005_en.pdf

Tonight's Presentation

Identify challenges we are facing in U.S. maternity care system

Share experience of *Transforming Maternity Care* Project to address the challenges

- planning phase to create "Blueprint for Action: Steps Toward a High-Quality, High-Value Maternity Care System," 2007-09
- implementation phase to carry out recommendations in "Blueprint for Action," 2010-

Challenges for U.S. Maternity Care

Poor international rank among OECD countries for

- maternal mortality
- low birthweight
- perinatal mortality
- neonatal mortality
- infant mortality
- cesarean section

OECD = Organisation for Economic Cooperation and Development

Challenges for U.S. Maternity Care

- U.S. makes greatest total health expenditure per person among all OECD countries (more than twice the average)

OECD = Organisation for Economic Co-operation and Development

Conclusion

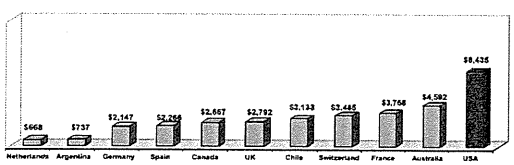
Considerable opportunities to

- improve performance
- reduce cost
- improve value

Challenges for U.S. Maternity Care

Average Maternity Services Payments, United States and Other Countries, 2010

Total Average Payments for Vaginal Birth, 2010 (US$)



Source: International Federation of Health Plans, 2010 Comparative Price Report
http://ifhp.com/documents/FHP_Price_Report2010ComparativePriceReport(2011201).pdf

Guidance for Safe, Effective Maternity Care

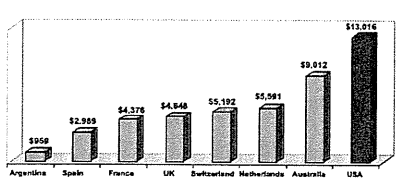
Vast amount of research reports, but difficult to

- identify the relevant studies
- know which are reliable and valid
- synthesize and draw a trustworthy conclusion

Can find a study to support just about any practice!

Challenges for U.S. Maternity Care

Total Average Payments for Cesarean Birth, 2010 (US$)



Source: International Federation of Health Plans, 2010 Comparative Price Report
http://ifhp.com/documents/FHP_Price_Report2010ComparativePriceReport(2011201).pdf

Guidance for Safe, Effective Maternity Care

Systematic reviews are valuable tools for clarifying the safety and effectiveness of specific practices.

They help us minimize bias, make trustworthy conclusions by:

- describing key parameters at the outset: question, outcomes, population, study designs, languages, years, etc.
- carefully searching for studies that meet these criteria
- evaluating the quality of the relevant studies
- summarizing results of better quality relevant studies, with meta-analysis if appropriate

Guidance for Safe, Effective Maternity Care

Maternity care got an early start in building a body of systematic reviews.

In 1989, Iain Chalmers and colleagues published compendia:

- *Effective Care in Pregnancy and Childbirth*
- *A Guide to Effective Practice in Pregnancy and Childbirth*
- *Oxford Database of Perinatal Trials*

This pioneering work led to creation of Cochrane Collaboration and is continued by its Pregnancy & Childbirth Group

Challenge for U.S. Maternity Care

Are we providing care that is consistent with high-quality evidence in systematic reviews (SRs)?

Compare lessons from SRs to actual maternity practices, using:

- birth certificate data
- national hospital discharge data
- Childbirth Connection's national *Listening to Mothers* surveys
- individual studies

Note: Rieko Kishi, NM, PhD, Showa University Northern Yokohama Hospital, has translated and adapted these surveys to understand maternity experiences in Japan: https://sites.google.com/site/mamanokoe/

Source: www.childbirthconnection.org/listeningtomothers/

Guidance for Safe, Effective Maternity Care

Now available: thousands of **systematic reviews** about safety and effectiveness of specific pregnancy, childbirth, postpartum, and newborn practices

Sources include:

- Cochrane Pregnancy and Childbirth Group (more than 600)
- Cochrane Neonatal Group (more than 350)
- worldwide journal literature (largest source)
- technical report programs from government agencies

Widely dispersed: can be challenging to find and access.

Challenge for U.S. Maternity Care

Do our clinical practice guidelines reliably use high-quality evidence and available systematic reviews (SRs)?

Two analyses of evidence supporting recommendations in U.S. obstetrics guidelines found:

- 35-42% based on expert opinion or consensus (level C)
- 35-40% based on limited or inconsistent evidence (level B)
- 23-25% based on good and consistent evidence (level A)
- very limited use of systematic reviews

Sources: Chauhan SP et al. American Journal of Obstetrics & Gynecology 2006;194(6):1564-72. Wright JD et al. Obstetrics & Gynecology 2011;118(3):505-12.

