Midwifery 29 (2013) 1151–1157

Contents lists available at ScienceDirect

Midwifery

journal homepage: www.elsevier.com/midw

Assessment of the implementation of the model of integrated and humanised midwifery health services in Santiago, Chile

Lorena Binfa, RM, MPH, PhD (Associate Professor)[a,*], Loreto Pantoja, RM (Lecturer in Midwifery)[a,*], Jovita Ortiz, RM (Lecturer in Midwifery)[a], Marcela Gurovich, RM (Lecturer in Midwifery)[a], Gabriel Cavada, PhD (Statistician)[b]

[a] Faculty of Medicine, School of Midwifery, Santiago, University of Chile, Avda, Independencia 1027, Santiago-Chile, Chile
[b] Faculty of Medicine, School of Public Health, Santiago, University of Chile, Chile

ARTICLE INFO

Article history:
Received 15 February 2013
Received in revised form
25 June 2013
Accepted 1 July 2013

Keywords:
Midwifery model
Humanisation of labour
Maternal and newborn well-being

ABSTRACT

Objectives: during 2007 the Chilean Ministry of Public Health introduced the Model of Integrated and Humanized Health Services, in addition to the Clinical Guide for Humanized Care during Delivery. Three years after its implementation, a study was conducted (i) to describe selected clinical outcomes of women who received care within this model, (ii) to identify the degree of maternal–newborn well-being and (iii) to explore the perception of this humanised attention during labour and delivery by both the professional staff (obstetricians and midwives) and consumers.
Design and method: a cross-sectional, descriptive study using both quantitative and qualitative methods was conducted with 508 women who delivered in two major hospitals within the National Health System in the metropolitan area of Santiago, Chile, from September 2010 until June 2011. The quantitative methods included a validated survey of maternal well-being and an adapted version of the American College of Nurse-Midwives (ACNM) standardised antepartum and intrapartum data set. The qualitative methods included six focus groups discussions (FGDs), with midwives, obstetricians and consumers. Additionally, two in depth interviews were carried out with the directors of the maternity units.
Findings: the quantitative findings showed poor implementation of the guidelines: 92.7% of the women had medically induced labours (artificial rupture of the membranes and received oxytocin and epidural anaesthesia), and almost one-third of the women reported discontent with the care they received. The qualitative findings showed that the main complaint perceived by the midwives was that the health system was highly hierarchical and medicalised and that the obstetricians were not engaged in this modality of assistance. The women (consumers) highlighted that professionals (midwives and obstetricians) were highly technically skilled, and they felt confident in their assistance. However, women complained about receiving inadequate personal treatment from these professionals. The obstetricians showed no self-critique, stating that they always expressed concern for their patients and that they provided humanised professional assistance.
Conclusions and implications for practice: by illuminating the main strengths and weakness with regard to the application of the model, these findings can help to inform strategies and actions to improve its implementation.

© 2013 Elsevier Ltd. All rights reserved.

Introduction

Humanistic health care means recognising users as a 'subject' not as an 'object.' This involves a move from paternalism to responsible autonomy, from medicalisation and technocracy to respect of the natural timing of normal delivery, while considering every woman as unique. This is, therefore, a women centred model (Lobo, 2002). Humanisation is nothing else than an active search to a closer relationship with a human being, offering the best health care attention (CMPH, 2007a).

Health attention that is humanistic encourages women to eat and drink at free will during labour, bring a companion of their choice, facilitate movement during labour and upright position for birth. Davis-Floyd defines two kinds of humanism, a superficial one 'in which the room is pretty, and the mother is treated kindly,

* Corresponding authors.
E-mail addresses: lbinfa@med.uchile.cl, lbinfa@hotmail.com (L. Binfa), lpantoja@med.uchile.cl (L. Pantoja).

0266-6138/$ - see front matter © 2013 Elsevier Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.midw.2013.07.001

but the intervention rate does not decrease; this is not the same as deep humanism 'in which the *normal physiology of birth* is honored' (Davis-Floyd, 2001).

Over the past three decades, Latin American countries have started a social movement towards humanisation of birth. As rates of caesarean sections rise, many undesirable outcomes such as prematurity, maternal infection and death tend to increase due to sections (Villar et al., 2006). Therefore, a larger number of consumers and health professionals are working together in trying to modify this practice. Health care in many Latin American hospitals (varying among institutions) is based upon a highly medicalised model of birth—enemas, lithotomy position, episiotomies and unnecessary caesarean sections, all with scarce companionship or support.

Chile has a mixed health system (public and private) in terms of financing, health insurance, and service delivery. The public system is finally supported by the National Health Fund, which covers almost 75% of the population. Additionally, the public system covers health care for 100% of the poorest population, including maternal and infant health (PAHO, 2011). With regard to sexual and reproductive care, midwives are usually the main health professionals providing normal birth assistance, whereas obstetricians are well trained to carry out the responsibility for solving obstetrical pathology (Davis-Floyd, 2001). In accordance with WHO/ICM and FIGO definitions, the main professional responsibility of a midwife is to dispense sexual, reproductive and perinatal health care (ICM, 1992). At present, Chilean midwifery training comprises a five year university programme, covering most of the activities stated in Women's Health Program commanded by the Chilean Ministry of Public Health (CMPH, 2007b). They provide the majority of gynaecological and obstetrics primary care activities, assisting normal labour and deliveries in the public system, working in collaboration with obstetricians (Segovia, 1998).

