Midwifery 30 (2014) e79–e90

Contents lists available at ScienceDirect

Midwifery

journal homepage: www.elsevier.com/midw

Perinatal women's perceptions about midwifery led model of care in secondary care hospitals in Karachi, Pakistan

Shahnaz Anwar, MScN, RN, RM (Instructor)*, Rafat Jan, PhD, RM (Associate Professor), Rahat Najam Qureshi, MBBS, FRCOG, FCPS (Associate Professor), Salma Rattani, MScN, BScN, RM (Assistant Professor)

Aga Khan University Hospital and School of Nursing and Midwifery, Stadium Road, Karachi, Pakistan

ARTICLE INFO

Article history:
Received 14 March 2013
Received in revised form
14 October 2013
Accepted 22 October 2013

Keywords:
Midwifery led care
Women's perceptions/experiences
Women's satisfaction with care

ABSTRACT

Objective: the purpose of this study was to explore the perceptions and experiences of perinatal women who have availed of midwifery led model of care (MLC) at secondary care settings in Karachi, Pakistan.
Design: a qualitative descriptive exploratory approach using semi-structured interviews.
Participants: a purposive sample of 10 women who had used MLC was enroled from each site.
Findings: content analysis highlighted that ‘women's satisfaction with MLC’ emerged as the main theme and, under this theme, the six categories that emerged were: (1) the admired capability and maturity of midwives, (2) the affordability of midwifery services, (3) a personalised relationship, (4) the empowerment of women to make decisions, (5) presence, and (6) a voiced concern regarding lack of marketing of MLC.
Key conclusions: the study findings revealed that women had an overall feeling of satisfaction with the maternity care provided by the midwives. Mostly, women appreciated the midwives' expertise in providing maternity care. Majority of the women acknowledged the continuous presence of the midwives during childbirth and the women shared that they were empowered to make decisions related to their care. Most of the women indicated that marketing for MLC is scarce and insufficient. Majority of the women are even not aware of this model; therefore, it is imperative to create awareness and to provide MLC access to women through robust marketing.
Implications for practice: the findings of this study may help to advocate and provide women-friendly maternity care, by giving choice and control to women during childbirth, providing comfort to women by using fewer medical interventions, and promoting normality by attending spontaneous vaginal childbirths.

© 2013 Elsevier Ltd. All rights reserved.

Introduction

Globally, the maternal mortality ratio (MMR) is 400 maternal deaths per 100,000 live births (WHO, 2000). Preventable causes that lead to maternal deaths include antepartum and post partum haemorrhage, pre-eclampsia and eclampsia, obstructed labour, sepsis, and unsafe abortions; approximately 80% deaths occur due to these causes (WHO, 2012). In 2005, the MMR was 490 maternal deaths per 100,000 live births in South Asia (WHO, 2005). Approximately 16,500 maternal deaths occur every year in Pakistan (PDHS, 2008). According to the results from the demographic and health survey (DHS) 2006–2007, the MMR for Pakistan ranges from 276 to 700 maternal deaths per 100,000 live births (PDHS, 2008). By comparison with other countries in the region, India accounts for 19% of the global maternal deaths; whereas, Bangladesh, Afghanistan, and Indonesia account for 3–5% of the global maternal deaths (WHO, UNICEF, UNFPA and The World Bank Estimates, 2010).

In the South Asia, NMR estimates are 33 deaths per 1000 live births (UNICEF Regional Office for South Asia, 2008), and in Pakistan this ratio is estimated to be 41 deaths/1000 live births (UNICEF, WHO, The World Bank, the United Nations Population Division, 2011). Furthermore, as stated by the Pakistan Demographic Health Survey (PDHS) 2011 report, the total fertility rate (TFR) in Pakistan is 3.17; thus, it is higher as compared to the TFR of other developing countries in the region such as India, Sri Lanka, Nepal, and Bangladesh (Population Reference Bureau, 2011). These data indicate the demand and need for maternal and child health (MCH) services in Pakistan.

Effective evidence-based maternity care with the least harm is optimal for childbearing women and newborns. A report by the Institute of Medicine of the United States (IOM) (2001) suggested

* Corresponding author.
E-mail address: Shahnaz.shahid@aku.edu (S. Anwar).

0266-6138/$ - see front matter © 2013 Elsevier Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.midw.2013.10.020

that maternity care should pursue the standard of providing effective care with the least injury by supporting women's own natural capabilities to give birth physiologically. The implementation of the use of a woman-friendly model is most evident in the midwifery led model of care (MLC). MLC is very old and it varies from country to country (Feldhusen, 2000). In this woman-friendly model, midwives support and maximise the opportunity for normal birth and safe motherhood by providing accessible, affordable, and acceptable maternal and newborn care, which ultimately empowers women by respecting their rights to information, choice, and involvement in their own care (RCM, 2000).

Hildingsson and Thomas (2007) claim that the use of MLC will help in decreasing maternal mortalities and morbidities because it aims to increase the utilisation of maternity services by a midwife who can provide safe quality care which leads to maternal satisfaction. It promotes normality by increasing the physiological capability of women to give birth with minimum or no interventions (Rooks, 1997). Moreover, MLC can be a significant maternal and child health care model as it focuses on women-centredness by being responsive to an individual woman's needs. It can enhance a client's satisfaction in the following ways: (a) a woman is given a choice and allowed to be personally involved in her own maternity care; (b) it enhances a woman's self-efficacy by making her realise that she is able to achieve her desired goal; and (c) a woman is provided competent, evidence-based, and cost-effective maternity care to improve her health and wellness (RCM, 2000).

