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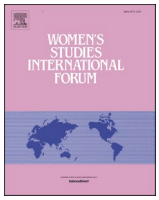

A multi-actor perspective of humanised midwifery care excellence: An exploratory survey

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ABSTRACT

Humanised midwifery care is a fundamental human right and need. This exploratory online survey presents a collective perception of meaningful standards of humanised midwifery care for excellent daily practice obtained from an international multi-actor group of maternity service users and providers. After performing a literature review, 137 key elements of humanised midwifery were extracted, listed, and rephrased into criteria. The criteria were distributed, and participants added 38 criteria. The perceived level of humanised midwifery performance was scored from 1 (low/substandard) to 10 (excellent). The 9–10 scores benchmarked humanised midwifery care excellence. 312 care professionals benchmarked 42 criteria, and 277 pregnant and postpartum women benchmarked 23 criteria showing a 30 % overlap. A total set of 50 criteria emerged, promoting humanised midwifery excellence. The benchmarking criteria suggest a shared conceptual thinking of person-centeredness and meaningfulness and provide a practical paradigm for the provision and receipt of humanised midwifery care.

1. Introduction

There are global calls to strengthen humanised midwifery care (United Nations, 2024; White Ribbon Alliance, 2013). A concept analysis of humanisation in pregnancy and childbirth describes this as the interactive process between care professionals and childbearing women encompassing attentiveness, sensitivity, encouragement, communication, and collaboration (Curtin et al., 2019). The humanisation of midwifery is complex and multifaceted - grounded in human rights norms and standards, including humanised, respectful practices of care focusing on the physical, psychological, and emotional well-being of childbearing women, with midwives as the forefront care providers (Curtin et al., 2022; Downe et al., 2018). The humane midwife has been described as a midwife embodying a philosophical stance that accords primacy to the autonomy, dignity, human rights, and well-being of the childbearing woman, rooted in principles of respect, empowerment, and compassion. This humane midwife underscores the imperative of fostering an environment conducive to informed decision-making, emotional support, and personalised engagement throughout the childbirth continuum with a strong sense of agency (Fontein-Kuipers et al., 2019). The great value and the meaning, bearing and significance of the humanisation of midwifery care in pregnancy and childbirth is a pivotal conceptual package of person-centred care (Newnham & Kirkham, 2019).

Despite the general agreement that humanised midwifery is a fundamental human right and need as well as an important component of the quality of respectful maternity care (Downe et al., 2018; Khosla et al., 2016), the day-to-day performance of humanised midwifery is not yet clearly outlined (Curtin et al., 2022). Additionally, the discourse around humanisation and dehumanisation shows multiple related meaning, evolving meaning and synonyms affecting the enactment of humanisation (Stollznow, 2008). Humanised midwifery currently seems to be a theoretical concept, lacking clarity on what actual care behaviour or practice should look like, therefore needing pragmatic guidance (Downe et al., 2018).

To develop humanised midwifery care excellence and promote its expansion, professionalisation, meaning and value, it will not only be necessary to identify how humanised midwifery is or should be operationalised in day-to-day practice and how it may be enabled from a global perspective, but also which elements are most important to guide

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a meaningful and powerful change towards humanised midwifery care excellence (Jolivet et al., 2021). The use of care professionals and childbearing women's reports appraising clinical performance and positive care behaviour, can catalyse enhancement of the quality of humanised midwifery care provided, and be a facilitator of a culture of humanised midwifery care (Bevan et al., 2019; Collins-Fulea et al., 2005; Ettorchi-Tardy et al., 2012; Kelly et al., 2016; Todres et al., 2009).

In this study, we aimed to describe a collective perception of the level of excellence or meaningful standards of humanised midwifery care, benchmarked by care professionals and pregnant and postpartum women. With the midwife at the core of interpersonal interactions with the childbearing woman during the continuum of childbirth (Fontein-Kuipers et al., 2018), the clinical practice of the midwife is at the heart of this study.

