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MSc Social Policy and Public Health

Master's Project Thesis

Negative Birth Experiences (NBEs) in the Netherlands: A qualitative content analysis on the driving factors of NBEs from the #breakthesilence social media campaign

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Abstract

Introduction: Recently there has been increasing awareness on negative birth experiences (NBEs) that occur among women in the Netherlands. The Dutch social media campaign, #genoeggezwegen (#breakthesilence), shared the stories of these women who endured such negative and traumatic birth experiences. This study aimed to identify the driving factors of NBEs in the Netherlands by analysing the stories shared by the #GG campaign, in order to better understand why NBEs occur in the first place.

Methods: A qualitative content analysis study was conducted using an existing dataset of #GG stories collected from the 2016 campaign and produced by van der Pijl et al (2020). Stories were analysed through a deductive and inductive coding procedure using Bohren et al's work on the mistreatment of women during birth and the WHO framework on improving maternal care.

Results: 416 stories were included for analysis. Themes that were identified were: health system conditions and constraints; power dynamics between the care provider and client; poor communication; lack of professionalism; culture surrounding natural childbirth; lack of emotional support; discrimination; and misinterpretation of interaction between the care provider and the client. Managing expectations was identified as an overarching theme.

Conclusion: This study demonstrates how several factors can interplay and influence a woman's experience of birth. Such factors can be at the interpersonal level, in which clients may need to manage expectations better and care providers provide better care. These determinants, however, are accompanied by and may also be influenced by systemic/institutional level factors, implying that there are changes to be made at a structural level to prevent NBEs.

Introduction

While childbirth is often a celebrated event, navigating labour and delivery is no simple task. When birth complications arise or when things do not go as the woman has planned, childbirth can be quite traumatising for women and may lead to adverse short- and long-term effects on their mental health, such as post-partum depression or post-traumatic stress (PTS) (Griffiths, 2019; Fontein-Kuipers et al., 2015). Sometimes, depending on the woman's mental health history, a birth experience may be so distressing that it can even result in post-traumatic syndrome disorder (PTSD) (Fontein-Kuipers et al., 2015; Perdok et al., 2018). While studies have yet to determine the extent of the problem, it is estimated that millions of women worldwide experience trauma from delivering their child (Griffiths, 2019). For these women with negative birth experiences (NBEs), it can be quite difficult to talk about NBEs due to fear of being perceived as a bad mother or as ungrateful for their baby. Consequently, such experiences are often not shared (Griffiths, 2019).

However, women are now raising awareness of this stigmatised issue by sharing their stories of NBEs, mostly through social media (Marsh, 2018). Around the world, women have reported incidents of mistreatment during childbirth, which usually took place in health facilities (WHO, 2015). One systematic review on the mistreatment of women during childbirth found that mistreatment can be divided into seven domains, which were also identified in other similar studies: physical abuse; sexual abuse; verbal abuse; stigma and discrimination; failure to meet professional standards of care; poor rapport between the women and providers; and health system conditions and constraints (Bohren et al., 2015). These practices contribute to NBEs and, depending on how they perceived these practices, women can suffer from trauma (Griffiths, 2019). Because many women worldwide have NBEs in health facilities, health systems may need to make changes to avoid NBEs (WHO, 2015). This is not only because NBEs are detrimental to mental health, but also because they may discourage expecting mothers from seeking maternal health care services for future deliveries. This could result in undoing global efforts in increasing the number of women worldwide

to access these services (WHO, 2015). Therefore, there is a global need to improve maternal care services in a way that it mentally and emotionally supports women during childbirth in order for them to have a positive birth experience (PBE), as well as reduces the likelihood of maternal mortality or morbidity.

The Netherlands is no exception to this need. Previous literature has estimated that more than 16% of women in the Netherlands had NBEs, while around 10% of women in the Netherlands suffer from either PTS or PTSD following their NBE (Rijnders et al., 2008; Stramrood et al., 2010). In 2016 and 2020, *Geboorte Beweging* (The Birth Movement) organised the Dutch social media campaign #*genoeggezwegen* (#breakthesilence). This encouraged women, birth companions, and care providers to share NBEs that they have experienced, witnessed, or contributed to (Geboorte Beweging, 2020). This movement helped raise awareness on the existence of the mistreatment of women in the Dutch maternal care system, and by doing so, emphasised the importance of also caring for the wellbeing of mothers, not just their physical health.

While it is evident that there are cases of NBEs in the Netherlands, what remains unclear are the underlying reasons behind this. Understanding why it happens can increase the likelihood of designing effective strategies and interventions to prevent NBEs happening in the first place. Hence, the aim of this research is to understand the reasons why NBEs occur in the Netherlands.

Existing research and theoretical framework

What does quality maternal care look like?

The prevalence of NBEs of women during childbirth suggests that it is not just a matter of a few individual incompetent care providers; rather, it implies that changes in policy and health systems are warranted to ensure that women have their needs met and that they receive quality,

respectful care. This, in turn, implies that people-centred care is essential in the maternal health care system (Freedman & Kruk, 2014).

In 2016, the WHO published a multidimensional, conceptual framework in their report 'Standards for improving quality of maternal and newborn care in health facilities' which health professionals can use to improve the quality of maternal health care in the context of the health system (Figure 1). Quality in maternal care entails timely, appropriate care that is aligned with professional knowledge and considers the preferences and desires of the individual women and their families (WHO, 2016).

