



Midwifery in the Netherlands

2017



Colofon

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Introduction

The Netherlands is not only famous for its tulips and windmills, its maternity system is just as outstanding. The Dutch tradition of free choice of place of birth, including home birth, is quite unique in the western world. This leaflet will provide information about the Dutch maternity and midwifery care system and will shortly mention some of the challenges we face.

1 Midwifery in the Netherlands

1.1 Structure

In the Netherlands, maternity care is organised in a so called primary, secondary and tertiary care model. The primary care, for low-risk women, is formed by midwives and General Practitioners (GPs). GPs are responsible for about 0.5% of all births, mainly in rural areas (Nivel, 2011). The secondary care consists of obstetricians and clinical midwives in general hospitals and the tertiary care comprises obstetricians and clinical midwives in academic hospitals.

The care is based on the idea that a healthy woman with an uncomplicated pregnancy (low-risk) is best taken care of by a midwife. This minimises her chances of receiving unnecessary interventions of any kind, gives her a high standard of care and is cost-effective.

A woman is accompanied in her pregnancy, birth and postnatal period by a midwife who is autonomous in her actions and decisions. Emphasis is placed on natural processes, with interventions only occurring when a problem arises. In this case, the midwife will consult or refer to an obstetrician.

Risk selection, a clear distribution of tasks and a good mutual co-operation between these different strata forms the strength of the Dutch system.



1.2 Obstetric and Midwifery Manual

Since 1959 a comprehensive list of pre-existing, pregnancy and perinatal related disorders has existed, which optimises the risk selection and referral. This manual, called the obstetric intervention list ('VIL'), has been prepared in a dialogue between primary, secondary and tertiary care professionals. It should be noted, however, that the manual is a guideline, and health professionals have the option to make autonomous decisions.

The VIL indicates which type of care is indicated, by the following subdivision:

- A** the care of a primary care midwife is considered sufficient
- B** an obstetrician should be consulted
- C** the care has to be given by an obstetrician
- D** the natal care should be given in a hospital but can be supervised by a primary care midwife

Some examples of VIL-indications and disorders:

- A** Previous miscarriages, previous premature birth (>33 weeks), cystitis.
- B** Anaemia (<5.6mmol/l), pregnancy induced hypertension, psychiatric illnesses.
- C** Diabetes mellitus, >24 hours of ruptured membranes, meconium-stained liquor, multiple birth.
- D** Previous PPH (>1000mL), previous retained placenta (manually removed).

An update of the version from 2003 is initiated by midwives, GPs, obstetricians, paediatricians and government authorities. Some subjects already have been updated, however, the process still continues. Unfortunately, there is not an English translation of the manual available. [The Dutch version can be found here.](#)

1.3 Facts

Inhabitants	17.082.084 (CBS, 2016)
Active midwives	3150, 29% works in a hospital (Nivel, 2016)
Active Ob/Gyns	805 (CBS, 2014)
Total Fertility Rate	1.66 (CBS, 2016)
Maternal age at birth of 1 st child	29.4 years average (CBS, 2016)
Maternal age at birth ≤ 17 years	0.1% (Perined, 2016)
Live Births	170.510 (CBS, 2016), primips 44.7% (Perined, 2016)
Home birth	13.1% (Perined, 2016), 20.8% (CBS, 2010-2012), 29.4% (CBS, 2005-2007)
Birth in primary care	29.0% (Perined, 2016), 28.6% ('13, Perined, 2013), 32.8% (Perined, 2008)
Referrals during pregnancy	35.8% (Perined, 2016)
Referral during birth	22.4% (Perined, 2016)
Induction of birth	22.0% (Perined, 2016)
Caesarean section	16.6% (Perined, 2016)
Vaginal birth after caesarean (VBAC)	54% ('02-'03, NVOG)
Epidural pain relief (1 st stage of birth)	21.8% (Perined, 2016); 11.3% (Perined, 2008)
Maternal mortality	4.8/100,000 live births (Perined, 2016)
Perinatal mortality (≥22.0 wks-7 days)	7.6/1000 births (Perined, 2016)
Foetal mortality (≥22.0 wks)	4.6/1000 births (Perined, 2016)
Foetal mortality (≥37.0 wks)	1.0/1000 births (Perined, 2016)
Neonatal mortality (1-7 days)	2.6/1000 live births (Perined, 2016)
Neonatal mortality (1-28 days)	3.1/1000 live births (Perined, 2016)
Women who start with breast feeding	80% (TNO, 2015)
Women who breast feed 6 months pp	39% (TNO, 2015)