2. Methods

2.1. Study approach

We used positive deviance as the approach to our study. Positive deviance is an assets-based approach using the identification of high-performance outliers to provide valuable insight into how to do things 'well' and to identify what 'good looks like' (Baxter & Lawton, 2022). This gives humanised midwifery practitioners a chance to reflect positively on what is going well, overcome challenges by identifying existing resources and approaches and adapt to benefit childbearing women and midwives (Baxter & Lawton, 2022).

2.2. Study design

An exploratory online survey was conducted among (1) pregnant and postpartum women/perinatal health care users and (2) perinatal care professionals/service providers. The study consisted of consecutive steps: (i) criteria of humanised midwifery care were generated from the literature and listed; (ii) the list of criteria was distributed; (iii) the various responders provided additional criteria; (iv) the responders scored all criteria, according to the perceived level of performance.

2.3. Item generation

Item generation consisted of three phases.

2.3.1. Searching the literature

First, a set of key elements was developed by exploring the topic of study and collecting as many perceptions as possible on humanised midwifery care. In January 2021, we (RB, YK) searched PubMed, Medline, and Ovid using the search terms (including truncations): humanis*, humaniz*, compassionate care, respectful care, midwi*, midwifery care, childbirth, parturition, and pregnancy. Boolean operators were added and combined. The search was limited to humans and publications in the English language published during the last five years (2016-January 2021). We included reviews, primary research, and case studies when data were collected from perinatal care service providers and childbearing women using maternity services. We included discussion and position papers and excluded conference abstracts, lecture notes, and theses. The search generated 186 results. Two researchers (RB, YK) independently screened titles and abstracts and selected 12 papers. We hand-searched the reference lists of the included articles and added 5 papers, resulting in a total of 17 papers.

2.3.2. Generating key elements from the literature

Second, to generate the key elements, we used the conceptual framework of the dimensions of humanisation developed by Todres et al. (2009) and contextualised to the midwifery context by Way and Scammell (2015), as our reference guide to seeking the elements of humanised midwifery in the documents. Two researchers (RB, YK) independently and blind from each other extracted elements of humanised midwifery from the sources, which were organised in Microsoft Excel©. After comparing the extracted data, 164 items were listed. After removing the duplicates, all authors agreed on 137 predefined items of humanised midwifery care (Fig. 1). Following an interactive and iterative process of conceptualising each item, the items were collectively (EM, ET, RB, YK) rephrased into criteria of humanised midwifery and were either identical to or close to the original text. The criteria of humanised midwifery were formulated with the midwife in mind, described in the third person. We did, however, differentiate in sentences/criteria construction between childbearing women and care providers. The criteria presented to childbearing women included personal pronouns (i.e. me) and possessive pronouns (i.e. my), for participants to better identify with the criteria.

2.3.3. Adding criteria

Third, additional criteria of humanised midwifery care were identified by pregnant and postpartum women and perinatal care professionals.

2.4. Sample and sampling

To obtain a collective perception of humanised midwifery we approached perinatal care professionals and perinatal healthcare users (pregnant and postpartum women). Participants had to be at least 18 years of age and participants from all countries were eligible. Care professionals were eligible when currently being professionally involved or having been involved in the care of pregnant and/or postpartum women during the last year, irrespective of years of experience. Care professionals were not limited to midwives but also included, for example, obstetricians, doulas, nurses, and antenatal educators. Childbearing women were eligible when pregnant or given birth during the last year, regardless of parity, place or mode of birth. We mobilised our international social and professional networks and used email and social media to distribute the survey, employing purposeful and snowballing sampling and voluntary response sampling methods.

2.5. Data collection

The 137 predefined criteria were listed in the online survey tool Lime survey© and distributed among perinatal care professionals and pregnant and postpartum women. Emails and social media posts included the link to the survey. Two separate routes were included in the survey, one for care professionals and one for childbearing women. The survey was developed in the Dutch language and after a process of forward and backward translation, a survey in the English language was developed (ET, YK). Although we included care providers and women with recent care experiences, we did not instruct the participants to focus on recent or single events per se, nor did we define humanised midwifery care. We were aware that the word humanisation is a word with multiple related meaning, evolving meaning and synonyms that can prohibit identifying specific personal fundamental and salient notions, potentially contributing to marginalising or disenfranchising the participants (Stollznow, 2008). The care professionals and women were asked to add criteria of humanised midwifery care they perceived were missing. To find perceptions of levels of performance of humanised midwifery care, responders rated the criteria on a scale of one (low/substandard) to 10 (excellent). Socio-demographic information and personal details were retrieved. The data were collected between May and September 2021.