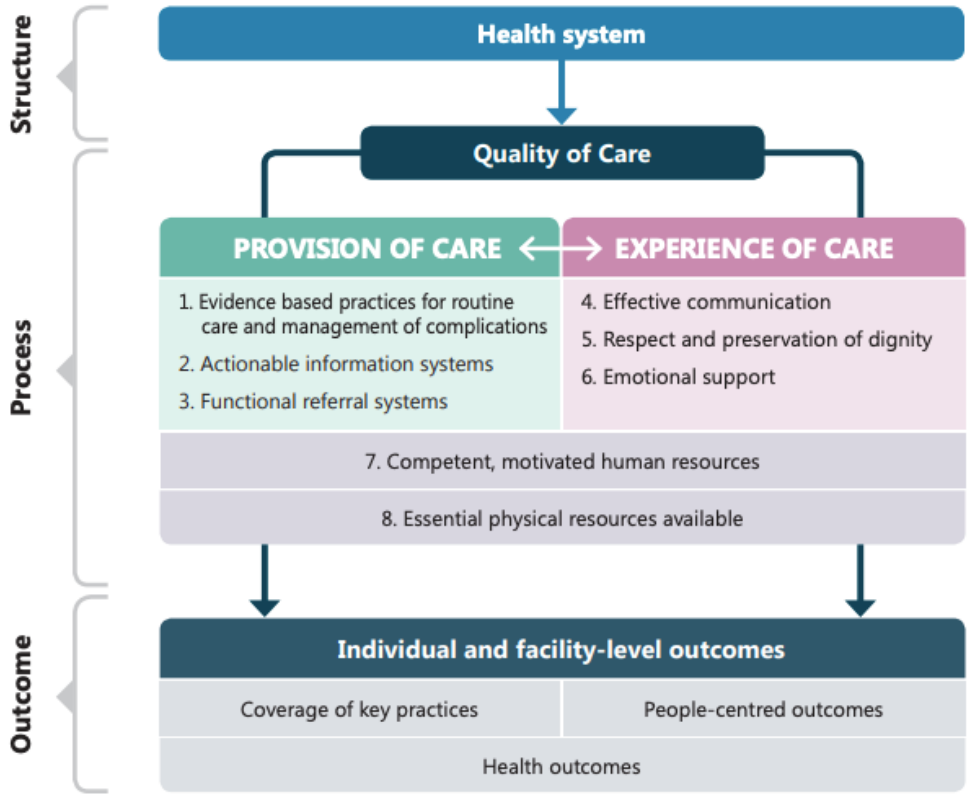

Figure 1: WHO framework for the quality of maternal and newborn health care (WHO, 2016)

In this framework, the health system provides the foundation in which quality of care can be improved, which in turn comprises of two interlinked dimensions: the provision of care (PoC) and the experience of care (EoC). Within these dimensions are eight standards of care (SoCs) that should be met. PoC includes 1) Evidence based practices for routine care and management of complications 2) Actionable information systems and 3) Functional referral systems. EoC entails 4) Effective

communication 5) Respect and preservation of dignity and 6) Emotional support. Cross-cutting SoCs include 7) Competent, motivated human resources and 8) Essential physical resources available. Improvements within these eight SoCs should lead to progress in the coverage of key practices, people-centred outcomes, and health outcomes (WHO, 2016).

According to WHO, EoC contributes to the advancement of health outcomes and the development of people-centred outcomes. This means it results in care that takes into consideration the personal preferences of women and, if applicable, the culture of their community. Following the framework, experience of care should be able to achieve these outcomes via communication, respect and dignity, and emotional support (WHO, 2016). As this current study concerns itself with maternal wellbeing, it focuses mostly on EoC, though PoC may also affect EoC according to the framework.

The SoCs can be further divided into quality statements, which are brief statements of priorities that indicate when quality of the domain has been achieved (WHO, 2016). Firstly, under the SoC related to effective communication, quality statements recommend that women and their families are provided with information about maternal care and have effective interactions with staff. Clients should experience coordinated care with clear, accurate information exchange between health professionals. Secondly, with regards to receiving care with respect and dignity, women should have privacy around the time of childbirth, and their confidentiality should be respected. Additionally, no woman should be subjected to mistreatment. Women should also be able to make informed choices in the services that they receive or are offered, and interventions or outcomes should be justified and clearly explained. Lastly, to provide emotional support, every woman should have the choice to experience childbirth with the companion of her choice, and that she receives support that increases her capability to give birth (WHO, 2016).

While people-centred outcomes is desirable in this model, there seems to be a “blind-spot” in that health authorities around the world have not paid enough attention to the occurrence of

NBEs of women in the maternal health care system (Freedman & Kruk, 2014). By researching the underlying reasons behind NBEs, there may be deeper insight into the structural issues of the maternal health care system, reflecting the poor performance of a health system in terms of quality as well as accountability. This is because it appears that health systems are not always being held accountable for the NBEs of women, particularly mistreatment of women, nor for the working conditions that may influence how individual care providers care for women (Freedman & Kruk, 2014).

NBEs of women in the Netherlands

Unfortunately, the WHO SoCs in the maternal care system are not always adopted or adhered to. Previous research in the Netherlands has investigated the types of NBEs that occur during childbirth in the Dutch health system (van der Pijl et al., 2020; M. Hollander et al., 2017). In one study by van der Pijl et al., women's NBEs from the Dutch social movement *#genoeggezwegen* were collected and the following recurring themes were found, all of which did not align with the WHO SoCs: lack of effective communication; failure to provide care with respect and dignity through use of force and lack of informed consent; and poor emotional support, particularly in cases of short- or long-term trauma following the delivery (van der Pijl et al., 2020). Interestingly, it was also found that NBEs was experienced equally in hospitals with obstetricians and at home or birthing centres with midwives, indicating that women have NBEs independent of the type of care provider or location and that improvement is needed at all levels of the Dutch maternal care system (van der Pijl et al., 2020). In another study, Dutch women mostly expressed that it was because of the lack of effective communication between themselves and the care providers that they had NBEs, mostly through: a discrepancy between the women's and the care provider's understanding of certain procedures; loss of autonomy and trust in the birth process; and conflict during negotiation of the birth plan, for example, against medical advice. The participants of the study also stated that after their previous NBE they searched for different care for their next birth delivery, usually a more

'holistic' midwife outside of the Dutch maternal care system, due to a major conflict or disagreement with their previous obstetrician or midwife (M. Hollander et al., 2017).

Very limited research has been done on the prevention of NBEs in the Netherlands, mostly focusing on those which led to trauma and PTSD (de Graaff et al., 2018). In one Dutch study, women with NBEs suggest care providers to: communicate or explain; listen (more); and support (more or better) emotionally or practically. Following WHO standards, this indicates that Dutch care providers need to improve on communicating effectively, providing emotional support, and ensuring that practical support is done in a respectful and dignified way. In the same study, 37% of women felt that they themselves could not have done anything to prevent the NBE, while others said that they should have asked for (26.9%) or refused (16.5%) specific interventions (M. Hollander et al., 2017). Again, this suggests there is lack of effective communication as these women were probably either insufficiently informed of interventions or they did not feel like they could speak openly to their provider. Another study observed that non-confrontational communication strategies enabled Dutch midwifery students to develop a trusting relationship with women. However, the students felt conflicted due to discrepancies between their own professional midwifery values and the preferences of women (Sanders et al., 2018). Once again, effective communication is necessary here to ensure that care providers can still implement good practice while also meeting the needs of women. Overall, there is still a need for better strategies to improve relationships between women and care providers in the system, and this may be achieved through a better understanding of these relationships.