Guidance for Safe, Effective Maternity Care

Without doubt, we need more knowledge to fill in gaps and evaluate changing maternity practices.

However, this large, growing body of systematic reviews can provide much valuable guidance for safe, effective maternity care practice.

Challenge for U.S. Maternity Care

Many evidence-practice gaps, including

- overuse of practices that waste resources and may cause harm
- underuse of many beneficial and generally safe practices
- broad practice variation across hospitals, clinicians, and geographic areas that cannot be explained by needs and preferences of women

Examples of Overuse in U.S. Maternity Care

- Labor induction
- Epidural analgesia
- Cesarean section
- Continuous electronic fetal monitoring
- Rupturing membranes
- Episiotomy

The Path to Improvement

Our report, *Evidence-Based Maternity Care: What It Is and What It Can Achieve* (NY: Milbank Memorial Fund, 2008)

- Framework for evidence-based maternity care
- Chapters on overused and underused practices with implications for large proportion of women and newborns
- Discussion of barriers to evidence-based maternity care
- Policy recommendations

Source: http://www.milbank.org/reports/0809MaternityCare/0809MaternityCare.html

Examples of Underuse in U.S. Maternity Care

- Smoking cessation interventions
- External version
- Vaginal birth after cesarean
- Continuous labor support/doula care
- Measures to bring comfort and promote labor progress
- Delayed and spontaneous pushing
- Non-supine positions for giving birth
- Delayed cord clamping
- Early skin-to-skin contact
- Interventions for breastfeeding initiation, duration
- Interventions for postpartum depression

Needs of Childbearing Women, Newborns

- Great majority of women and newborns are healthy and at low risk for problems
- U.S. hospital care routinely involves many interventions to start labor; hasten labor and birth; and monitor, prevent, or treat side effects of these interventions
- Appropriate maternity care makes judicious use of interventions, limiting them to situations when they are truly needed and supported by good evidence

Source: http://www.milbank.org/reports/0809MaternityCare/0809MaternityCare.html

Conclusion

Much of the maternity care women and newborns receive is not consistent with the best evidence despite unprecedented body of comparative effectiveness research to guide policy, practice, education, and quality improvement

Evidence-Based Maternity Care Framework

- Provide **effective care with least harm** to childbearing women and newborns
- Possible care paths often have very different benefit/harm profiles
- Give priority to effective paths that are least invasive, ideally with limited or no known harms

Consistent with: First, Do No Harm

Source: http://www.milbank.org/reports/0809MaternityCare/0809MaternityCare.html

Evidence-Based Maternity Care Framework

For women and newborns without special problems or risks, **effective care with least harm** generally protects, promotes, and supports their innate, mutually regulating hormonally driven processes for labor, birth, breastfeeding, and attachment

- These physiologic neuroendocrine processes — the biological foundation of childbearing — confer physical psychological, and social benefits
- These processes can help many women and newborns avoid risks of surgery, drugs, and other interventions
- Higher levels of care are appropriate for those with complications or special risks

CHILDBIRTH CONNECTION

Source: http://www.milbank.org/reports/0809MaternityCare/0809MaternityCare.html

Transforming Maternity Care Steps

- **Vision**: figure out where we want to go
- **Blueprint**: figure out how to get there
- **Implementation**: head off in that direction

Sources: http://www.whijournal.com/issues?issue_key=S1049-3867(09)X0008-3
transform.childbirthconnection.org

CHILDBIRTH CONNECTION

Evidence-Based Maternity Care Framework

Protect these processes by avoiding disruption and interference (e.g., needless intervention, noise, personnel)

Promote these processes through health system research, education, quality measurement, policies, values, etc.

Support these processes with skillful facilitation (e.g., comfort measures, encouragement, supportive care)

Few U.S. maternity care clinicians — primarily midwives — have core knowledge and skills for this type of care

CHILDBIRTH CONNECTION

Source: http://www.milbank.org/reports/0809MaternityCare/0809MaternityCare.html

Transforming Maternity Care Planning Phase

Multi-year collaboration with more than 100 leaders from across health care system, 2007-09:

- Multi-stakeholder ¥ benefit from diverse
- Multi-disciplinary / perspectives, experiences
- Open, transparent group process to reach consensus through discourse
- Two direction-setting papers:
  "2020 Vision" and "Blueprint for Action"