(Please find the mentioned figures at the following websites: [CBS](#), [Nivel](#), [PRN](#), [TNO](#))

1.4 Registration of perinatal data

All maternity caregivers; midwives, GPs, obstetricians and paediatricians, register their antenatal, natal and postnatal care and outcomes; 96% of all births are registered in this system (PRN, 2014). The data are collected and analysed by the Dutch perinatal registration ([PRN](#)), which is a governmental institute.

1.4.1 Obtaining data

If you want to obtain data about healthcare, midwifery and obstetrics in the Netherlands, you can consult the following organizations:

[Eurostat](#) (European Commission)

[National Public Health Compass](#) (Ministry of Health)

[Netherlands institute for health services research \(NIVEL\)](#)

The Health Council of the Netherlands
The Netherlands Perinatal Registry (PRN)
StatLine (Central Bureau for Statistics)

1.5 Education

There are three academies for midwifery in the Netherlands, in Amsterdam (our capital), Rotterdam and Maastricht. The first one also has a location in Groningen, in the north of the Netherlands. These academies are all part of universities for applied sciences:

Midwifery Academy Amsterdam and Groningen

Midwifery Academy Maastricht

(Zuyd University of applied sciences)

Midwifery Academy Rotterdam

(Rotterdam University of applied sciences)

Dutch midwives have not been trained as nurses! A Dutch nurse cannot work as a midwife and vice versa. Midwifery is a direct entry study

The tuition fee is set by the government and is €1984,- for Dutch students for the year 2016-2017. For some groups there can be another fee.

The midwifery training is a four year, fulltime, direct entry education which leads to a Bachelor of Science degree. The total study load is 240 ECTS and equals 6800 hours of education. A minimum of 100 ECTS are spend on internships in primary care (minimal 60 ECTS) and in secondary/tertiary care. These internships are spread over the four education years. Theory education, skills training and the bachelor thesis cover the remaining time. Students are primarily trained to become independent midwives in primary and



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secondary care.

Nationwide 220 students enrol each year. They have had an extensive assessment which selects the best candidates. Yearly, around four times more candidates apply for the course than places are available.

Students from abroad may be accepted when they are proficient in Dutch (NT2, level 2) and after their diplomas have been assessed by participation in an extensive assessment procedure.

Since there are many Dutch midwifery students that need placements for their training, it is difficult to arrange an internship for foreign student midwives. For more information please contact the KNOV at info@knov.nl.

Nuffic, a Dutch institute for international cooperation in higher education, launched a website for foreign students with lots of information

1.5.1 University level?

To maintain the strong autonomous position of Dutch midwives and the high level of care for low-risk women, it is important that midwives are empowered by being academically trained to a high standard. Attempts to bring the midwifery training to a Master of Science are still in progress.

1.5.2 Advanced education

A Dutch midwife who wants to continue her education in midwifery has the following options:

European Master of Science in midwifery (MSc)(Midwifery Academy Maastricht). This master prepares midwives to work in the field of research, health promotion and policy making (link: <http://www.av-m.nl/master-education>).

Health Sciences / Specialisation Midwifery Science (MSc) (Midwifery Academy Amsterdam Groningen / VU University, Amsterdam). This master prepares midwives to work in the field of research and policy.

Master physician assistant (MSc) (H, Rotterdam)

Clinical midwife (UMC, Utrecht)

These two programmes educate midwives to work in a hospital. Midwives must have employment in a hospital before they can enroll.