The Dutch maternity care system

Dutch maternity care is divided into primary, secondary, and tertiary levels. Primary care comprises of midwives and General Practitioners and is reserved for low-risk women. Secondary and tertiary care involves obstetricians and clinical midwives, however, secondary care takes place in general hospitals while tertiary care is in academic hospitals (KNOV, 2017). Additionally, according to

the Royal Dutch Association of Midwives (KNOV), since 2017 there has been a push towards integrated maternal care which combines midwifery- and obstetrician-led care in order to improve continuity of care (KNOV, 2017).

It is interesting to note that in Dutch culture it is relatively more common compared to other Western countries for women with low-risk pregnancies to have natural childbirth, whether that is at home or in a facility without medical intervention (Johnson et al., 2007). In fact, it used to have the highest proportion of births occurring at home compared to the rest of Europe (Dreaper, 2010). However, with the medicalisation of childbirth and more women being scared to give birth at home, this reduced from 80% to just 13% of women between 1950-2015 (DutchNews.nl, 2017). Despite more Dutch women today choosing to have facility-based births, there seems to be a trend in recent years of expecting mothers refusing to be referred to hospitals for childbirth even if they are considered to be at high risk of complications (Holten et al., 2018). In one Dutch study, it was found that those who chose to give birth at home, even after being advised by medical professionals against it, often times did so due to previous NBEs with facility-based births (M. Hollander et al., 2017).

Drawing from these studies, it seems that care providers within the Dutch maternal care system need to improve their services for women to have PBEs. A way to do this seems to be through establishing more personal relationships and continuity of care, that is, to maintain a close and continuous relationship between the woman and the care provider (Gulliford et al., 2006). This, in turn, could contribute to care that fosters effective communication, respect and preservation of dignity, and emotional support. One study in the Netherlands observed an association between experienced continuity of care and experienced quality of care during labour. It also found that continuity of care was significantly higher for women who were in midwife-led care compared to obstetrician-led care (Perdok et al., 2018). Holistic midwifery, in particular, is increasingly popular. It is characterised by its high continuity of care and more multidimensional care that especially focuses

on the psychological, emotional, and spiritual needs of the client (M. Hollander et al., 2019) (University of Minnesota, 2016). Though holistic midwives are trained formally and can legally provide medical care, they work outside of the formal Dutch health system and place more importance on the natural process of childbirth. Holistic midwives seem to be fulfilling a need for women who feel that the formal Dutch maternal care system has failed them and for women who want a better relationship with their care provider (M. Hollander et al., 2019). Although holistic midwives provide an alternative solution, this still begs the question of how relationships between care providers in the system and women can be improved to prevent NBEs in the first place.

Potential drivers for NBEs during childbirth

In addition to determining the types of mistreatment during childbirth, the systematic review by Bohren et al also suggested potential reasons that mistreatment occurred. These include: the prioritisation of good health outcomes for the mother and the baby, for example, through forcing an unconsented medical intervention unto the mother; the power dynamics between the care provider and the mother; misinterpretation of interaction between the care provider and the mother; poor communication skills of the care provider; and health system conditions and constraints. The latter factor is interesting in that it suggests that it is not only because of the individual behaviour of care providers that women have NBEs, but that it is also because of the organisation of the health system. Bohren et al makes a distinction between health system factors that directly and indirectly contribute to the mistreatment of women. Ways in which health system issues can directly cause the mistreatment of women is through, for example, a lack of resources such as partitions that allow women to have more privacy, particularly during more invasive procedures like vaginal examinations. Indirect effects, meanwhile, can be experienced through lack of medications or poor infrastructure. This can lead to more stressful working conditions and consequently care providers behaving poorly. Shortage of staff can have both direct and indirect effects: no staff to attend to women can directly result in women feeling neglected, while the extra burden on the remaining staff can leave staff feeling stressed and act poorly towards women. Thus,

in addition to being a type of mistreatment, health system issues may also offer contextual explanations as to why mistreatment occurs (Bohren et al., 2015).

Therefore, the WHO cross-cutting SoCs can also be applied as these relate to the human and physical resources of the health system. With regards to human resources, quality statements recommend that all women should have access to at least one skilled birth attendant and support staff at all times. These skilled birth attendants and support staff should also have the appropriate competence and skills mix to meet the requirements of childbirth care. Additionally, health facilities should have managerial and clinical leadership that is responsible for developing and implementing appropriate policies and creating a supportive working environment for staff. Under physical resources, quality statements recommend that water, sanitation and energy supplies, medicines, and supplies and equipment for routine maternal care and management of complications should be available (WHO, 2016).

Research question

A substantial amount of research globally and in the Netherlands has previously identified different types of NBEs of women in the maternal care system. However, there seems to be insufficient research on the influential drivers of NBEs in the Netherlands. To that end, the current study's research question is the following: "What factors contribute towards negative birth experiences of women in the Netherlands?". Based on existing literature on the responsibilities of health systems to improve maternal care from Freedman and Kruk (2014), WHO (2016), and van der Pijl et al. (2020), as well as on the popularity of the informal practice of holistic midwifery from Hollander et al. (2017), I expect that the main issue at hand is not merely at the interpersonal level between the woman and the care provider, but also at the structural level of the health system.

Research methods

Design, procedure, and sampling

This study investigated stories of NBEs shared during the #genoeggezwegen (#GG) campaign in 2016. This was done by analysing secondary data from an existing dataset created by van der Pijl et al (2020), which consisted of textual transcripts of the #GG stories posted on social media. In the original data collection, all pictures that were posted by *The Birth Movement* on their Facebook page were downloaded. The textual content of these pictures were transcribed into a Word document. Some individuals shared their #GG story in multiple pictures. In these cases, the textual content of the pictures posted by the individual were combined into one story. These stories are in Dutch and range in length from two to 350 words. This type of research was suitable to answer the research question due to the diverse and vast sample of stories, each about NBEs, that could be collected and analysed.

The dataset was produced by the original researchers to determine the types of disrespect and abuse that occur during childbirth by analysing the stories submitted by mothers. By contrast, this current study investigated the drivers behind NBEs using perspectives shared by care providers and birth companions in addition to mothers. Excluded stories include those that were duplicate, those that only showed gratitude for the #GG campaign, and those that solely described subjective feelings without mentioning external factors, and thus not offering additional context. Selected stories were translated from Dutch to English by the author (NG) and a volunteer assistant (TH). Stories were stored on the qualitative data programme Nvivo for coding analysis.

