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Practices of skilled birth attendants during labour, birth and the immediate postpartum period in Cambodia

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ABSTRACT

Objective: maternal and perinatal morbidity and mortality rates in Cambodia are high. The provision of quality care by skilled birth attendants (SBAs) in a supportive working environment is an important strategy to reduce morbidity and mortality. There has been little emphasis on examining this issue in Cambodia. The objective of this study was to establish SBA reported practices during labour, birth and the immediate postpartum periods and the factors affecting this.
Methods: a descriptive qualitative design was employed using in-depth interviews and focus group discussions with midwives, nurses and doctors with midwifery skills in two health centres and three referral hospitals in one province of Cambodia. Data were analysed using a thematic framework.
Findings: SBA practice is not always consistent with evidence-based standards known to reduce morbidity and mortality. Ten inter-related themes emerged, which described patterns of SBA practice, were identified. These were: skills in the care of labouring women; provision of support in labour; interventions in the second stage of labour; management of the third stage of labour; cleanliness during birth; immediate care of the newborn infant and immediate postnatal care; lack of policy and authority; fear of litigation; workload and lack of human resources; and financial incentives and socio-economic influences.
Conclusions: a gap exists between evidence-based standards and current SBA practice during labour, birth and the immediate postpartum care. This is largely driven by the lack of a supportive working environment.
Implications for practice: the findings of this research provide maternal health services, workforce planners and policy makers with valuable information to contribute to the continuous quality improvement of maternity care. The findings highlight implications for practice that may improve the quality of maternal health care. Recommendations for decision makers were made and further research is needed in order to develop theories and recommendations to improve SBA practice in Cambodia, to the benefit of the Cambodia women and newborn babies.

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1. Introduction

Every year, an estimated 350,000 women die from pregnancy-related complications worldwide (UNFPA, 2011) and 99% of these women are from developing countries (World Health Organization, 2010). A critical component of efforts to reduce maternal mortality is a competent and well managed health workforce. In particular, this means the availability of skilled birth attendants (SBAs) (AbouZahr and Wardlaw, 2001) who can deliver evidence-based interventions (Kerber et al., 2007) in a functioning health system that provides emergency maternity care and special care for newborns with problems (World Health Organization, 2008).

A skilled birth attendant is an accredited health professional such as a midwife, doctor or nurse who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns (World Health Organization, 2004). This definition is debatable because of the underlying assumptions that SBAs have a standardised level of skills and knowledge. In reality,

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there are varying standards of health professional training globally and a range of practices across the cadres (Graham et al., 2001; World Health Organization, 2004).

The proportion of births attended by skilled birth attendants has been used as a proxy indicator to monitor progress towards achievement of Millennium Development Goal (MDG) 5, which aims to reduce maternal mortality by three quarters and provide universal access to reproductive health by 2015 (UNDESA, 2011). While the proportion of births attended by a SBA is important, it is also essential to consider the environment and workplace in which care is provided (Adegoke and Van den Broek, 2009; Adegoke et al., 2011). This includes appropriate remuneration, education and supportive supervision, access to transportation, reliable medical supplies and effective regulatory frameworks and policies (World Health Organization, 2004). It is critical to build an understanding of SBA practice in maternity settings including their skills and competence.

A number of studies have examined the skills and competencies of skilled birth attendants and related health outcomes in countries with a high maternal mortality ratio. These studies highlight the differing levels of knowledge, attitude and skills by country and health facility (Harvey et al., 2004). Knowledge of the skills and competencies of SBAs is, however, limited in Cambodia (Sheratt et al., 2006).

1.1. The health system in Cambodia

The maternal mortality rate in Cambodia has decreased from 580 per 100,000 in 1999 to 290 per 100,000 live births in 2008 (UNFPA, 2011). Despite these improvements, it is estimated that Cambodia will not reach the MDG5 target of a 75% reduction in the number of maternal deaths from 1990 levels (Bryce et al., 2008). The major causes of maternal mortality in Cambodia, as elsewhere in the world (AbouZahr, 2003), are abortion-related complications, obstructed labour, haemorrhage, eclampsia and sepsis (Ministry of Health Cambodia, 2006a).