CHILDBIRTH CONNECTION

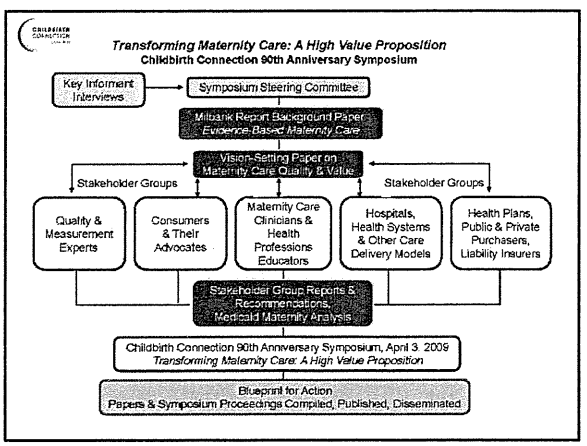
Source: http://www.whijournal.com/issues?issue_key=S1049-3867(09)X0008-3

How Do We Reliably Provide the Right Maternity Care at the Right Time?

- "Every system is perfectly designed to get the results it gets." — Paul Batalden
- "The definition of insanity is continuing to do the same thing over and over again and expecting a different result." — Albert Einstein

The solution is to change the system in which maternity care is delivered

CHILDBIRTH CONNECTION



Transforming Maternity Care: Looking Forward with Shared Perspective

- **A vision is:**
- a framework for possibility
- a long clear sightline radiating forward
- a statement of fundamental human desires
- an open invitation and an inspiration for people to create ideas and events that correlate with its framework

Source: Zander RS and Zander B. The Art of Possibility: Transforming Professional and Personal Life. New York: Penguin, 2000.

2020 Vision for a High Quality, High Value Maternity Care System

Fundamental Values and Principles

6 Aims, adapted Institute of Medicine definition of quality:

- woman-centered
- safe
- effective
- timely
- efficient
- equitable

Vision paper available at: http://www.whijournal.com/issues?issue_key=S1049-3867(09)X0008-3

Transforming Maternity Care: Looking Forward with Shared Perspective

- **A vision provides:**
- a focal point for change
- a clear, shared definition of the goals
- motivation to change, even when it is hard
- a rallying point that brings stakeholders together in service of a perceived greater good

Source: Kotter J. Leading Change. Boston: Harvard Business School Press, 1996.

2020 Vision for a High-Quality, High-Value Maternity Care System

Other Foundational Values & Principles for Maternity Care

- life-changing experience
- care processes protect, promote, and support physiologic birth
- care is evidence-based
- quality is measured, performance is disclosed
- care includes support for decision making, choice
- clinician satisfaction and fulfillment are core values

Vision paper available at: http://www.whijournal.com/issues?issue_key=S1049-3867(09)X0008-3

Transforming Maternity Care

2020 Vision for a High-Quality, High-Value Maternity Care System

- Fundamental values and principles that apply across the whole continuum of maternity care
- Goals for each phase and for providers and settings for maternity care
- Attributes of the larger system that can reliably provide high quality, high value care to all childbearing women, their newborns and families

Vision paper available at: http://www.whijournal.com/issues?issue_key=S1049-3867(09)X0008-3

2020 Vision for a High-Quality, High-Value Maternity Care System

Levels A & B: Women and their Support Networks, and Microsystems that Provide Direct Care

- care during pregnancy
- care around the time of birth
- care after giving birth
- key participants
- care settings

Source of level A-D framework: Berwick DM. A user's manual for the IOM's Quality Chasm report. Health Affairs 2002;21(3):80-90.

2020 Vision for a High-Quality, High Value Maternity Care System

Level C: Health Care Organizations

Envisioning system attributes that:

- strengthen the structure of the care delivery system
- strengthen the maternity care workforce
- foster high-quality maternity care
- provide woman- and family-centered care

Vision paper available at:
http://www.whijournal.com/issues?issue_key=S1049-3867(09)X0008-3

www.childbirthconnection.org

Fable to Illustrate the Vision

- Common response: "But we are already providing maternity care that is [fill in the blank: woman-centered, high-quality, evidence-based] now."
- The fable was developed to compare a woman experiencing common elements of care within the present system and her friend who experiences care within the envisioned system
- Brings to life implications of the proposed vision for women, newborns and families

Fable available at: http://transform.childbirthconnection.org/vision/allegory/
Vision paper available at:
http://www.whijournal.com/issues?issue_key=S1049-3867(09)X0008-3

www.childbirthconnection.org

2020 Vision for a High-Quality, High-Value Maternity Care System

Level D: The Macro Environment of Care

Envisioning system attributes that:

- strengthen performance measurement
- improve the functionality of payment systems
- strengthen professional education and guidance
- close priority gaps in research
- improve the functioning of the liability system
- pursue other strategies for fostering reliable delivery of high-quality maternity care

Vision paper available at:
http://www.whijournal.com/issues?issue_key=S1049-3867(09)X0008-3

www.childbirthconnection.org

Transforming Maternity Care

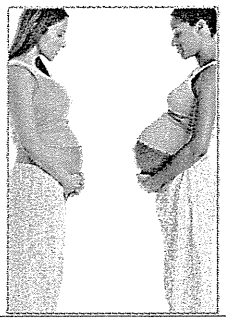
Blueprint for Action:
Steps Toward a High-Quality, High-Value Maternity Care System

"Who needs to do what, to, for, and with whom to improve the quality of maternity care over the next five years?"