According to Zander and Chamberlain (1999), in many countries during the antenatal, intrapartum, and postnatal periods, a woman receives 75% of her care from a midwife. Women view midwives as their primary care providers during the maternity phase (Rooks, 1997). Women are satisfied with midwifery care and identify that care provided by midwives is client-centred and cost-effective. Moreover, a woman chooses a midwife because she feels that midwives are reluctant to interfere with nature and, thus, they try to use their personal skills more than any technology (Walker, 2001). In addition, women are capable of giving birth by using their own power (self-efficacy), hence, pregnancy and childbirth are seen as common life events by midwives (Rooks, 1997).

To manage childbirth effectively and to emphasise women's needs, different models of maternity care have been introduced in many developed countries (Heavey, 2010; Sandall et al., 2010). The important models of care other than MLC include a medical-led model, family doctor-provided care, and a shared-model of care (Hatem et al., 2008). In MLC, women identify a midwife as their lead health professional in the planning, organising, and delivering of care throughout the antepartum, intrapartum, and postpartum periods, and for the care of the newborn. The philosophy of care in MLC is seen holistically by women, because it acknowledges that psychosocial elements, such as the relationship between the woman and her family and her care provider are crucial components of physical and clinical maternal and child health (Rooks, 1999). During childbirth, a woman should be considered as the primary decision maker and she has the right to the information that enriches her decision-making capabilities (ICM, 2002). Moreover, as supported by Sandall et al. (2010), MLC can be considered as one of the leading childbirth models in the future for normalising and humanising childbirth for a woman.

In the medical-led model of care, obstetricians are the primary care providers during different periods of childbirth; an obstetrician is present to attend to the woman, and nurses provide the postnatal care. In the family doctor-provided care, a medical doctor is present for attending to the birth and midwives provide intrapartum and postnatal care but they are not involved at the decision-making level. In the shared model, the organisation and delivery of the care of a woman, from the initial booking to the postnatal period, is shared between different health professionals that include a midwife and/or an obstetrician (Hatem et al., 2008).

In rearranging existing maternity services in order to introduce MLC, emphasis has to be placed on ensuring the availability of trained and knowledgeable midwives for providing maternity care to women. In many developed countries, autonomous trained midwives are responsible for providing maternity care to women during childbirth. On the contrary, in Pakistan, MLC is not popular due to a greater emphasis on the medical-led model. Moreover, in private and government health care facilities in Pakistan, MLC is provided by midwives who are trained and licensed by the Pakistan Nursing Council; in community settings maternity care is provided by the traditional birth attendants (TBAs), who do not have formal training (Jafarey et al., 2008).

Maternity centres with midwives are often not popular because it is believed that midwives lack necessary knowledge and competencies. Hence, women are often not encouraged to go to those centres where services are provided specifically by midwives. It is believed that the midwifery training centres in Pakistan do not prepare midwives to be autonomous health care providers because of their short study duration: 15 months for pupil midwives (direct entry program), 12 months for nurse midwives (post-licensure), and 18 months for community midwifery training (Jafarey et al., 2008). However, according to the Pakistan Nursing Council (PNC) midwifery curriculum (2005), it is obligatory for a midwife to be able to take a comprehensive history and perform physical examination according to a mother's condition, and conduct normal births and refer women with complications to the obstetrician. Therefore, successful MLC is available in Pakistan to women from trained midwives who are expert in conducting normal childbirth and in detecting and appropriately referring deviations from the normal.

Midwifery training is provided in many secondary and tertiary care hospitals in Karachi. In one of the tertiary care hospitals, four secondary sites were merged in 2009 for an improvement in maternal and child health service provisions. To reinforce midwifery care practices, at present, MLC has been introduced in only two sites to fulfil the above mentioned objectives. In these secondary care units, MLC is available along with the medical-led models.

Both quantitative and descriptive exploratory qualitative studies have been done in different countries focusing on client satisfaction with respect to continuity of care by midwives, midwives' competency, cost-effectiveness of MLC, satisfaction with choice, control, and presence of the midwife. These have been done in relation to women's perceptions and experiences with MLC.

In Pakistan, MLC has been less active in the past few years due to the emphasis on the obstetric model of care. A review of the literature indicated a significant gap with regard to the use of MLC and women's experiences in the Pakistani context i.e. Jafarey et al. (2008). Hence, it was felt that further research was needed to explore the perceptions and experiences of the Pakistani women who had utilised MLC. This study was undertaken to explore MLC at two sites, to explore women's experiences and perceptions about MLC.

The purpose of the study was to explore the experiences and perceptions of Pakistani perinatal women who had used MLC during the antenatal, intrapartum, and postnatal periods at the secondary care settings. This study also aimed to identify the advantages and disadvantages, and the challenges of using MLC.

Methods

For this study, qualitative descriptive exploratory research design was used. As perceptions and experiences varied from woman to

Download English Version:

https://daneshyari.com/en/article/10515822

Download Persian Version:

https://daneshyari.com/article/10515822

Daneshyari.com