Data operationalisation

The drivers of mistreatment and the WHO SoCs have been integrated into a singular overarching framework (Table 1). This table was used to guide the categorisation of the textual content of the #GG stories.

Potential drivers of the mistreatment of women	Potential elements	Standard of care potentially violated
Power dynamics between care provider and mother	Extreme/coercive measures to gain compliance from the mother Not providing care if mother was noncompliant Undesirable actions by the care provider were deemed necessary for the mother's and baby's health outcomes	*No. 4, No. 5, No. 6*
Misinterpretation of interaction	Unfair blame placed on care provider Birth complications	*No. 4*
Poor communication skills of care provider	Forgetting to communicate with mother Avoiding communication with the mother because it was repetitive	*No. 4*
Health system conditions and constraints	Lack of resources Lack of policies Facility culture	*No. 5, No. 6, No. 7, No. 8*

Table 1: Potential drivers of the mistreatment of women (Bohren et al., 2015; WHO, 2016)

Data analysis

A qualitative social media content analysis was carried out and was conducted using a deductive and inductive coding procedure. Textual transcripts were coded according to the drivers of mistreatment identified by Bohren et al (2015). However, because Bohren et al. focused solely on factors of mistreatment of women by care providers and not NBEs in general, an inductive coding procedure was done to allow further investigation into possible factors of NBEs. This procedure was done by identifying any additional emerging themes and categorising them accordingly. Inductive coding was guided by the WHO framework and existing literature.

Consideration of ethical aspects

The original data collection from van der Pijl et al was deemed by the medical ethics committee of Amsterdam UMC as not requiring ethics approval. The anonymised dataset is now publicly available online as a supporting document to the research article. Original posts of the #GG stories was not searched for in order to avoid linking the textual transcripts to the individuals who posted them. Data analysis was carried out on the VPN of Utrecht University.

Results

Of the 533 stories that were in the dataset, 117 stories were excluded while 416 stories were included for analysis (Figure 2). Most of the stories were from the perspective of the woman who gave birth (381), while others were from the birth companion's (8) and care provider's (27) perspective. A large majority of the stories were describing the childbirth stage (labour and delivery) or immediately afterwards, while the rest described prenatal care and postpartum care. A few stories described other types of situations such as stillbirths, miscarriages, and interactions with professionals other than care providers. Most of the stories described a combination of these situations, for example, sharing the experiences of the pregnancy as well as the birth. The setting of the stories differed, with most of them taking place at the hospital (214) and some at home (12). Other stories involved both settings or a transfer to the hospital (31), while the rest were unclear as to where the story occurred. Care providers were identified in 303 stories, including the: doctors (17); gynaecologists (110); midwives (130); nurses (77); assistants (14); anaesthesiologists (11); trainees (32). Interventions mentioned in the stories included Caesarian sections, vaginal examinations, suturing, epidurals, and episiotomies. Stories were written in different formats including prose, poetry, bullet points, quotations, and screenplay format. The stories in Dutch ranged from 14 words to 308 words.

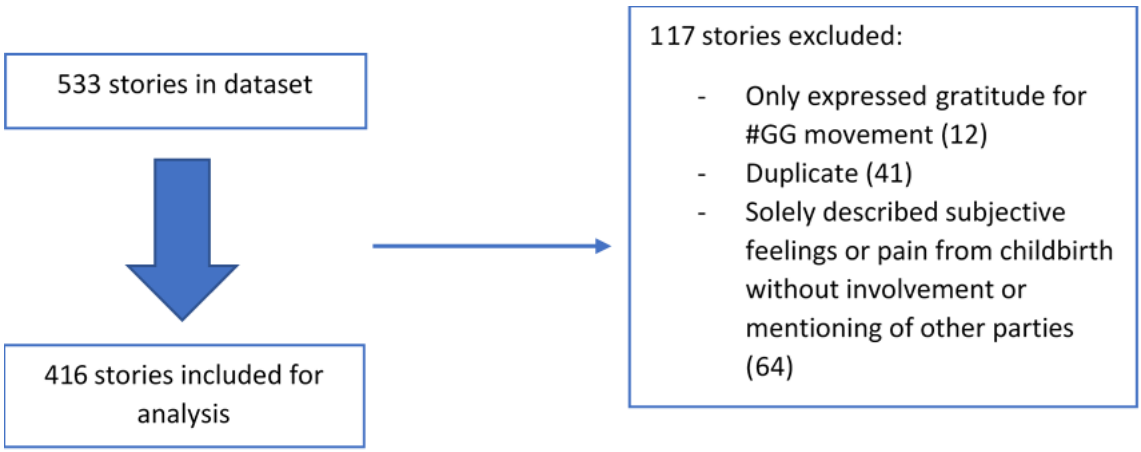

Figure 2: Exclusion/inclusion flowchart

With almost all stories it was difficult to determine with certainty if a care provider was actually at fault, especially if an action was deemed necessary. It was also not possible to validate the stories. Therefore, all stories were analysed at face value. For example, if a mother described that she felt like she was not taken seriously by the care provider, this was noted as such.

Drivers of NBEs from deductive and inductive coding

From the process of inductive coding, five additional themes emerged: lack of professionalism; culture surrounding natural childbirth; lack of emotional support; discrimination; and the role of the birth companion. Overall, the most common themes to appear were power dynamics between the care provider and client, followed by health system conditions and constraints, and then poor communication between the care provider and the client. All themes are presented in Table 2 below.