Blueprint available at:
http://www.whijournal.com/issues?issue_key=S1049-3867(09)X0008-3

www.childbirthconnection.org

A Tale of Two Births
A Fable to Illustrate the Vision



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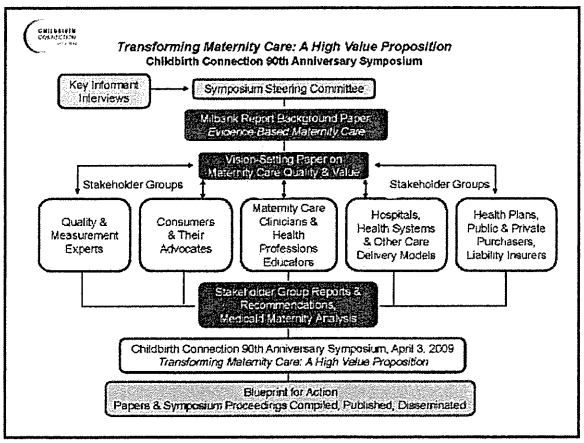


Blueprint for Action: Steps Toward a High-Quality, High-Value Maternity Care System

Critical focus areas common to all groups:

- Performance measurement and leveraging of results
- Payment reform to align incentives with quality
- Disparities in access and outcomes of maternity care
- Improved functioning of the liability system

Blueprint available at:
http://www.whijournal.com/issues?issue_key=S1049-3867(09)X0008-3

www.childbirthconnection.org

Blueprint for Action: Implementation, 2010-

Initiatives to achieve Blueprint recommendations by

- Childbirth Connection
- Childbirth Connection and partners
- others in the context of ongoing national and state health care reform and quality improvement

www.childbirthconnection.org

Blueprint for Action: Steps Toward a High-Quality, High-Value Maternity Care System

Additional critical focus areas (each workgroup chose 2 or 3 especially relevant to their sector):

- Scope of covered services for maternity care
- Coordination of maternity care across time, settings, and disciplines
- Clinical controversies (home birth, VBAC, vaginal breech and twin birth, elective induction, and maternal demand cesarean section)
- Decision making and consumer choice
- Scope, content, and availability of health professions education
- Workforce composition and distribution
- Development and use of health information technology (IT)

www.childbirthconnection.org

Blueprint for Action: Implementation, 2010-

Initiatives of Childbirth Connection include:

- website to support maternity care quality improvement: transform.childbirthconnection.org
- monthly eNews focusing on maternity care quality improvement resources
- advocate for childbearing women and newborns as national health care reform act provisions are implemented
- promote improvement of maternity care delivery system through Facebook, Twitter, Transforming Maternity Care blog

www.childbirthconnection.org

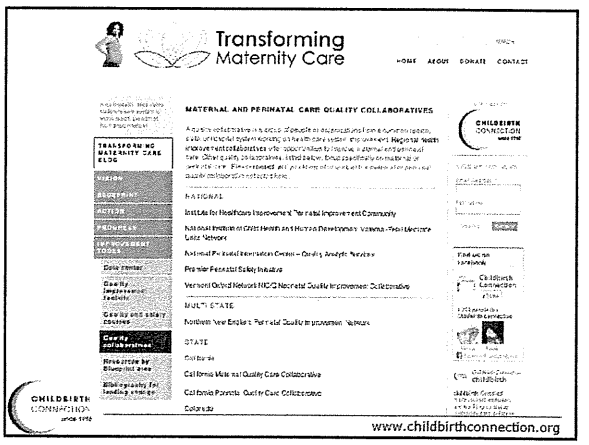
Blueprint for Action: Steps Toward a High-Quality, High-Value Maternity Care System

- Five stakeholder workgroups developed detailed sector-specific reports
- Actionable strategies in 11 critical focus areas
- Synthesized into a comprehensive Blueprint for Action by the Symposium Steering Committee
- Full stakeholder reports are published online at:

www.transform.childbirthconnection.org/

Blueprint available at:
http://www.whijournal.com/issues?issue_key=S1049-3867(09)X0008-3

www.childbirthconnection.org



www.childbirthconnection.org

Blueprint for Action: Implementation, 2010-

Initiatives of Childbirth Connection and partners include:

- with Foundation for Informed Medical Decision Making, a multi-year program to develop maternity care decision aids
- with American Congress of Obstetricians and Gynecologists and Senate and House offices, Quality Care for Moms and Babies Act filed in Congress
- with Institute for Healthcare Improvement, development of algorithm and clinician and women tools for most accurate gestational age dating
- with AMA Physician Consortium for Performance Improvement Maternity Care Work Group, develop priority performance measures for physicians

Rapid gains in maternity care quality, outcomes, and value are within reach.