Teacher in midwifery, first degree (VU, Amsterdam)

1.6 Dutch midwifery research



Ank de Jonge (copyright: AVAG)

Almost 4% of all Dutch midwives have completed a master in midwifery science. So far, 27 midwives have acquired a PhD in midwifery science and several midwives are working on their PhD thesis.

All the academies have research departments focused on

Midwifery Science, conducting studies and PhD trajectories.



Raymond de Vries (copyright: AVM)

In Amsterdam, dr. Ank de Jonge, associated professor, is responsible for the Midwifery Science department at VUmc. In Maastricht, dr. Raymond de Vries is appointed as professor Midwifery Science and dr. Marianne



Hanneke Torij

Nieuwenhuijze as professor of Midwifery, in a collaboration between University Maastricht and Zuyd University of Applied Science. In Rotterdam, Hanneke Torij is professor of Maternity care in a collaboration between Erasmus

University and Rotterdam University of Applied Science.



Marianne Nieuwenhuijze

The Royal Dutch Organisation of Midwives, the KNOV, has initiated a Midwifery Science Board in 2011. It will stimulate evidence based midwifery by providing talented midwives with a PhD scholarship or a fellowship for post PhD midwives. Besides, the Midwifery Academy Amsterdam-Groningen provides funding for practising midwives who aim to obtain a master degree.

If you are interested in midwifery science in the Netherlands, there are several research initiatives that can provide you with more information:

Year index midwifery research

Kennispoort Midwifery

Midwifery Research Network Netherlands

Consortium for women's health and reproductivity studies

Netherlands institute for health services research (NIVEL)

Midwifery Science (Midwifery Academy Amsterdam Groningen)

Studies in progress

Academic Collaborative Centre (Midwifery Academy Rotterdam)

Studies in progress

Midwifery Science (Midwifery Academy Maastricht)

Studies in progress

1.7 Registration as a midwife

After finishing education, a Dutch midwife is obliged to register in a nationwide register for health professionals before she can actually work as a midwife. This so called BIG-register is open to the public. A midwife needs to renew her registration every five years. The most important requirement for on-going registration is a minimum of 2080 hours spent working as a midwife in five years. The title midwife (verloskundige) is legally protected.



1.8 KNOV

The Royal Dutch Organisation of Midwives, the KNOV, originates from a merging (1975) of several Dutch midwifery organisations. The oldest of these was founded in 1898! Currently, the KNOV has 3300 members. These are primary and secondary care midwives, midwifery students, midwifery scientists, midwifery teachers and retired midwives. Regionally midwives are organised in partnerships. These partnerships help midwives for example in collaboration with hospitals.

The KNOV has a board of five people which develops future policies. The president of the board is midwife Mieke Beentjes. These policies are executed by about 40 employees working at the KNOV-office.

The KNOV is engaged in several activities:

- Strengthening the position of midwives and midwifery by advocacy and lobbying.
- Improving the quality of midwives and midwifery practices. The KNOV offers schooling, it has developed several instruments for measuring quality and it supervises the quality register for midwives.
- Developing guidelines for midwifery care, in cooperation with other professionals, such as GPs, obstetricians and paediatricians.

- Publishing a magazine for midwives with a mix of midwifery science and current midwifery affairs.
- Hosting an independent complaints committee where clients of midwives can turn to.

In 2012, the KNOV released a vision statement about midwifery care in the Netherlands. Key issues are:

- Freedom of choice of place of birth for low-risk women.
- Focus is on the woman and her partner. All maternity care is organised around her and her family.
- Every woman has accessibility to a midwife, some will need an obstetrician as well.
- Continuity of care for each woman, integrating midwifery and specialist care.
- The midwife will be an academically trained midwife to maintain her independent, autonomous, medical profession.

1.9 Quality regulation

The KNOV has initiated a quality register for midwives in 2006. Registration is not compulsory, but around 80% of all midwives have registered so far. To maintain registration, a midwife has to have a digital portfolio showing a minimum of 200 hours of training and additional education over a period of five years.

The KNOV has also initiated a register for midwives who have advanced training and experience in external cephalic version (ECV) of the foetus.

Nearly 100 midwives have registered so far. To maintain her registration, a midwife has to perform a minimum of ten ECVs each year.