2.6. Analysis

We used the Statistical Package for the Social Sciences© (SPSS) version 28 for the analysis. We compared the characteristics of completers with non-completers (responders who only provided socio-demographic and personal details or those who scored <90 % of the

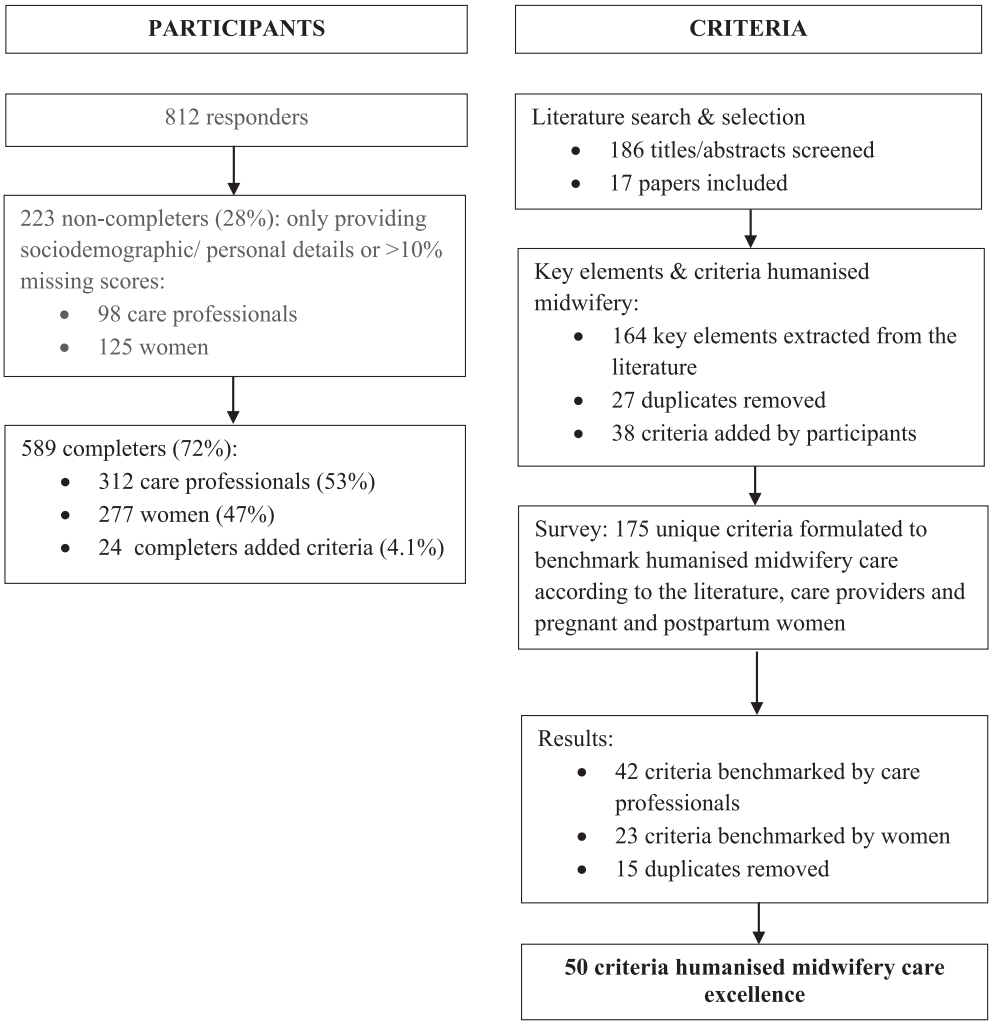

Fig. 1. Flowchart participants and criteria.

predefined criteria) using the *t*-test and Chi-square. We used the Net Promoter Score (NPS) to analyse and interpret the ratings (Bevan et al., 2019; Krol et al., 2015). The 9–10 scores were considered high-level performance markers or meaningful indicators of humanised midwifery, the 7–8 scores as passively promoting or moderate-level performance markers, and the ≤6 scores were categorised as not promoting or low/substandard humanised midwifery care performance indicators (Bevan et al., 2019; Krol et al., 2015; McDonald & Shaw, 2019).