Blueprint for Action: Implementation, 2010-

More initiatives of Childbirth Connection and partners:

- with Consumer-Purchaser Disclosure Project, develop model comprehensive set of maternity care quality measures
- with National Quality Forum, identify continuing and new perinatal quality measures for national endorsement
- with Catalyst for Payment Reform and Center for Healthcare Quality and Payment Reform, commission national report on cost of maternity care to drive payment reform
- with Louisiana Birth Outcomes Initiative, develop and implement comprehensive program to improve maternal and newborn health

Thank You!

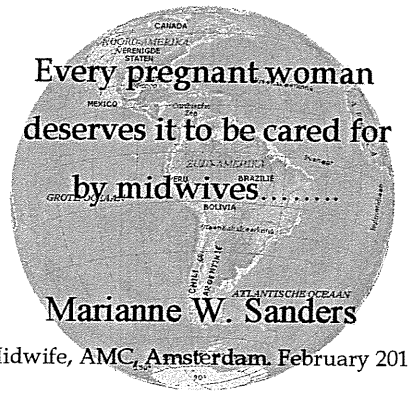
Carol Sakala, Director of Programs
Childbirth Connection
sakala@childbirthconnection.org

Request eNews: transform.childbirthconnection.org
www.facebook.com/ChildbirthConnection
twitter.com/childbirth

Blueprint for Action: Implementation, 2010-

Compatible initiatives in context of national and state health care reform and quality improvement:

- multiple groups working to test ways to align financial incentives with quality
- numerous collaboratives are working on maternity care quality improvement at state and other levels
- capacity of electronic health records to routinely and systematically measure and report performance is improving
- a growing number of reports clarify that rigorous quality improvement programs can quickly lead to plummeting liability claims, payouts, and premiums



Every pregnant woman deserves it to be cared for by midwives.....

Marianne W. Sanders

Midwife, AMC, Amsterdam. February 2012

Hi, collegues in Tokio

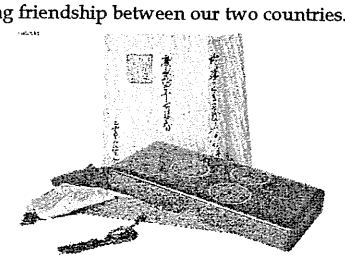
- こんばんは、ご来場の皆様、今夜ここへお集まりいただいた事に心から感謝をし、オランダからのご挨拶とさせていただきます。

Curriculum Vitae

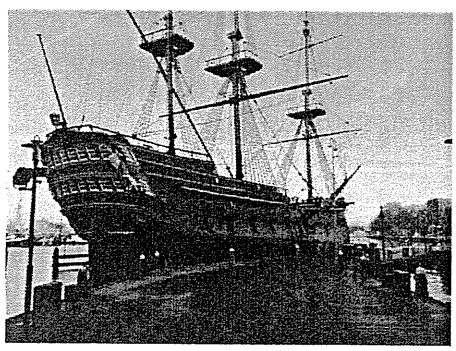
1976	Registered nurse, the Wilhelmina Gasthuis at the University of Amsterdam
1980	Registered midwife, Midwifery Academy, Amsterdam. Locum, part time teaching
1981 - 1984	Academic Medical Centre, primary and secondary care
1984 - 1999	Independent midwife, primary care, Amsterdam-North
1999 -	AMC, secondary care Home monitoring of high risk pregnancies Practical training of international student midwives: Dutch Midwifery Tour Secretary White Ribbon Alliance

Tokugawa Ieyasu

- The Year 2009: the 400th Anniversary of Trade Relations between Japan and the Netherlands and commemorates the longstanding friendship between our two countries.