The health system in Cambodia is largely publicly funded with a small non-government and private sector. Health infrastructure, personnel and services were severely damaged over three decades by a violent civil war. In 1991, the country began restoring its political, social and economic structures, and health sector reform was launched in 1995. Midwifery training was reintroduced across the country in the early 1980s, which aimed to rapidly increase the supply of and access to primary and secondary midwives. A primary midwife undergoes a one year-training programme after completing secondary school education without necessarily attaining a year 12 grade. A secondary midwife completes a four-year training programme that was increased from three to four years in 2003 (Sheratt et al., 2006). Medical doctors undertake an eight-year programme with an additional three years to major in a specialty, for example, obstetrics (Ministry of Health Cambodia, 2010b).

Cambodia has prioritized maternal health, including increasing the proportion of births attended by a SBA to enhance the quality of care during childbirth in health facilities and reduce maternal mortality (Ministry of Health Cambodia, 2010a). However, there are still significant regional variations with less than half of all rural women giving birth in a health facility compared with 86% of urban women (CDHS, 2010). Most women still give birth at home without the assistance of a skilled birth attendant (Chomat et al., 2011). Socio-cultural factors, such as low levels of education and economic concerns still prevent many women from accessing public health services (UNFPA, 2011).

Alongside efforts to increase the proportion of births attended by a SBA, the Cambodian health workforce is currently experiencing a severe health-care personnel shortage due to high turnover and poor supply. There is a ratio of 7.9 midwives and nurses per 10,000 people and 2.3 doctors per 10,000 people (World Health Organization, 2011), which is lower than 2.3 per 1,000, the minimum estimate for ensuring at least 80% of births are served by SBAs (Speybroeck et al., 2006). Factors such as low salaries, poor living conditions and the work environment contribute to the workforce shortages and low retention rates (Henderson and Tulloch, 2008; Chhea et al., 2010). As a result, many Cambodian government health providers, particularly SBAs, work in both private and public sectors to supplement their incomes (Kingdom of Cambodia, 2005; Sin et al., 2005).

In 2007, the Cambodian government introduced a cash incentive of US$10–15 per live birth to be paid directly to SBAs who delivered babies in health facilities. This was to promote health facility births and address problems stemming from dual public–private practice and informal patient charges that impact on women's access to public services. Despite this, salaries remain inadequate (Hardeman et al., 2004; Kingdom of Cambodia, 2005) as increases are unlikely to be sustained due to resource constraints (Janovsky and Peters, 2006). In addition, the provision of essential reproductive health drugs to health facilities, including oxytocin, misoprostol, magnesium sulphate (Liljestrand et al., 2009) and access to medical supplies (Ministry of Health Cambodia, 2009) and procedures, such as caesarean section (Ministry of Health Cambodia, 2010a), are also limited.

Despite the introduction of midwifery training programmes, significant health sector reform and government cash incentives for SBAs, there has been little examination of the practices of SBAs in the country. A midwifery review by the Ministry of Health in Cambodia in 2006 indicated that problems of SBA supply and distribution was compounded by issues of skills and aptitude. More than 50% of primary and secondary midwives did not feel confident or competent to manage a normal birth (Sheratt et al., 2006). Another review, the national assessment of the Ministry of Health of Cambodia focused on the availability, quality and utilization of emergency obstetric and newborn care (Ministry of Health Cambodia, 2009), but did not take the skills of the SBAs into consideration. This study, therefore, aimed to explore the practices of SBAs and the factors that enable and constrain their work in one province in Cambodia.

2. Methods

A descriptive qualitative design was undertaken using a naturalistic inquiry approach (Guba and Lincoln, 1982). This approach was suitable for describing, analysing and understanding the perceptions and views underpinning SBA practice as it enabled the target phenomenon to be examined without the preselection or manipulation of study variables and a priori commitment to any one theoretical view (Sandelowski, 2000). Ethical approval was granted by Human Research Ethics Committees (HREC) at the University of New South Wales and the National Ethics Committee for Health Research, Ministry of Health Cambodia. Informed consent (in Khmer) for participant in individual in-depth interviews and focus group discussions was obtained from all skilled birth attendants prior to participation.

Public maternity settings in the provincial hospital, two referral hospitals and two health centres in one province of Cambodia were purposively selected as they reflect similar levels of basic emergency obstetric care provision, but different levels of comprehensive emergency obstetric care. The levels of care represented in this study are similar to those across all the provinces in Cambodia. The province in which the study was undertaken was selected as it is well known to the author who had established access to key participants. The name of this

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