The quality of Dutch midwifery is also externally monitored by a government authority, the Health Care Inspectorate.



A steering committee with members of the KNOV and the Dutch association of obstetricians and gynaecologists (NVOG) is formed to formalise the position of the clinical midwife in legislation. Moreover, they want to determine the role and position of the clinical midwife and therefore a specialists register is required. Only midwives who have completed a master-education can be register in this specialists register. At the moment there are conversations with different parties and hopefully the specialists register is realised in 2017.

1.10 Working in the Netherlands

Midwives from abroad who are interested in practicing midwifery in the Netherlands must be able to communicate in Dutch (NT2, level 2). Their diplomas will be required to be assessed by the ministry of health, this procedure is free of charge. Depending on competencies and experience, it may be necessary to follow an additional course which gives an introduction into Dutch midwifery. The midwifery academy of choice offers the candidate a customized program.

If a midwife from abroad wants to work in the field of education, research or management, it is not necessary to register with the ministry of health.

Some midwives from abroad create their own employment as a doula or as a childbirth educator for expats.

The KNOV organises a yearly Dutch Midwifery Summer School to give midwives from abroad an introduction to the Dutch midwifery system. Upcoming summer school is scheduled for May 2017. Please contact the KNOV for further information, info@knov.nl

1.10.1 Midwifery practices



In 2015 there were 532 primary midwifery practices in the Netherlands (Nivel, 2016). Most primary care midwives work in group practices, with two or three colleagues. In total 96% of the women get some care of the primary midwife during pregnancy, labour or in the postpartum period. Midwifery practices have a specified working area to guard timely care. They offer prenatal consults during the week and have a

midwife on call 24/7. A shift normally last 24 hours. During this shift, a midwife combines both postnatal visits at home and natal care, at home or in the hospital. If she cannot visit a client in labour because she is assisting another client, she will call a colleague from her own or a neighbouring practice to attend to her client.

NIVEL is a Dutch institute for health services research, which publishes a yearly report about Dutch midwives. Email address: receptie@nivel.nl.

Approximately 5% of the Dutch midwives have a solo practice (Nivel, 2016). Often they have an agreement with a neighbouring practice to occasionally cover for them in order to allow them to have some time off. To enable them to take holidays, they usually won't accept new clients for a certain period each year. Of midwives 17.2% is locum (Nivel, 2016). These are mostly midwives who have just finished their education. In total 29.2% of all active midwives work in a hospital as a clinical midwife (Nivel, 2014).

1.10.2 Finances and insurances

Every midwifery practice has contracts with the different health insurances. All citizens of the Netherlands are obliged to insure oneself for standard care; midwifery care is included. The standard insurance for an adult is partly received through taxes. Additional to this the individual costs are around €1200,- plus an

Midwives obtain the following amounts for their given care (2017):

Antenatal € 487,05

Natal € 529,52

Postnatal € 294,18

Total: € 1310,75

These amounts are yearly adjusted by the Dutch Healthcare Authority

mandatory contribution of €385 each year. Children are covered free of charge until the age of eighteen.

Practices have a free choice in how to arrange antenatal care. The average number of consults is 10 to 12 times in one pregnancy, with distinction between in consult time of 10 to 45 minutes. Some practices incorporate a home visit at around 35 weeks of pregnancy, which is a recommendation from the government but comes without financial compensation until now. If care is only given for a part of the pregnancy, for example, due to miscarriage, change of midwife or referral to secondary care, that part of the pregnancy can be claimed by the health insurance. There are fixed prices for different care periods.

The remuneration for natal care is always the same amount, independently of birth duration or whether the woman stays under the care of a midwife or is referred to an obstetrician. Natal care starts when the membranes rupture or when contractions have started.

The financial compensation given for postnatal care is also always the same, independently whether the midwife visits the client only once or several times. A visit is often scheduled every other day for eight to ten days after birth and takes between fifteen minutes and

There is an additional budget for clients with poor socio-economic background. Whether the midwife can claim this extra amount (23%) is based on the zip code of the client.

one hour to complete. The midwife works closely together with a maternity assistant during the postnatal period.