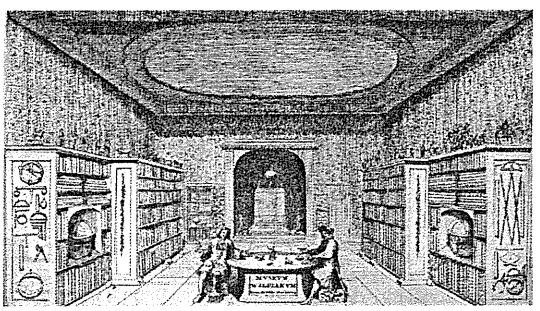
The Amsterdam



Amsterdam around 1650

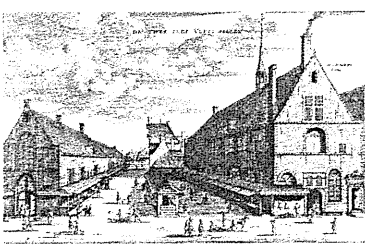
Obstetrical care in Amsterdam around 1700

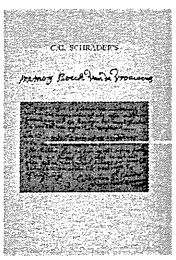
- 200.000 inhabitants
- 6000 deliveries per year
- 120-140 midwives and
- some (6-10?) barber-surgeons, specialized in obstetrics: 'obstetricians'



Czar Peter the Great (1672-1725) visits in 1697 the cabinet of Jacob de Wilde in Amsterdam.
He bought in 1717 the complete Ruysch collection of 2000 specimens.

Examination of midwives Amsterdam





C.G.Schrader. Memoryboeck van de Vrouwens
Het notitieboek van een Friese vroedvrouw
1693 – 1745, KNMG, UB Amsterdam.

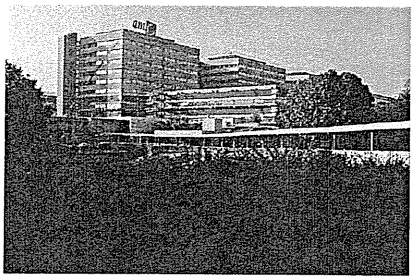
6 gevallen van placenta praevia totalis
op circa 3000 bevallingen = 2 per 1000.
2 vrouwen overleden door bloedverlies,
4 vrouwen hebben het overleefd.

Kloosterman GJ. Verloskundige kanttekeningen bij vrouw Schraders 'memoryboeck'. In: C.G.Schrader's Memoryboeck Van de Vrouwens MJ van Lieburg en GJ Kloosterman. Rodopi, Amsterdam, 1984, blz. 62-63.

Law practice medicine 1865

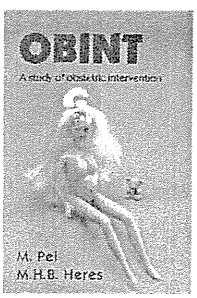
- "The midwives are authorized to provide assistance or medical advice, only in undisturbed natural course of parturition.
- In all other cases, they call on the help of a doctor in medicine, authorized in obstetrics. "

Academic Medical Centre, Amsterdam



AMC

A study of obstetric intervention



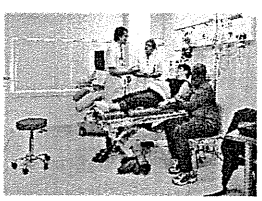
Thesis: Maria Pel (1995)
"A hospital that wants a reduction of the number of obstetric interventions, should engage midwives""

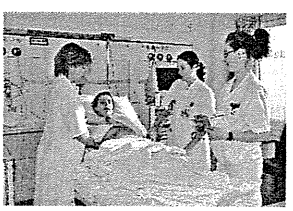
M.Pel et al. Provider-associated factors in obstetric interventions. Eur J Obstet Gynecol 1995

Midwives in AMC

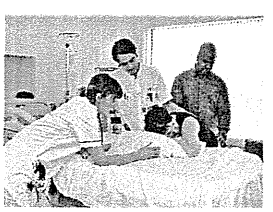
- Delivery department, 3 shifts in 24 hours
- Outpatients clinic, antenatal care
- Education of medical students
- Home-monitoring
- Ultra sound
- Research

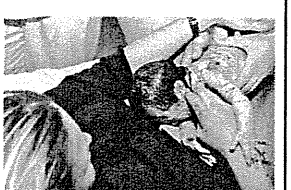
Midwife and medical student



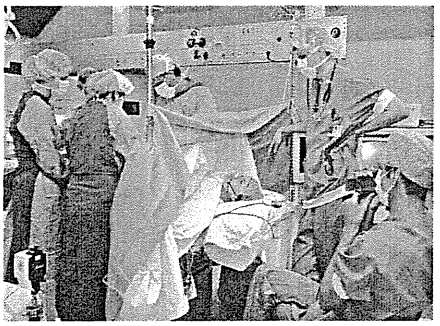


Care during birth





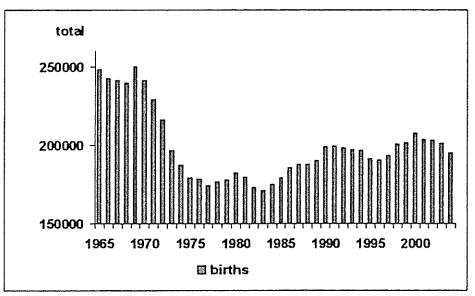
The theatre for C Sections, partner important.



