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

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ABSTRACT

Objective: in 2010, a pilot study was conducted among women who were attended by midwives in the public sector in Santiago, Chile. The purpose of that study was to evaluate the implementation of the 'Model of Integrated and Humanized Health Services', and the Clinical Guide for Humanized Attention during Labour and Childbirth. Results of that study indicated 92.7% of women had medically augmented labours (artificial rupture of the membranes, oxytocin and epidural analgesia). One third of the women reported discontent with the care they received. This study replicated the pilot study (2010) and was conducted in seven regional hospitals across Chile. The objectives were to : (i) describe selected obstetric and neonatal outcomes of women who received care according to this new guide, (ii) identify the level of maternal–neonatal well-being after experiencing this modality of attention, and (iii) explore professionals' perceptions (obstetricians and midwives), as well as consumers' perceptions of this humanised assistance during labour and childbirth.

Design: this is a cross sectional and descriptive, mixed methods study, conducted in two phases. The first phase was quantitative, measuring midwifery processes of care and maternal perceptions of well-being in labour and childbirth. The second phase was qualitative, exploring the perceptions of women, midwives and obstetricians regarding the discrepancy between the national guidelines and actual practice.

Setting: maternity units from seven regional hospitals from the northern, central and southern regions and two metropolitan hospitals across Chile.

Participants: 1882 parturient women in the quantitative phase (including the two Metropolitan hospitals published previously). Twenty-six focus groups discussions (FGD) participated from the regional and metropolitan hospitals for the qualitative phase.

Measurements/Findings: all women started labour spontaneously; 74% of women had spontaneous vaginal childbirth. Caesarean section was the outcome for 20%, and 6% had childbirth assisted with forceps. A high number of medical interventions continued to be performed in all regions, deviating widely from adherence to the national clinical guidelines. Most of the women did not receive any oral hydration, almost all received intravenous hydration; most were under continuous foetal monitoring and medically augmented labour. The majority of women received artificial rupture of membranes, epidural anaesthesia and episiotomy. Most delivered in the lithotomy position. Two thirds of women surveyed perceived adequate well-being in labour and childbirth. Findings from focus group discussions of women (FGD=9; n=27 women), midwives (FGD=9; n=40) and doctors (FGD=8; n=29) indicated lack of infrastructure for family participation in birth, inadequate training and orientation to the national guidelines for practice, and lack of childbirth preparation among women. Some women reported mistreatment by personnel. Some midwives reported lack of autonomy to manage birth physiologically.

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Key conclusions: birth is managed by midwives across the public sector in Chile. Despite evidence-based guidelines published in 2007 by the Ministry of Health, birth is not managed according to the guidelines in most cases. Women feel that care is adequate, although some women report mistreatment.
Implications for practice: efforts to provide midwife-led care and include women in participatory models of antenatal care are recommended to promote women-centred care in accordance with the Chilean national guidelines.

Introduction

Chile is recognised among Latin American countries for its improvement in maternal and neonatal indicators (PAHO, 2006, 2008, 2011; WHO, 2014). Over 99% of births take place in hospitals, but Chile has one of the highest rates of caesarean section of the region (Gibbons et al., 2012). The caesarean rate has been increasing in the last few years, from 34.7% of all births during 2000, up to 40.5% in 2013 (CMPH, 2013). Also, an overutilization of obstetrical interventions has been reported in Chile (Binfa et al., 2013), based on the WHO assessment that caesarean rates over 10% are not associated with decreases in maternal or infant mortality (WHO, 2015). The World Health Organization considers the rate of caesarean sections and the prevalence of obstetrical interventions to be indicators of the quality of maternal and perinatal clinical care (WHO, 1985, 2015).

Midwives in Chile provide the majority of gynaecological and obstetric primary care, attending normal labour and childbirth in the public system, working in collaboration with obstetricians (Segovia, 1998). Currently, midwifery education in Chile is a five-year undergraduate academic degree programme. After a one year residency which is the fifth academic year, midwives take the responsibility for providing direct services, as well as enhancing and improving women's health and quality of life throughout their lives. Newborn health is also a core component of their professional practice.