2.7. Ethics

The Ethics Committee Social and Human Sciences Antwerp University (SHW_21_36, 16 January 2021) approved the study after reviewing the research proposal, the information letter for participants, the informed consent form, and the survey items. Before initiating the survey, all respondents signed an electronic informed consent form, built into the online survey.

3. Results

3.1. Participants

A total of 812 surveys were returned, including 589 completed criteria scores (completion rate 72 %). Care providers completed 312 surveys and pregnant and postpartum women completed 277 surveys. Twenty-four completers added criteria (Fig. 1).

The care providers came from 22 countries, mostly from Europe (e.g. Belgium, Denmark, Greece, Norway, the Netherlands, Slovakia, Italy, United Kingdom) (72 %). Care providers also practised in Australia and New Zealand (18 %), North America (e.g. USA, Canada) (4 %), South America (e.g. Suriname, Ecuador, Brazil) (3 %), and Africa (e.g. Namibia) (3 %). Most care providers identified as female and were predominantly midwives, while other professions and care domains were also represented. Sixty-seven midwives combined community and hospital-based midwifery (Table 1). There were significantly more midwives among the 98 non-completers compared to the 312 completers (p.002).

Pregnant and postpartum women came from 12 countries, mostly from European countries (e.g. the Netherlands, Belgium, Portugal, Spain, United Kingdom) (84 %), but also from Africa (e.g. Tunisia, Morocco) (7 %), Asia (e.g. Philippines) (5 %), and Mid/North America (e.g. Honduras, USA) (4 %). The responders were on average equally divided between pregnant and postpartum women. Most women received or had received shared antenatal care from the midwife and obstetrician and most births had occurred in a hospital setting. The pregnant and postpartum women had high levels of education (Table 1). The 125 non-completers had significantly more often given birth at home than the 277 completers ($p < .001$).

Table 1
Characteristics care professionals and pregnant and postpartum women.

	%/ N	Mean (SD)	range
Care professionals (n = 312)			
Age		39 (±12.35)	18–74
Gender			
Female	99/ 309		
Male	0.6/ 2		
Unknown	0.3/ 1		
Level of education			
Secondary education	2.9/ 9		
Bachelor's degree	74.4/ 232		
Master's degree	21.8/ 68		
PhD	0.9/ 3		
Community midwife	89.7/ 191		
Hospital midwife	32.4/ 101		
Student midwife	3.5/ 11		
Doula	2.9/ 9		
Antenatal educator	3.2/ 10		
Psychologist	2.9/ 9		
Maternity care assistant	0.9/ 3		
Obstetrician	1.3/ 4		
Nurse	1.3/ 4		
General Practitioner	0.3/ 1		
Health insurance	0.3/1		
Academic	11.2/ 35		
Pregnant & postpartum women (n = 277)			
Age		31.08 (±3.94)	20–43
Level of education			
Secondary education	1.8/ 5		
Bachelor's degree	72.5/ 201		
Master's degree	25.3/ 70		
PhD	0.4/ 1		
Pregnant	47.7/ 132		
Gestation in weeks		24.04 (±9.19)	1–39
Postpartum	52.3/ 145		
Postpartum in weeks		21.03 (±14.94)	1–53
Main care provider			
Midwife	17/ 47		
Obstetrician	24.9/ 69		
Shared care	58.1/ 161		
Place of birth			
Home	4/ 11		
Birth centre	0.4/ 1		
Hospital	95.6/ 265		