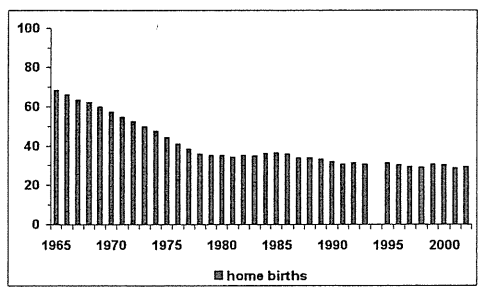
Basic assumptions

- Pregnancy, birth and childbed are physiological processes that can take place at home.
- Right care, right place, the right caregiver

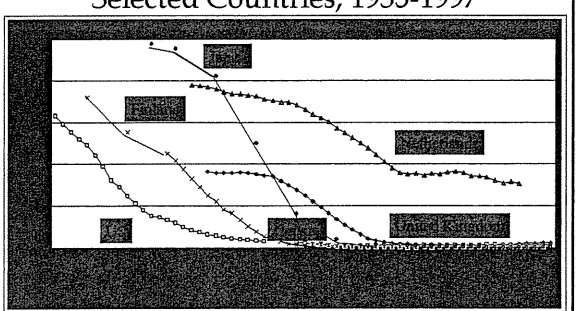
Births in The Netherlands

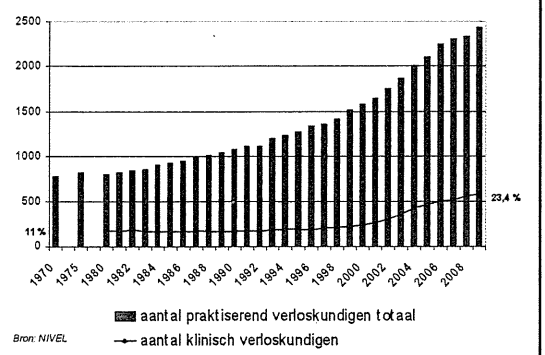


Home births in The Netherlands



Out of Hospital Births, Selected Countries, 1935-1997

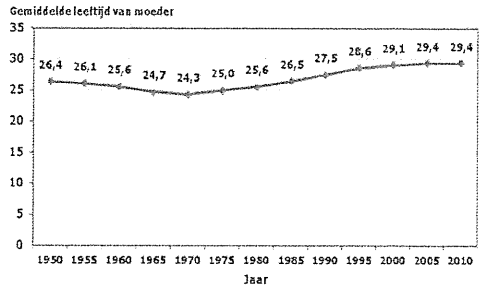




Midwives in The Netherlands

01-01-00	Midwives in total			1584
01-01-11 +938 Growth 59%	**Midwives in total** (Male collegues	2%		**2522** 47)
01-01-11	➢Independent practise	55%		**1382**
	➢Paid employment	34%		**733**
	-Secondary care		25%	641
	-Independent practise		6%	159
	-Health Centre		3%	65
Nivel	Locums	11%		**275**

Average age of the Dutch mothers



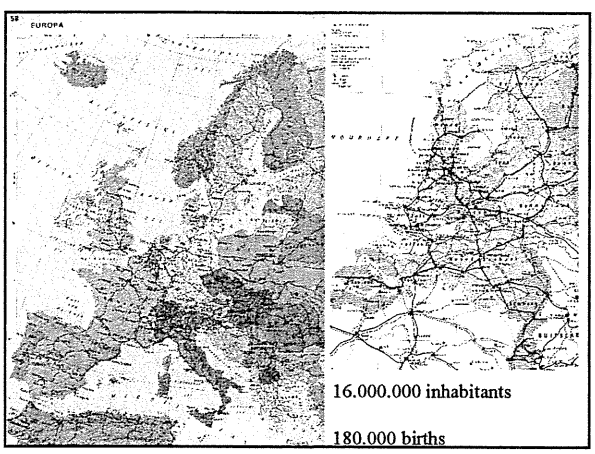
Expertise area of the midwife

Midwifery profession aims at:
optimum outcome

- Medical checks, risk selection, social checks and monitor all facts of pregnancy, childbirth and puerperium period
- Prevention of complications women / children:
  - Assessing obstetric risk : risk selection
  - Translating risk in obstetrical strategy
  - On the outcome of risk:
    providing medical advice and assistance

A successful system with natural and home birth needs:

- Appropriate screening for risk on complications: Education
- A well developed system of referral
- Appropriate (intrapartum) transport
- Direct care by an obstetrician
- A system of postpartum home care..