Funding of the delivery of health services in Chile is a mixed public and private system. The public system is financed by the National Health Fund (FONASA), covering almost 75% of the population under health services. Furthermore, the public system covers health care for 100% of the poorest population, including maternal and infant health (PAHO, 2011).

The objectives stated by the Chilean Ministry of Public Health for the decade 2000–2010, and updated to 2011–2020 (CMPH, 2011), are to improve sanitary indicators, decrease health inequalities, and provide high quality services, in accordance with the expectations of the population and scientific evidence.

The scientific literature has reported the efficacy of midwifery-led care models (Stapleton et al., 2013), based on midwives' skilled competences for attending normal childbirths and taking into account women's needs or woman-centred models of care (McCourt, 2014; Tracy et al., 2014; Clark et al., 2015; Cummins et al., 2015). These practices have led to the reduction in the number of caesarean sections (Hodnett et al., 2012; Faucher, 2013).

In line with the evidence, during 2007, the Chilean Ministry of Public Health adopted the 'Model of Integrated and Humanized Health Services', and introduced the Clinical Guide for the Humanized Attention of Labour and Delivery. The main objective of this guide is to guarantee access for all pregnant women in Chile to appropriate professional assistance during labour and childbirth, in a safe, personalised, and humane manner (CMPH, 2007).

Activities to achieve the objectives of this clinical guide, include strengthening the relationship between the patient and clinician, promoting continuous emotional support, encouraging different positions that allow women free movement during the second stage of labour, offering different pain relief alternatives (pharmacological and non-pharmacological), minimising intrapartum foetal monitoring, promoting the reduction of episiotomy and labour augmentation, and promoting mother and child bonding (CMPH, 2007).

In 2010, three years after the publication of the Clinical Guidelines for the Humanized Assistance of Labour and Childbirth, our research team of university-based midwifery faculty conducted a pilot study in two big maternity hospitals belonging to the National Health System, in Santiago, the capital of Chile. Our aims were to: (i) describe selected obstetric and neonatal outcomes of women enroled in the study who received care according to this new guide, (ii) identify the level of maternal–neonatal well-being after experiencing this modality of attention, and (iii) explore professionals' perceptions (obstetricians and midwives), as well as consumers' perceptions of this humanised assistance during labour and childbirth. Findings from the 2010 study (pilot) revealed no changes with regard to the implementation of the recommendations promoted by the guidelines; 92.7% of the women had medically augmented labours (artificial rupture of the membranes and receiving oxytocin and epidural anaesthesia), and almost one-third of the women reported discontent with the care they received (Binfa et al., 2013).

These results moved us to our current research question: would the results from the Santiago study be similar across the Chilean nation? Although past government administrations have made strong efforts toward decentralisation, most of the resources and population of the country remain concentrated in the capital of Santiago.

This led us to further question if the cultural, ethnic, climatic and/or geographical differences among seven regions of Chile would result in different service outcomes for midwifery care. Also, are there midwifery strengths in other locations outside of Santiago that could be shared to improve the implementation of this guide and model of care across Chile? The present study, therefore, replicated the same purpose and objectives of the 2010 pilot study carried-out in Santiago (Binfa et al., 2013), but it was conducted in seven regional hospitals of the fifteen regions of the country. Funding and time limitations precluded a study of all fifteen regions but we sought geographic representation by involving two of the hospitals in the north (Iquique y Coquimbo), two in the central zone (Rancagua y Valparaíso) and three in the southern part of the country (Concepción, Ancud and Coihayque). The funding for this study was granted by the Chilean National Fund for Health Research (FONIS-SA12I2079).

Material and methods

Ethical approval

Ethical approval to conduct the study was obtained from the Ethical Committee for Research on Human Beings at the Faculty of Medicine, University of Chile and the local Ethical Committee at