Potential drivers of NBEs	**Elements**	**Number of references**	**Standard of care violated**
Role of the birth companion		***9***	***No. 6***
	Birth companion absent	4	
	Birth companion did not provide emotional support	2	
	Birth companion did or could not intervene	3	
Discrimination		***17***	***No. 5***
	Age	2	
	Beauty standards	6	
	Racism	3	
	Sexism	2	
	Sizeism	3	
	Other	1	
Hospital was too far		***2***	***No. 8***
Lack of emotional support		***93***	***No.6***
	Denial of birth companion	14	
	Complex emotional needs not addressed	18	
	Food and drink not provided (sufficiently)	7	
	Grief support not provided	4	
	Woman not allowed/supported to adopt preferred position	22	
	Woman not allowed/supported to choose birthplace	4	
	Woman not allowed/supported to cope in her own way	24	

Lack of professionalism of the care provider		***116***	***No. 4, No. 7***
	Unprofessional behaviour	47	
	Not intervening when woman wanted help	8	
	Care provider not used to childbirth	3	
	Poor training	11	
	Care provider made a mistake or performed poorly	41	
	Forgetting to care for the woman	6	
Misinterpretation of interaction/unfair blame		***170***	***No. 4***
	Birth complications	83	
	Undesirable interventions or actions were deemed necessary (for the woman's and baby's health outcomes)	46	
	Care provider's actions were unintentional or they thought that they were helping	10	
	Woman (went) against instructions or advice	31	
Natural childbirth		***33***	***No. 4, No. 5, No.6***
	Culture/sentiments surrounding natural childbirth	11	
	Pain relief not provided	22	
Poor communication between care provider and woman/birth companion		***305***	***No. 4***
	Care provider avoiding communication because it was repetitive	0	
	Woman was ignored	59	
	Improper, little, or no introduction from the care provider	14	
	Care provider seemed insensitive or indifferent	156	
	Woman was not (sufficiently) informed	76	
Power dynamics between care provider and woman		***459***	***No. 4, No. 5, No. 6***
	Woman was blamed, shamed, or belittled	52	
	Extreme or coercive measures to gain compliance from the woman	57	
	Lack of accountability from the care provider	18	
	Lack of consent from the woman	127	
	Lack of dignity for the woman	60	
	Lack of respect for the woman	100	
	Not believing woman or not taking her seriously	60	
	Not providing care when woman is noncompliant	5	
	Reluctant to provide care or advice to woman	27	
	Convenience for the care provider	28	
Power dynamics between care provider and woman: Forced medicalisation of childbirth		***182***	***No. 4, No. 6***
	Baby taken away	37	
	Forced interventions	81	

	Undesirable interventions or actions were deemed necessary (for the woman's and baby's health outcomes)	46	
	Unnecessary action	18	
Health system conditions and constraints		***211***	***No. 5, No. 6, No. 7, No. 8***
	Busy environment	21	
	Facility culture - Bribery and extortion - Unclear fee structure - Unreasonable requests of women by care providers	0 0 0 0	
	Lack of policy (redress)	4	
	Lack of resources - Care provider not present - Physical conditions - Staffing constraints - Supply constraints	69 37 1 22 9	
	Lack of time, rushing	49	
	Long waiting time	42	
	Protocol	10	
	Work hierarchy	16	
Health system conditions and constraints: Discontinuity of or interrupted care		***226***	***No. 3, No. 4, No. 5***
	Birth plan changed or ignored	42	
	Change of shifts	15	
	Discrepancy between care providers	20	
	Incorrect information on the woman's file	2	
	Multiple care providers	83	
	Transfer to hospital	31	
	Unknown care provider	33	

Table 2: Themes coded from #GG stories according to deductive and inductive coding (Bohren et al., 2015)

Power dynamics between care provider and mother

Over half of the stories demonstrated the power dynamics between the care provider and the woman, with the care provider usually being more dominant and taking almost complete control over the birth, often showing a lack of respect for the woman or birth companion. Women often expressed that care providers carried out interventions, against the woman's wishes, that were deemed necessary by the care provider for the mother's and baby's health outcomes.

[…] "I'm going to do an episiotomy," said the midwife. I did not consent. "But he has to get out NOW". I didn't want a cut. She cut. (story 162, mother's perspective)

Sometimes this goes as far as taking extreme or coercive measures to gain compliance from the mother, such as emotionally threatening the mother or the birth companion that the mother or the baby will die.

[…] I should never have said to your husband, "Do you want to raise your children on your own?" just to achieve a hospital birth... (story 429, midwife's perspective)

Other times, care providers placed the woman in great physical distress to ensure that she complies, such as tying her up to the bed.

[upon learning an emergency C-section was required]: I panic and try to climb off the bed. I am pushed onto the bed, pants taken off, catheter, and to the OR. I am totally baffled when they tie my arms and cut my belly open. […] (story 114, mother's perspective)

Care providers sometimes blamed mothers for the NBEs, or suggested that the mother did not handle the birth well. Other times care providers avoided accountability if they made an error or had no substantiation for their actions when women tried to blame them.

[…] At my request for scientific substantiation for the usefulness of her interventions: she did not have to justify herself, years of experience. […] (story 160, mother's perspective)

Sometimes care providers did what was most convenient for them, though this may be due to their poor working conditions. However, this did not always mean that it was ideal for the mother as well.

I once broke the water of a woman in labour. Without explanation. Without asking for permission. Because I wanted it to "hurry up", because I wanted to go home ... I'm deeply ashamed! (story 257, midwife's perspective)

Power dynamics can also be reflected in the medicalisation of childbirth procedures, where care providers force medical interventions upon the woman giving birth.

> *I wanted a natural childbirth. In the end I was stuck with an epidural in my back, blood pressure monitor in my left arm, an IV in my right arm, 2 vaginal probes / I was shaken all over my body. […] (story 436, mother's perspective)*

Lack of emotional support

In about a fifth of the stories, mothers described that they did not have the emotional support that they needed to endure childbirth. This includes not having their chosen birth companion with them, which was sometimes due to the care provider not allowing them to accompany the mother, which may be due to the hospital's own policies.

> *[…] My husband was not allowed to come, despite our begging, he shouted, this way I'm going to miss the delivery! […] (story 306, mother's perspective)*

Sometimes mothers were not allowed to adopt their preferred position for labour or delivery, which would have helped them cope with childbirth mentally and physically (WHO, 2016). The reasons for this were not usually clear, however in some stories it is implied that it was either not convenient for the care provider or it was not found to be optimal for the delivery.

> *I pleaded several times after yelling on the bed again, "I have to get up, this isn't working! ". But nobody listened ... all eyes were set on my crotch. Pulling [the baby's] head, tugging on my stomach ... and all because the doctor did not find the birthing stool practical. (story 105, mother's perspective)*

Some women had complex emotional needs, for example due to trauma from a previous birth or sexual assault or due to pre-existing mental health conditions. However, they did not always receive emotional support from their care providers.

I knew about your trauma, she knew about your trauma. She had her fingers in you, you said stop, she did not stop. I stood by and watched and said nothing. I was not protecting you. Sorry! (story 435, midwife's perspective)

Poor communication between care provider and mother

In over a third of the stories, care providers made comments that suggested indifference and lack of sensitivity towards the mother. In many of these stories, the care provider seems to be unfazed by what are probably very commonplace medical procedures whereas the mother is unfamiliar with them.