16.000.000 inhabitants

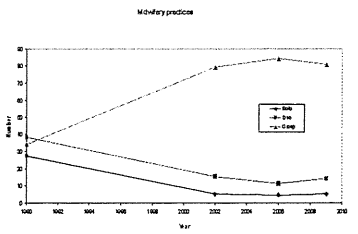
180.000 births

Birth assistent
Kraamverzorgster

- ➢ Assisting the midwife during birth and giving nursing care immediately afterwards
- ➢ Taking care of the new mother / new infant
- ➢ Giving information and instruction on (breast)feeding and baby care;
- ➢ Guaranteeing hygiene during birth and puerperium;
- ➢ Taking care of family members and other children;
- ➢ Doing household tasks.

DVD of the system

Midwifery practises / modules



Time table and finance midwifery care

Check ups during pregnancy → 10 to 12 times

Delivery → average 3-6 hours

Postnatal check up → 5 to 7 times

Postnatal check up at 6 weeks

Payment per complete care unit € 1200,00

Modern (future)care for low-risk women

- Embrace modern technology
- Well equipped home birth part of this technology
- Technology at a home birth
- Evidence based information to women

Maternity care system now

- Low risk women in primary independent midwife led care
- Choice between home and hospital birth
- Midwife assisted by maternity care assistant or obstetric nurse
- Risk factors or complications ⇒ referral to obstetrician

Obstetrical care in the Netherlands

- Primary care
- Secondary care
- Tertiary care

Obstetric manual

Subjects of the Obstetrical Manual/ Vademecum

- Design of obstetric co-operation
- Quality requirements for professionals in obstetrics
- Perinatal Audit
- Obstetrics ultrasound
- List of obstetrics indications

- Since Spring 1997, reviewed in 2003 and 2011.
- Available (in English) on Internet:
  http://europe.obgyn.net/nederland

Vademecum Divisions of care

Primary care	A
Consultation situation	B
Secondary care	C
Transferred primary care	D

Examples Vademecum

- Primigravida, healthy, 40 years
- Primigravida, epilepsy without medication
- Primigravida, a heart condition with haemodynamic consequences

• Primary care	A
• Consultation situation	B
• Secondary care	C
• Transferred primary care	D

- Multigravida, PPH in history
  (more than 1000 cc)
- Multigravida, ventouse / forceps in history
- Multigravida, kidney failure

• Primary care	A
• Consultation situation	B
• Secondary care	C
• Transferred primary care	D

Midwifery care

Primary care → low risk pregnancies
(physiological pregnancies)

- Midwives
- General Practitioners providing obstetrical care

Secondary care → high risk pregnancies
(pathological pregnancies)

- Obstetricians

Births in Amsterdam

- 2000 n = 10.643
- 2004 n = 10.596
- 2010 n = 10.700
-

n = 10.700
/ ¥

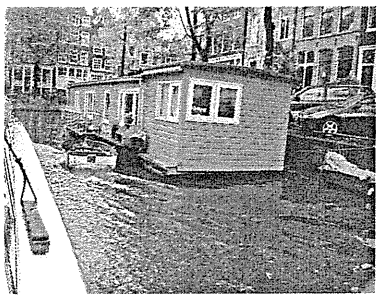
Primary care
n = 3500

Secondary care
n= 7200

70% home births
n = 2000

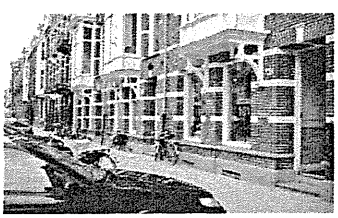
Houses in Amsterdam

Houses in Amsterdam

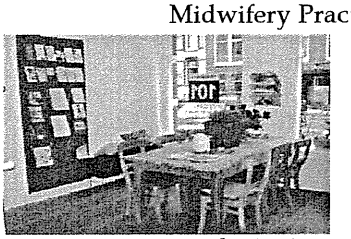


Midwifery Practice

" Johannes Verhulst "



Midwifery Practice



- Start in primary care 84.9%
- Home birth 30.3%
- Primary care hospital birth 10.2%

- Referral pregnancy spec. care 44.3%
- Referral labor spec. care 16.8
- Start in specialist care 15.1%

Research in primary care

- Interventions to prevent referrals to secondary care:
- Quality of care
- AROM at 42 weeks
- CIF >> to cephalic position, external version

Thesis 2011

- Interventions in midwife led care in the Netherlands to achieve optimal birth outcomes. Effects and women's experiences.

Marlies Rijnders, et al.
Research-Midwife
TNO, Child Health

June 2011 Amsterdam