3.2. Benchmarking criteria of humanised midwifery

The participants added 82 items to the predefined 137 items, of which 44 within- and between-group duplicates were removed. Adding the 38 remaining criteria, resulted in 175 unique criteria representing humanised midwifery care according to the literature, care providers, and pregnant and postpartum women. Of the total set of criteria, 78 % originated from the literature and the participants added 22 %. (Fig. 1). From the 175 criteria of humanised midwifery care, a total of 50 criteria (28.6 %) received 9/10 scores, 116 criteria (66.3 %) received 7/8 scores and 9 criteria (5.1 %) received ≤6 scores. The care providers benchmarked 42 of the 175 criteria (24 %), 26 originating from the literature and 16 added criteria (Table 2). Childbearing women benchmarked 23 of the 175 criteria to (13.1 %), 14 originating from the literature and nine added criteria (Table 3). The healthcare providers and childbearing women agreed on 15 criteria to benchmark humanised midwifery care, showing a 30 % agreement. Fifty distinct benchmarking criteria, representing excellence in humanised midwifery care, emerged.

4. Discussion

In this study, we elicited a set of criteria for humanised midwifery care based on the rates of perceived excellence of an international multi-actor sample of care professionals and pregnant and postpartum women. To our knowledge, this has not been studied in such a way before. The criteria listed by the care professionals benchmark humanised midwifery care excellence by a person-centred and relation-based approach, acknowledging interpersonal interaction and the space of birth, including the pregnant/birthing person's significant others, aiming for meaning rather than function (Boyle et al., 2016; Fontein-Kuipers et al., 2018; Kuipers et al., 2023; Summer Meranius et al., 2020). The criteria refer to the midwife's core philosophy underpinning care, and the course of actions and interpersonal interactions between the midwife and the childbearing woman, including reciprocity, collaboration, and partnership as well as organisational elements (Fontein-Kuipers et al., 2018; Fontein-Kuipers et al., 2019). The criteria,

Table 2
Criteria benchmarking humanised midwifery according to care providers.

	The midwife
1.	adapts care when the needs of the woman change or alter [a]
2.	explains to the woman when she/he is available [a]
3.	explains to the woman how she/he can be contacted [a]
4.	addresses the woman as indicated by the individual [a]
5.	introduces her/himself (name) and explains her/his role when meeting the woman [a]
6.	does not interrupt, hurry, or distract the woman during conversations [a]
7.	answers all the woman's questions [a]
8.	explains every action/procedure to the woman being carried out [a]
9.	is kind and compassionate [a]
10.	acknowledges the emotions of the woman, verbally and non-verbally [a]
11.	takes the experiential knowledge of the woman as serious, valid, and relevant as own professional knowledge [a]
12.	discusses and identifies the maximum number of midwives to be involved in the care of the individual woman as part of practice organisation [b]
13.	involves the woman's partner [b]
14	shows a genuine interest in the woman and the woman's life (course) [b]
15.	informs the woman about individual/team birth statistics (SVD, CS, instrumental births…) [c]
16.	provides care when the woman's wishes are outside recommended care [c]
17.	conducts the booking visit at the woman's preferred place of choice [c]
18.	has a woman-centred philosophy and commits to it [c]
19.	has no preconceived ideas or assumptions about the woman [c]
20.	uses the woman's own words to describe emotions [c]
21.	uses neutral language, does not voice personal opinions about the woman or her decisions, when talking about the woman to others [c]
22.	makes colleagues aware when they do not use neutral language, and/or voice an opinion about the woman [c]
23.	and the woman discuss and share their mutual expectations [c]
24.	believes the pregnant/birthing person [c]
25.	shares the woman's birth plan with other/multidisciplinary colleagues [d]
26.	safeguards the wishes and needs of the woman during consultation, referral, and multidisciplinary care [d]
27.	spends time to be with the woman [d]
28.	shares her/his philosophy of care with the woman [d]
29.	continues to support the woman in choices when these are not congruent with own personal preference [d]
30.	hands over care in the presence of the woman when referral is necessary [d]
31.	remains involved in the woman's care after referral [d]
32.	validates her/his understanding of the worries and fears of the woman [d]
33.	provides all available evidence [d]
34.	asks the woman what is of importance to her [d]
35.	asks the woman for her personal opinion [d]
36.	There is always room for others to be with the woman (when agreed by the woman) [a]
37.	The birth process is leading and has priority over protocols [c]
38.	There is access to water (immersion) and/or water birth [c]
39.	There is system in place for when complaints are received, an enquiry is opened to do something with the results (on every organisational level) [c]
40.	There is a midwife present at every birth [d]
41.	Case loading/one-to-one care is the norm [d]
42.	Birth takes place in a homely environment/atmosphere [d]

Note: the word woman is used to represent the childbearing woman: the woman who is physically pregnant or gives/ has physically given birth to a child.
[a] Criteria from the literature benchmarked by both women and care providers (n = 12).
[b] Added and benchmarked criteria by both women and care providers (n = 3).
[c] Added and benchmarked criteria by care providers (n = 13).
[d] Criteria from the literature benchmarked by care providers (n = 14).