What would have been a normal delivery by through labour induction, it suddenly turned out that my son was going to be a difficult delivery. The female gynaecologist said, just go and have a solid cry, then we would have the drama done and over with and then we can prepare you for the operation. […] (story 75, mother's perspective)

Sometimes care providers did not provide enough information to the mother, if at all, and often did not introduce themselves or did so inappropriately. Consequently, women often felt uninformed and disrespected.

[…] Gynaecologist left without saying anything.
[…] And another gynaecologist was called, came to have a look without introducing himself, looked between my legs and just shook his head and left again. […] (story 128, mother's perspective)

Other times, care providers ignored questions or comments coming from the mother or birth companion and only continued doing what they were doing, again leaving the woman feeling uninformed.

My orders stated: “Stop the vaginal examination when I say 'stop' ". There is an examination. I say "Stop", but she does not stop. My husband says, "Hey she says 'stop'! ". She just keeps going. (story 70, mother’s perspective)

Lack of professionalism

In about a quarter of the stories, mothers described the lack of professionalism among care providers. In half of these stories, the care provider appears to be poorly skilled or made errors which contributed to or worsened the mother’s NBE.

[…] I got an infection due to improper stitching of the episiotomy. (story 295, mother’s perspective)

Often it was a trainee who was given too much responsibility or improper supervision that errors were made or that an intervention was more unpleasant than normal. Occasionally, supervisors encouraged trainees to practise on mothers, without obtaining consent, leaving the mothers to feel like a test subject. Other times, trainees had to take over because the (highly) skilled care provider was not available, which in turn may be due to staff constraints.

[…] It was going to be a good lesson if the intern stitched me. The suture would dissolve by itself. The consequence; an infected torn suture and a whole ugly scar now. (story 381, mother’s perspective)

In the other half of these stories, the care provider displayed negative attitudes and appeared to be grumpy, snappy, or angry towards the mother or birth companion. However, these attitudes in turn may be attributed to the working conditions.

[…] after a hellish first 24 hours of the childbirth, I indicated to the midwife and the anesthesiologist that I can no longer do it, I was exhausted...
I was snapped at that I shouldn't act like a princess ...[…] (story 310, mother’s perspective)

In a few of the stories, care providers did not step forward to intervene when the mother felt distressed due to another care provider. Such inaction on the care provider's part, or the mother's if she did not request further assistance, may contribute to NBEs.

> *I stood there and I watched. Watched how to put aside the wishes of the woman in labor. I was not protecting her. I kept my mouth shut. I still feel guilty about this :((story 256, midwife's perspective)*

Health system conditions and constraints

In over a third of the stories, conditions and constraints due to the health system seemed to contribute to mothers' NBEs. This may be because of the lack of resources and staffing constraints, which could exacerbate the busy environment of hospitals and also lead to long waiting times, as well as rushing deliveries.

> *[…] There was no room for me in the overcrowded maternity ward. Me and my newborn son were shoved into a small room, where we spent the rest of the night alone. (story 299, mother's perspective)*

> *I realize that I am part of a health care system that makes it impossible to provide the best personal care for every woman. Nor have enough time. […] (story 252, midwife's perspective)*

Some stories suggested that the workplace for care providers can be hierarchical. This sometimes meant that care providers were reluctant to contact their superiors, leading to a delay in receiving proper care.

> *[…] at 5.24am my son was born. The placenta would not detach and people were scared to call the gynaecologist out of bed […] The gynaecologist came at 8:00. (story 239, mother's perspective)*

Other times, care providers felt pressured to act in a certain way to please or maintain a good relationship with their superiors.

> *The gyn allowed me to finish the delivery. He wanted an episiotomy. I didn't think the episiotomy was necessary. Still, I cut you open ... I thought a good relationship with the gyn was more important than to spare your suffering... I'm sorry! (story 449, midwife's perspective)*

Health system constraints: Discontinuity of or interrupted care

In almost half of the stories, discontinuity of care was implied, which may also be an indicator of the constraints of the health system. Of these stories, most stated that there were multiple care providers involved. This sometimes overwhelmed and exhausted the mother, particularly when there was a shift change at the hospital.

> *Change of shifts while I was on the operating table waiting for a Caesarean section. "I don't like your attitude! " someone snapped, because I didn't feel like shaking their hand during my contractions with the umpteenth person. […] (story 106, mother's perspective)*

Transfers, shift changes, and multiple care providers also meant that not only was the mother dealing with a lot of unfamiliar faces during vulnerable moments, it sometimes meant that discrepancies or disagreements between care providers occurred. This led to delayed or undesired care. Interestingly, in some cases transfers occurred out of convenience for the care provider. This again may suggest poor working conditions.

> *Despite GBS bacteria, both gyn and midwife had given positive advice at home to return home the same day after delivery. Paediatrician on duty thought otherwise and said brutally that I should not contradict her and could safely go but my child had to stay.[…] (story 336, mother's perspective)*

Broke your water without consultation, hoping for meconium. So that I had an excuse to transfer your case to someone else and go to bed. (story 442, care provider's perspective)

Sometimes the birth plan of the mother was changed, without consultation or consent, or was completely ignored by the care provider.

[…] My cry for their help was not heard. Our birth plan was ignored UNTIL it turned out to be too late, then suddenly it had to be looked at. Because it went faster than they thought. […] (story 305, birth companion's perspective)

Discrimination

In a few of the stories, mothers received offensive and judgmental remarks from their care providers regarding their (young) age, race, sex, size, or how their body looked. Such stories reveal that there are perhaps more deep-seated societal issues in Dutch maternity care.

I was 17 when I had my first child. When I was crying at 8 cm and pushing I said I could not last much longer, the nurse said that I "should have thought that when [I] had sex. Old enough for sex is also old enough for the pain of childbirth. " […] (story 365, mother's perspective)

[…] The first attempt to get the epidural failed: I "was too fat," said the doctor. He grumbled to the nurses in front of me about my disturbing size… (story 98, mother's perspective)

[…] I cried out: we're done now!
the doctor said yeah well, there's always women who are going to be difficult about everything. (story 520, mother's perspective)

Culture and sentiments surrounding natural childbirth

As mentioned previously, natural childbirth tends to be encouraged and medicalisation is avoided as much as possible in Dutch culture because childbirth is not perceived as a medical issue but rather a

natural process (Johnson et al., 2007). This is sometimes seen in the stories, with care providers either downplaying the mother's pain, denying requests for pain relief, or ignoring the mother when pain relief was not working.