If a midwife works fulltime, she will take care of the antenatal, natal and postnatal care of approximately 105 women annually.

As an independent midwife, you need to have indemnity insurance arranged by an agency. Fortunately, it is very rare in the Netherlands to get confronted with a claim. Many midwives choose to have invalidity insurance in case they are sick. Independent midwives are obliged to contribute to a pension fund for midwives.

1.11 Antenatal testing and ultrasound examination

Every pregnant woman in the Netherlands is informed about tests, that gives information about the risk that the baby has the Down's, Edward's or Patau's syndrome. The combination test has already been offered for several years and gives risk calculation. If the risk is 1:200 or higher, the client is subsequently offered a non invasive prenatal test (NIPT), a chorionic villi sampling or an amniocentesis. These additional tests are always performed in a hospital that has a specific licence for this purpose. From 1 April 2017 woman can also choose for the non invasive prenatal test (NIPT) as first screeningtest. This test gives more exact information about the chromosomes. The costs for both tests is around €175,-.

A second antenatal test that women can choose is the 20 weeks ultrasound. This ultrasound screens the foetus on congenital abnormalities like a spina bifida and heart defects. The 20 weeks ultrasound examination is performed in a hospital that has a specific license for antenatal testing. For the 20 weeks ultrasound the costs are covered by the health care insurance.

If the foetus suffers from a medical condition from which it will certainly die during or shortly after birth, or if it will be seriously handicapped, the parents have a choice to terminate the pregnancy until 24 weeks pregnancy.



Standard care for low-risk woman includes two ultrasound scans: one in the first term to set the due date and if necessary one at 36 weeks pregnancy to confirm the position of the baby. For additional ultrasounds there needs to be a medical indication. Ultrasounds are sometimes made by the midwife herself in her own practice, otherwise the woman is referred to a primary care ultrasound centre.

There is a lively debate about whether or not an extra ultrasound at 30 weeks pregnancy would reduce perinatal morbidity and mortality by detecting intra uterine growth retardation. The IRIS-study investigates this subject and hopefully first results will be presented in 2017-2018.

1.12 Centering Pregnancy

CenteringPregnancy™ is a health care concept originating from the USA, whereby a pregnant woman gets an active role in her care. Women with the same gestational age have group consults with 8 to 12 other women. The consults combine blood pressure measurement and examination of the fetal growth with awareness, sharing knowledge and experiences, learning health literacy and encouraging mutual support and friendship. These group consults last for 120 minutes.

The KNOV has a collaboration with TNO to implement CenteringPregnancy in Dutch midwifery practices. Nine practices participate in this pilot. Data about the following outcomes is collected:

- Client satisfaction
- Pregnancy outcomes

- Comparison of time investment with CenteringPregnancy and individual consults

Results from American research show that CenteringPregnancy decreases the change on premature birth and ensures that women have more knowledge, are better prepared on giving birth and are more satisfied with the care they received.



Copyright: CenteringPregnancy

Results of the Dutch pilot are expected in 2017.

1.13 Choice of home or hospital birth

Low-risk women may choose whether to give birth at home or in the hospital (outpatient clinic). This free choice of place of birth is quite unique in the (western) world and is an important pillar of the Dutch maternity system.

If a woman makes the choice for a home birth, her primary care midwife will attend the birth, assisted by a maternity assistant. The insurance company provides a maternity box, which contains bed protectors, maternity pads, gauze and sterilizing alcohol amongst other necessities. The midwife brings



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her own equipment, including a neonatal resuscitation set with oxygen. If complications arise, the midwife will refer to an obstetrician or paediatrician. Every hospital in the Netherlands accepts these referrals from primary care midwives. Midwives use ambulances for transport in high risk situations. Because of the good infrastructure, the median arrival time of an ambulance is ten minutes (Gezondheidsraad, 2011). The most common reason to refer a woman during birth is medicinal pain relief and/or slow progress of the first stage (16,3% of all referrals), followed by meconium stained liquor (8.8%) and prelabour rupture of membranes without contractions for more than 24 hours (4.1%) (Perined Insight LVR 1 2015). Of all referrals 1,9% is urgent.