Table 3
Criteria benchmarking humanised midwifery according to childbearing women.

	The midwife
1.	adapts care when my needs change or alter [a]
2.	explains to me when she/he is available [a]
3.	explains to me how she/he can be contacted [a]
4.	addresses me the way I want to be addressed [a]
5.	introduces her/himself (name) and explains her/his role when we meet [a]
6.	does not interrupt, hurry, or distract me when I am talking [a]
7.	answers all my questions [a]
8.	explains every action/procedure she/he carries out [a]
9.	is kind and compassionate [a]
10.	acknowledges how I feel, verbally and non-verbally [a]
11.	regards my experiences and knowledge about myself and my situation as serious, valid, and relevant as her/his own professional knowledge [a]
12.	discusses with me the maximum of number of midwives involved in my care [b]
13.	involves my partner [b]
14.	shows an active interest in me and my life (course) [b]
15	uses non-medical understandable language [c]
16.	concentrates on only me while performing an internal examination [c]
17.	supports me in having a conversation with the obstetrician [c]
18.	genuinely tries to establish a relationship with me [c]
19.	is available when I ask for her/him to be or when I indicate that I need her/him to be available or when this is important to me [d]
20.	takes all the time that I need to let me explain my situation or myself in my own words [d]
21.	There is always room for others to be with me care (when agreed by me) [a]
22.	During antenatal care I meet all members of the midwifery team, getting to know all midwives before I am going to give birth [c]
23.	My feelings are considered as important parameters in decision-making [c]

Note: the word woman is used to represent the childbearing woman: the woman who is physically pregnant or gives/ has physically given birth to a child.
[a] Criteria from the literature benchmarked by both women and care providers ($n = 12$).
[b] Added and benchmarked criteria by both women and care providers ($n = 3$).
[c] Added and benchmarked criteria by women ($n = 6$).
[d] Criteria from the literature benchmarked by women ($n = 2$).

benchmarked by childbearing women, show that the pregnant and birthing woman is at the heart of care. These criteria suggest that the humanised midwifery care process is aimed to facilitate a personalised and meaning-laden trajectory, fortifying well-being where the needs of the childbearing woman are linked to personal authenticity and agency but also to mediation and practical and logistic support and assistance (Ford, 2020). The criteria of humanised midwifery care benchmarked by both care professionals and childbearing women, seem to share a conceptual and meaningful thinking of person-centredness (Fontein-Kuipers et al., 2018). The criteria provide a practical paradigm for the provision and receipt of humanised midwifery care and help to inform care standards and care strategies based on the international and multi-actor perceived excellence of humanised midwifery care women (Cantor et al., 2024).

Most benchmarking criteria originated from the literature, reinforcing the literature to represent care users' and care providers' voices, contributing to the validity of the extracted criteria. The participants considered many criteria to be passively promoting humanised midwifery care excellence or to be moderate-level performance markers suggesting that the participants were very well able to distinguish between providing clarity about what 'good' humanised midwifery looks like (Baxter & Lawton, 2022). The 50 benchmarked criteria can be considered as unequivocal conditions to create a change. The 15 overlapping criteria between care providers and childbearing women are critical components of humanising midwifery care excellence. Care professionals, predominantly consisting of midwives, benchmarked more criteria compared to childbearing women. This could be caused by a need to voice a sense of institutional momentum, the participating care professionals trying to mediate between humanity and the institutional demands, time and pace and institutional cogs (Newnham et al., 2017). Or, on the contrary, care professionals might have felt the need to safeguard their capacity to be 'with woman' and provide person-centred care (Fox et al., 2022), emphasising this through benchmarking. Both these reasons might have contributed to a higher input of midwives. The discrepancy between care provider and care user participation might also be explained by the fact that childbearing women are not always aware that human rights are violated and are sometimes used to act submissive and compliance or not always have a clear idea of what to expect from care or care providers (Curtin et al., 2022; Solnes Miltenburg et al., 2016). As our study took place in the aftermath of the COVID-19 pandemic when restrictions started to ease off worldwide, care providers and women likely reflected on their experiences of social distancing and restrictions contributing to a critical perspective of the human aspects of care (Flaherty et al., 2022). In that sense, maybe our criteria that make up excellent humanised midwifery care are a result of a period where humanity and human contact were at stake, contributing to the realisation of its importance and what is needed to provide and receive humanised midwifery care.