> *[…] Every request for an epidural was ignored, "your body can never hurt more than you can handle". And she gave a dafalgan. In the end I screamed in pain. […] (story 275, mother's perspective)*

The opposite can also be observed, with many women desiring more natural procedures even against the care providers' opinion. These situations often led to forced medical interventions, as shown previously, or putting their own health or baby's health at risk.

Misinterpretation of interaction

In almost all stories, it was possible that mothers placed unfair blame on the care provider, however, this is difficult to determine. Nevertheless, unfair blame may be more likely if the mothers themselves wanted to go against medical advice or disobey instructions. This could lead to misinterpretation of the interaction with the care provider if the care provider just wanted to ensure the safety of the mother or only had good intentions.

- *growth ultrasound, 10 weeks: the heart had stopped beating. I could take the pills or directly have a curettage, but I wanted my (healthy) body to do this itself. "That is really dangerous, madam ". […] (story 233, mother's perspective)*

> *[…] Despite my good intentions, this was not always in the interest of the mother… (story 448, midwife's perspective)*

Other times, mothers may already be primed for NBEs or poor interactions with the care provider if they were having birth complications that would inevitably result in more interventions and interactions, or a more painful delivery. Such complications include pre-eclampsia, tearing, or breech births, among others. Although the women in the stories did not explicitly attribute their NBEs to

their birth complications, birth complications may still be an important influential factor in how women experience the birth.

Overarching theme: Expectation management

In all stories, it was evident that mothers were expecting their care to proceed in a different way, or that their care provider would act differently. This discrepancy between expectations and reality could lead to women feeling disappointed and having a NBE.

> *It was agreed that I would not be left alone during the delivery. That was forgotten! […] (story 383, mother's perspective)*

> *My delivery was initiated at my request. When I got a wave of contractions from the contraction inducers that had been administered for a whole week, a nurse said: "What are you whining about? You wanted this yourself, didn't you ?! " (story 469, mother's perspective)*

Discussion

Following previous research on identifying the types of mistreatment that occurs in Dutch maternity care, this thesis explored the drivers of negative birth experiences of women in the Netherlands through analysis of the #genoeggezwegen stories posted on social media.

Expectation management was an overarching theme that was identified. Managing expectations has been linked to overall experience of childbirth; the less a woman's expectations are fulfilled, the more likely she is to have a NBE (Karlström et al., 2015). One explanation for this could be that they were not sufficiently informed. The reasons for their insufficient knowledge, in turn, could be due to the health system failing to successfully communicate with clients and to develop realistic expectations with them prior to childbirth (Fenwick et al., 2005). However, it could also be due to the woman's own level of health literacy. Maternal health literacy (MHL) is the ability of the

mother to access, understand, and apply information to optimise her own and her baby's health (Phommachanh et al., 2021). High MHL can enable mothers to be better informed, form more realistic expectations, and thus more likely to have a positive birth experience (WHO, 2016).

One of the main themes in the stories was the power dynamics between the care provider and the mother, with often the care provider having a more dominant role in the birth procedure or exerting control over the woman. This phenomenon has been documented in previous research. In one study conducted in Turkey, care providers use more "authoritarian" attitudes towards women and defended their approach by explaining that their medical knowledge justifies this type of attitude (Cindoglu & Sayan-Cengiz, 2010). In a South African study, nurses felt superior to their patients because of an interplay of factors including organisational issues, professional insecurities, and a need to assert control and their professional and middle class identity (Jewkes et al., 1998). Consequently, having such medical authority can lead to care providers preventing women from being able to make their own informed decisions (Altman et al., 2019). This, in turn, may contribute to women feeling that they have lost their autonomy, which has been previously linked to NBEs (van der Pijl et al., 2020).

Power dynamics can be further reflected in stories where births were forcefully medicalised. For example, care providers may enforce their medical authority through carrying out undesirable (and often forced) interventions or actions that were deemed to be necessary for the woman's and baby's health outcomes (Cindoglu & Sayan-Cengiz, 2010). On the other hand, this also raises the questions to what extent were forced medical interventions actually necessary from a medical perspective – and if they were necessary, to what extent were women's expectations of maternal care improbable or unrealistic, thus contributing to NBEs. Additionally, women sometimes went against instructions or advice provided by the care provider and did not appreciate being reprimanded when doing so. Again, such input from the care providers may not necessarily be given solely because of their own desire to control the birth but because it was necessary for the woman's

and baby's health. Thus, such interactions may have been misinterpreted by the women. Nevertheless, having noncompliant clients raises an ethical dilemma of how much freedom a woman can have in dictating how her delivery should proceed if it is at the expense of her own or her baby's health (Schyns-Van Den Berg et al., 2018).

Poor communication between the care provider and client was another common theme among the stories. In this study, care providers talked to the mothers in an insensitive or indifferent manner to the woman's situation, and in such a way that they seemed desensitised towards childbirth and its procedures. This has been described in previous research in which care providers either: fail to recognise that some routines may be traumatic for the mother; felt that procedures that are commonplace to them are unfamiliar for the mother; or placed much more attention to biomedical care rather than social or emotional care (Flacking & Dykes, 2017) (Shakibazadeh et al., 2018). Another way in which poor communication was demonstrated was in how clients were not always (sufficiently) informed of certain interventions or actions, or were ignored. In the stories, it was not always clear why women were not sufficiently informed, though previous research has suggested reasons such as care providers being so busy that they forgot to communicate with the woman (Kruger & Schoombee, 2010) or that explaining every action was too repetitive for the care provider (García-Jordá et al., 2012). Interestingly, in stories where women were ignored by the care provider, about half of them involved lack of informed consent, implying that the medical authority of care providers may also play a role in how communication is conducted between care providers and clients. Furthermore, because the stories implied that there were discrepancies between the client's expectations and reality, this further highlights the importance of care providers to clearly and respectfully communicate to women and birth companions. This is especially important if they are not able to fulfil those expectations.

While it is apparent that individual care providers contribute to NBEs, the #GG stories also suggest more systemic issues at hand, namely lack of resources, long waiting times, and lack of time.

A literature review found that some of the most significant factors contributing to poor working conditions in health facilities include long working hours, shift work, physical infrastructure, and shortage of staff. It also found that such working conditions can have a negative impact on the physical and mental wellbeing of health care workers (Manyisa & van Aswegen, 2017). As a result, care providers under stress from poor working conditions may be prone to displaying unprofessional behaviour and having poor interactions with clients, leading to NBEs (Bohren et al., 2015).