If a low-risk woman opts for an outpatient birth she has to pay a contribution of about €300-400. Some health insurances cover this expense. Her birth will be attended by the primary care midwife who provided antenatal care and also attends home births. The midwife is assisted by a maternity assistant or an (obstetric) nurse who is employed by the hospital, this depends on local agreements. Usually, women with an uncomplicated birth leave the hospital in 2 to 4 hours after birth.

Women who have an increased obstetrical risk give birth in a hospital, without extra costs to themselves. A secondary or tertiary care professional will attend them during birth. This is either a clinical midwife, a general doctor or an obstetrician in training, who will call an obstetrician if complications arises.

An extensive cohort study about the safety of planned home birth versus planned outpatient hospital birth in the Netherlands showed that a planned home birth was just as safe as a planned outpatient hospital birth. This study included nearly 530.000 low-risk women and was published in the British Journal of Obstetrics & Gynaecology (BJOG, 2009).

1.14 Pain relief

During pregnancy Dutch midwives provide information about medical pain relief and they provide high quality of continuous support during birth. In this way they try to optimise their care and minimise the need for medical pain relief.

Currently, there are only a few birth centres where gas and air pain relief is available, which can be administered under the supervision of a primary care midwife. An adequate system of ventilation is necessary for health reasons, whereby such pain relief can only be administered in a hospital or birth centre and not at home.

Midwives can administer sterile water injections if they are competent in order to place these injections. This way of pain relief can be administered at a home birth.

When a woman is in need of medicinal pain relief, an obstetrician is consulted. Depending on the situation, the most appropriate method is selected. In general there are three types of medicinal pain relief used in the Netherlands, all of which are administered in hospital:



Epidural analgesia – This type of pain relief is always administered by an anaesthesiologist. Sometimes this specialist will come to the delivery room, in other hospitals the woman is transferred to the operation complex. In 2008, the Dutch association of anaesthesiologists agreed on the 24/7 availability of epidural pain relief for women in labour. When a woman receives an epidural, her care is the responsibility of an obstetrician and she and her baby will be monitored continuous during labour.

Remifentanil PCA i.v. – A second option of pharmacological pain relief is remifentanil. In the past, there have been some incidents of maternal breathing problems and thereby not all hospitals offer this option. When remifentanil is given, the responsibility for the delivery is shifted to an obstetrician.

Pethidine i.m. –An obstetrician can prescribe pethidine, sometimes combined with sleeping medication. After administration of the medication by a nurse it is depending on the hospital protocol whether the primary care midwife will continue the care immediately, after four hours, or that the woman gives birth under the responsibility of the obstetrician or a midwife working under supervision of an obstetrician.

1.15 Maternity services

A maternity assistant (in Dutch: kraamverzorgster) provides assistance during a low-risk birth at home or an outpatient hospital birth. Besides assistance of the mother she supports the mother during labour and provides care in the early postnatal period.

The first eight to ten days after birth the maternity assistant gives care at home to the mother and her newborn. If a woman has given birth in the hospital for medical reasons, she will also receive care from a maternity assistant at home. The maternity assistance performs medical checks, supports breast feeding, gives information, takes care of light household chores, prepares meals and takes care of other children if necessary. She is of great significance for the new parents and their baby and has an important prevention task.

Every mother is entitled to 49 hours of maternity care, 24 hours being the legal minimum. The amount of hours is calculated individually,



depending on factors such as hospital stay, choice for breast feeding or formula feeding and health status after birth. A midwife can indicate more hours of maternity care if necessary, maximal up to the tenth day. During the first postnatal week the midwife is responsible for the care given to mother and child. The basic health care insurance covers the expenses for the maternity assistant, apart from the contribution of €4,10 per hour which the parents have to pay themselves. Sometimes the health care insurance will cover these costs, if the parents are additional insured.

The maternity assistant has completed vocational education and training for three years. She is an employee at a maternity care organisation or she can be self-employed.