Ultimately, the findings presented here add to the body of knowledge emerging in humanising midwifery. The 50 criteria benchmarking humanised midwifery care excellence address aspects such as the personhood, autonomy, and preferences of pregnant and postpartum women. The criteria represent respect for childbearing women, respect for their privacy and consent, but above all to inform a care standard including recognition of the distinct needs and preferences of childbearing women and care providers and supporting the agency of women and care professionals and the connectedness between them (Newnham et al., 2017). Although our study is a first attempt to operationalise the abstract concept of humanised midwifery care, the development of a guide for reflection on practice, drawing from the findings presented here for the advancement of humanising midwifery in future may also be justified. To develop a measurement tool based on our findings, more research is needed to validate the meaning of our findings in clinical practice before measuring the effect of humanised midwifery care excellence as benchmarked by our participants.

4.1. *Strengths and limitations*

The results need to be interpreted within the limitations of the study. Care providers and pregnant and postpartum women self-selected when deciding to participate in the study which means the responders might have an affinity with the topic of study, positively or negatively. This study largely included participants from Western countries when it is known that the lack of humanised maternity care is much higher in low-income countries (Shuman et al., 2023), affecting the generalisability of our findings to low-income countries. In addition, the survey was distributed through the professional networks of the researchers, which might explain the high percentage of midwives among the care professionals and an over-representation of Western countries, affecting the generalisability of our findings as humanised midwifery care might be influenced by socio-cultural norms and beliefs (Khosla et al., 2016). Non-responder pregnant and postpartum women more often had given birth at home. Women with a homebirth are more likely to experience a humanised birth (Clancy & Gürgens Gjaerum, 2019). Maybe the non-responding women therefore did not feel the need to participate, suggesting that the pregnant and postpartum responders might have experienced dehumanised care as opposed to the non-responders, indicating response bias. Additionally, we did not provide the participants with a definition of humanised midwifery care, which could have caused an overlap between the differentiation between respectful maternity care, humanised midwifery and care based on human rights, as described by Downe et al. (2018). This being more a conceptual description with implied meaning rather than a pragmatic one, we believe that the participants in our study expressed what is fundamental and salient to them in day-to-day care when they think about humanised midwifery care (Stollznow, 2008), providing a practical guide and recommendations.

5. Conclusion

We elicited a set of criteria for humanised midwifery care excellence according to an international multi-actor group. The benchmarking criteria suggest a shared conceptual thinking of person-centredness and meaningfulness and provide a practical paradigm for the provision and receipt of humanised midwifery care. Findings may contribute to enhancing existing humanising care frameworks and models in maternity services. The benchmarked criteria can be considered as conditions to shift an abstract concept of humanised midwifery care into a pragmatic package of critical components and care strategies for humanising midwifery care to create a change in midwifery practice.

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CRediT authorship contribution statement

Yvonne J. Kuipers: Writing – original draft, Supervision, Resources, Methodology, Investigation, Formal analysis, Conceptualization. **Roxanne Bleijenbergh:** Writing – review & editing, Resources, Investigation, Formal analysis, Data curation. **Ellen Thaels:** Writing – review & editing, Validation, Investigation, Formal analysis. **Eveline Mestdagh:** Writing – review & editing, Validation, Project administration, Investigation.

Declaration of competing interest

There are no conflicts of interest to be reported.

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