Chile is well recognised among Latin American countries for its improved maternal and neonatal indicators (PAHO, 2006, 2008, 2011) and its positive impact on the reduction of maternal and infant mortality. During the past seven years, however, this trend has stabilised. If maternal and infant mortality does not continue to decrease, the millennium goal of reducing maternal mortality will not be accomplished (CMPH, 2008).

Chile has one of the highest rates of caesarean section (30.7%) of the region (Gibbons et al., 2012). This figure has been considered as an indicator of the quality of maternal and perinatal assistance (WHO, 1985). In line with this, the objectives stated by the Chilean Ministry of Public Health in 2000 (CMPH, 2011), are to improve health indicators, decrease health inequalities, and provide high quality services, in accordance with the expectations of the population. In 2007, the Chilean Ministry of Public Health adopted the 'Model of Integrated and Humanized Health Services' (CMPH, 2007a), and specifically, the Clinical Guide for Humanized Care during Delivery. The main objective of these guidelines is to guarantee access to all pregnant women in Chile for appropriate professional assistance during labour and delivery, as well as 'achieving a safe, personalised and human delivery.' This assistance highlights continuous emotional support, minimising intrapartum fetal monitoring, offering different pain relief alternatives (pharmacological and non-pharmacological), promoting different positions that allow free movement, reduction of episiotomy, avoiding enemas and trichotomy, also promoting mother and child bonding (CMPH, 2007b).

Therefore, after three years of the implementation of the Clinical Guide for Humanized Care during Delivery, midwifery researchers from the University of Chile conducted a study with the following objectives: (i) to describe selected clinical outcomes of women who received care according to this new guide, (ii) to identify the level of maternal–neonatal well-being after experiencing this modality of attention, and (iii) to explore the perception of this humanised assistance during labour and delivery by professional staff (obstetricians and midwives) and consumers. This paper is a report of this study.

Material and methods

A cross sectional, descriptive study using both a quantitative and qualitative methods, was conducted with 508 women who delivered at two major hospitals within the National Health System in the Metropolitan Area, Santiago, Chile from September 2010 until June 2011.This methodological design allowed a better understanding of the problem under study(Creswell and Plano-Clark, 2007). The quantitative method was used during the first stage of the study in order to assess the following objectives: (i) to describe selected clinical outcomes of the women enroled receiving care according to this new guide (ii) to identify the level of maternal–neonatal well-being after experiencing this modality of assistance. Inclusion criteria included primiparous and multiparous women who were admitted in the labour ward with 2–3 cm of cervical dilatation, whose physiological labour was a minimum of 4 hours; these criterions ensured that participating women could make a choice regarding different options offered by the guide. For multiparous women, an interconception period not greater than 3 years was considered to assure a possible comparison of their perception with regard the prior model. Another criterion was capacity to give and signed an informed consent. Women with mental health problems or drug abuse were excluded from this study. The planned sample size was estimated based on the assumption that each item of the guideline was accomplished 50% of the time. Therefore, the sample size to test this hypothesis with a 95% confidence interval and a maximum acceptable error of 5% was of 400 women.

Data collection: All quantitative data were collected in the postpartum ward by midwifery students attending their last course (5 years), previously trained specifically for this purpose, and supervised by members of the research team. To gather data for objective (i) an adaptation of the Intrapartum Data Set Care, developed by the American College of Nurse-midwives (ACNM), validated in 1991 (Greener, 1991) and published in1999 (copyright) for educational or research purposes (ACNM, 2010). This instrument was translated to Spanish and adapted to the Chilean context by the research team and assessed by an expert committee from Emory University Atlanta-USA. These data as well as the sociodemographic background were obtained from the medical records, and if necessary, interviewing participants, and for the objective (ii) the Maternal Well-Being Assessment Scale (Uribe et al., 2008), (validated in Chile) through an interview performed to participants who accomplished inclusion criteria.

Data analysis: Continuous variables were described through percentiles, mean and standard deviation; categorical variables were described in terms of frequencies and proportions. Continuous variables were compared by *t*-Student test and categorical variables were compared by Fisher's Exact test between maternity hospitals. A data base was constructed through an excel file and data were analysed through the statistical package STATA, version 12.0. Significance level was 5% and confidence intervals were 95%.

The qualitative method was used in the second stage of the study to address objective (iii) to explore the perception this humanised attention during labour and delivery by both the professional staff (obstetricians and midwives) and consumers. The participants were women meeting the same inclusion criteria but not necessarily the same participants interviewed in the quantitative phase of the study. They were recruited as volunteers

Download English Version:

https://daneshyari.com/en/article/10515864

Download Persian Version:

https://daneshyari.com/article/10515864

Daneshyari.com