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1.16 Maternity leave

Women in the Netherlands have a minimum of sixteen weeks maternity leave. A woman can choose to start her leave between 34 or 36 weeks pregnancy, but not later. She always has a minimum of ten weeks of maternity leave after birth. So if a woman gives birth beyond her due date, she can get seventeen or even eighteen weeks maternity leave.

The government pays self-employed women a minimum wage for sixteen weeks. Often, these women (also midwives!) have an invalidity insurance which covers her income during maternity leave.

If a woman goes to work and gives breastfeeding, she is entitled for nine months after birth to use up 25% of her working hours to breastfeed or express breastmilk. The employer has to provide a separate room for this purpose or has to allow her to visit her baby.

Fathers receive up to two days of paid leave and three days of unpaid leave, the day of birth excluded

1.17 Current debate

In a global context, care for women and infants in the Netherlands is safe and well organised. However, Dutch maternity care is undergoing major changes in the last years.

After publication of relatively high perinatal mortality rates a steering committee has been commissioned by the government to give advice how the care can be improved. Since, there have been invested in better cooperation between the different caregivers and casus of perinatal mortality and severe morbidity have been discussed in audits to indentify substandard care. At this time, options for more integrated care (combined midwifery-obstetrician led care) are been examined with the goal to improve cooperation, provide more continuity of care en to give the woman the most appropriate care at any time. Different models are possible which also give a shift of competencies and finances. The efforts to improve care and decrease perinatal mortality has effect (Flenady et al,2016).

Also in Dutch maternity care a trend towards more medicalisation is seen. The rates of induction and medical pain relief have increased a lot in the last twenty years (Amelink-Verburgh et al, 2009; Offerhaus et al, 2013). On the other hand, the number of women giving birth with a primary care midwife or at home is decreasing (Perined Insight LVR 1). Especially the referrals in the last weeks of pregnancy en during the first stage of labour have increased. The changed policy on pregnancy induced hypertension en serotinity are partly the explanation for this change. As compared with 10-15 years ago, during labour more women are referred for wish for pharmacological pain relief and dystocia of the first



stage of labour (Amelink-Verburgh et al, 2009; Offerhaus et al, 2013). Many midwives hope that integrated care gives opportunities to give more continuity of care and has an empowering effect on the women like described in several articles (Lancet Midwifery series , 2014; de Jonge et al, 2014 van Haaren, 2014; Maassen et al, 2008).

The increase in referral rates and decrease of planned home births is possibly also due to the focus within society and in the press on the risks of childbirth (Christiaens et al, 2012; de Vries et al, 2014). Once in a while, safety of home birth and the Dutch maternity care model is featured in the press. At the same time 82% of women want to keep the possibility of the choice of home birth (TNS NIPO, 2013). Within this challenging context the KNOV and her members strive towards keeping pregnancy normal and safe by investing in evidence based integrated team work so that all women can receive continuity of care from a midwife plus the additional care of a specialist (obstetrician) when necessary.

1.18 International affairs



The Netherlands is a country with a long history of autonomous, independent midwifery. This makes it an ideal location for international organisations in this field.

The International Midwives (ICM), has its The Hague, our administrative

also represented in The European Midwives Association is based in Antwerpen, Belgium.



Confederation of headquarters in capital. The KNOV is (EMA), which board

Safe Motherhood

Dutch midwives are actively involved in Safe Motherhood through the KNOV charity midwives4mothers (m4m). This organisation helps to reduce maternal and infant mortality by empowering midwives in developing countries. Over the last years, they have built an intense collaboration with the midwifery association of Sierra Leone (SLMA) and the midwifery association of Morocco (AMSF) through their twin2twin project. In the twinning-projects 25 Dutch midwives were paired with 25 colleagues from Sierra Leone or Morocco and exchanged knowledge and experiences. Both projects lasted four years and were successful. The last project was completed in 2016. For more information see also Twitter and Facebook. If you want to learn more about the unique twin2twin method to empower midwives, developed by KNOV and Midwives4Mothers, please download the twintowin application in the appstore (available from June 2017)