Stories from care providers offer an interesting perspective on the hierarchical structure of facilities, with some implying that they did not want to challenge the hierarchy while other stories also showed that they could not authorise certain actions without their senior colleague. This often meant waiting for the more senior care providers to be available to provide care, or that they did not want to be reprimanded by their senior colleague if they were to intervene or disagree with an action. This fear of challenging the hierarchy among care providers is understandable as workplace bullying within the health care sector has been documented in previous research, the victims of which tending to be care providers who were younger (and so likely to have less experience), female, and lower in the organisation hierarchy (Ariza-Montes et al., 2013). Consequently, certain care providers may choose to preserve their relationships with other colleagues over providing quality care to clients.

Lack of policy on redress is another apparent systemic issue. Health facilities, as well as individual care providers, did not always properly address women's complaints. This left women without redress among other consequences. Facilities not holding themselves or care providers accountable could lead to women feeling more discouraged to come forward to file complaints (Bohren et al., 2015). This also means that facilities miss the opportunity to learn from their mistakes and improve their services, and thus NBEs would only continue to happen.

Another systemic issue was found in the discontinuity of care. With multiple, unfamiliar care providers and changes in birth plans, women in the stories may have had NBEs due to loss of

autonomy and dignity as well as poor information exchange between care providers. Continuity of care during childbirth is known to be crucial and has been supported in a systematic review which found that continuous support throughout labour and delivery has many health benefits for the mother and the baby (Hodnett et al., 2013). It would be interesting to see how birth experiences may change if the Dutch maternal care system has already been working towards a more integrated model of care since 2017 (KNOV, 2017).

Strengths and limitations

Currently, this may be the first study that explores the drivers of NBEs in the Netherlands, and also the first that analyses NBEs from #GG stories provided by care providers and birth companions in addition to stories. The additional perspectives, in turn, provide more context and perspectives on why NBEs occur, with care providers even sometimes explaining why they carried out a certain action. Thus, including these perspectives enable a more comprehensive understanding of NBEs. Because this may be the first study to explore drivers of NBEs in the Netherlands, it was particularly important to carry out inductive coding to identify new themes and sub-themes. This was complemented by deductive coding, which allowed for coding the drivers that had been previously determined in prior research and further strengthened this study.

Analysing stories that were shared on social media brought its own benefits and drawbacks. As acknowledged by the previous researchers van der Pijl et al. (2020), these stories offered substantial and unique insight into the types and ways in which NBEs occurred in Dutch maternity care due to the unfiltered character of social media posts. However, they were limited in length (they were shared on A4-sized posters) and thus missing a lot of, and possibly crucial, context. Stories were also almost always told from one perspective, so it was difficult to see if an action was intentional or if a woman was overreacting. Some stories were written in poor Dutch, and so interpretations might not have always been accurate. Missing context and perspectives, as well as poor writing skills, meant that with all stories it was not possible to validate them nor was it possible

to determine who was actually at fault. This is especially the case when a vast majority of the NBEs occurred during labour and delivery when the woman was in a vulnerable state and emotions were running high. Additionally, as also acknowledged by van der Pijl et al. (2020), it was not clear how long ago these stories took place, while with other stories it was mentioned that it had taken place almost a decade ago. This meant that there is a possibility of "recall bias" or that the stories "may stem from an earlier era that no longer represents present-day maternity care" (van der Pijl et al., 2020). As a result of all these limitations, the actual cause of the NBE in every story was not always clear-cut.

Another limitation is that findings of this study cannot be generalised to the Dutch population for several reasons. One reason is that these stories were part of a social media campaign, and so stories that were collected could only come from social media users who were willing to share their story publicly. Therefore, the results of this study are only likely to depict either a partial representation of the problem or that specific groups are not represented. Another reason is that no demographic data was collected in the original study. Having such data, furthermore, could be useful in identifying groups that are more likely to have NBEs, and could reveal gaps in the maternal care system that the health system fails to address. Lastly, it is worth reiterating that this campaign was organised by The Birth Movement, an organisation which may sometimes be perceived as one-sided as they focus mostly on the clients' perspectives of NBEs and not on the care provider's perspective. As a result, the stories from clients tended to be the most extreme examples of NBEs, which may only represent a small proportion of births in the Netherlands, to highlight the importance of The Birth Movement's cause. An additional limitation is that with a focus on clients, the #GG campaign produced significantly fewer stories provided by care providers, and as mentioned previously, such stories proved to be very useful and valuable in this study.

Recommendations

Despite the above-mentioned limitations surrounding the validity and prejudiced nature of the stories, these should not discount the validity of the experiences and feelings of the women who

had these NBEs. This study shows that there is a clear need for health systems to exercise more effort in ensuring PBEs, which could be assisted by making use of the WHO framework on quality maternal care. Following this study's findings, it is recommended that care providers be trained in informed consent as well as communication, particularly with setting realistic expectations and clearly explaining interventions and procedures. On a structural level, medical programmes should highlight the importance of accountability, and this can be further strengthened by facilities enforcing their own policies on redress. Ultimately, the Dutch government also has a large part to play in ensuring that facilities have sufficient physical and human resources to mitigate poor working conditions for care providers.

Because these stories were preferential towards client experiences, it is also recommended that future studies conduct a qualitative study focusing on care providers to further contextualise the NBEs. Though it may not be possible due to the anonymisation of the stories, it would also be beneficial to carry out a follow-up study on these women, or women in future #GG campaigns, to collect demographic data. This can provide more context as to why NBEs occur and who are most likely to have NBEs. Following this, it would be interesting to explore the experiences of marginalised and minority groups in Dutch maternal care as they are probably more likely to have NBEs due to factors such as income, education and health literacy, race, language, religion, and culture. Such a study should also analyse the role of intersectionality in the experiences and treatment of these groups to address gaps in the provision of quality maternal care to every mother in the Netherlands.

Conclusion

This study investigated the drivers of negative birth experiences of women in the Netherlands by analysing social media posts from the #genoeggezwegen campaign. It found that the most common drivers were the power dynamics between the care provider and the client, health system conditions and constraints, and poor communication between the care provider and the client. While women and birth companions may benefit from managing their expectations better,

that is not to say that there is not more that the individual care provider or Dutch maternal care system can do to ensure that people-centred care is truly implemented, so that each woman in the Netherlands has the opportunity to have a positive birth experience.

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