



BIRTH: AN EVENT WHICH REQUIRES EXCELLENCE IN HEALTHCARE QUALITY

This issue of our journal includes a reflection article on differences observed in the quality of healthcare during childbirth. These differences have a negative impact on pregnant women of lower income brackets, adolescents, and women with high risk pregnancies.

Ideally, labour and delivery should be a “gratifying experience” which, apart from applying the best evidenced-based practices, involves “respecting the physiology of childbirth; intervening only when necessary; identifying, understanding and respecting the social and cultural background of the mother; providing emotional support; granting decision-making power to the pregnant woman, and ensuring autonomy and privacy.” These should be the criteria used for assessing quality of care during birth, as part of a broad humanistic approach. This implies consideration not only of the traditional quality criteria, but of other domains such as human rights, cultural background, and basic ethical principles.

Humanised childbirth is the term coined to encompass these criteria. It was embraced by the Clinical Practice Guideline for early detection of abnormalities during labour and care of normal and difficult delivery prepared by the Colombian Ministry of Health and Social Protection (1). It involves aspects pertaining not only to medical care and assistance during the physiological process of labour and delivery with measures such as pain control and avoidance of inadequate practices like the use of enemas or perineal shaving, but also other aspects such as taking into account the preferences and fears of the pregnant woman, respect for her culture, and ensuring her right to autonomy and privacy at that very special moment

of her life. (2) Failure to abide by these criteria might result in a birth experience accompanied by a perception of abuse, which has been designated as obstetric violence (3).

Most of the available literature on the topic of humanised birth comes from Latin America and the area of nursing (4-8). The term “humanisation”, according to the definition of the Royal Spanish Academy, seeks to describe the “act of making something human, familiar or agreeable” (9). It tries to highlight the nature of the care that is provided during labour and birth, to capture the emotional meaning of something that is the opposite of inhuman or dehumanised care described by Hollander *et al.* as traumatic experience during childbirth. This author points out that things such as the loss or absence of control, fear for the life or health of the baby, pain or intense physical discomfort, poor communication or failure to receive explanations about the expected results of diagnostic tests or treatments, feeling ignored when an intervention is refused, or the perceived deprivation of practical or emotional help, were the issues most frequently associated with traumatic experiences during childbirth, and that preventing their occurrence was within the power of the caregivers (10).

We believe that it would be more appropriate to refer to excellence in care during childbirth. According to the definitions of the Royal Spanish Academy, excellence refers to superior quality or goodness that makes something worthy of unique appreciation or esteem, or deserving the respect and courtesy accorded to people on account of their situation (9).

When analysing the quality of obstetric care, the minimum acceptable level is the absence of avoidable maternal deaths, followed by a reduction in preventable maternal near-miss. The next tier is safe care, secured through the implementation of the analysis of clinical incidents and risk management systems designed to reduce the occurrence of avoidable adverse events. The top tier in quality assessment would be excellence in childbirth care, attained through compliance with the criteria described above, that are included under the concept of humanised childbirth.

Excellence in childbirth care is an area that concerns, in particular, obstetricians, general practitioners, nurses working in the areas of maternal and perinatal health, and anaesthesiologists. It also concerns health service organisations, from scientific directors and managers all the way to housekeeping operators and security staff. Likewise, it should be of concern of higher education institutions where faculty, undergraduate and graduate students in medical and surgical specialties, and masters and doctoral programs dealing with maternal health, must all promote awareness of the principles and the theories that support excellence during birth.

The paper that prompts this editorial approaches the problem from a general perspective and makes us ask the question: What is the situation of excellence in childbirth care in Colombia? To what extent does childbirth care comply with the principles of excellence? Is this compliance the same for all pregnant women?

In 2008, Conde Agudelo *et al.* (11) published the results of a survey on the intrapartum use of evidence-based interventions. The survey was conducted in eight public and seven private institutions in Cali, Colombia, and was based on the review of the clinical records of low risk pregnancies and in-depth interviews with healthcare providers. It found a frequency of 70% and 75% in the use of enemas and shaving, respectively, and the presence of a companion in 14% of cases. The providers recognised the benefits

of giving support to the patient during labour, but they offered multiple explanations as to why this support does not happen in reality in public hospitals, unlike the situation experienced by patients in private institutions.

As mentioned previously, in the Care Guidelines for childbirth published in Colombia in 2013 (1), the first recommendation is to embrace the principles that support humanised care in childbirth. Other recommendations are designed to ensure care on the basis of those principles and include the presence of a companion of the patient's choice; the suggested frequency of vaginal examination, ensuring privacy and respect during the procedure; good communication when interventions are required or when complications emerge; the right to pain control if requested by the patient, preferably by means of neuroaxial techniques; and avoiding the use of enemas and perineal shaving.

There is little information regarding the implementation of these recommendations in cases of uncomplicated delivery, and even less regarding whether they are applied equally in private and public institutions, regardless of socioeconomic status, age, or clinical condition of the patients; however, there is information that could shed light on the existing situation.

For example, in the Management Guidelines for Labour and Childbirth published by the Bogota Health Secretariat in 2013 (12) mention is made of pain control during labour using opioids and "peridural analgesia whenever it is available". This leads to the assumption that this technique, recognised as the best for pain control during childbirth, is not offered consistently in public institutions in Bogota (13). If this is the case in the city of Bogotá, where the best standards of care are available for maternal care in public institutions, doubts emerge regarding pain control in Level I hospitals located in other regions of the country and, in particular, in the rural areas. These inequalities in obstetric analgesia in Colombia

have been discussed in the past (14). If the majority of deliveries in Colombia take place in the institutional setting (98.6%) (15), obstetric analgesia, including neuroaxial techniques, must be offered and given to that same proportion of pregnant women. The infrastructure conditions and service offerings should include full availability of obstetric analgesia nationwide.

Another hurdle to the implementation of the Childbirth Guideline is the economicistic approach adopted by national and local health authorities and healthcare administrators, which emphasises efficiency over effectiveness, safety, patient preferences and patient rights. In the case of Bogotá, the current administration has decided to centralise obstetric care in a few hospitals (16), increasing geographic barriers for pregnant women, and disregarding the principles of excellence in childbirth care, respect for preferences, cultural background, and the right to autonomy. This kind of decision affects more women from low income brackets, and is yet additional proof of the inequity prevailing in the realm of health in Colombia, and in maternal health in particular, as already pointed out. (17)

What should be the role of scientific societies and the academia?

Scientific societies are called upon to play a very important role in ensuring that the principles of excellent and equitable care during childbirth are complied with for all pregnant women. First of all, they must create awareness among specialists in obstetrics, anaesthesia, and paediatrics, and among general practitioners and nurses, regarding the importance of respecting the rights of women in labour, and exhibiting an ethical, polite and caring behaviour, beyond institutional limitations, using the best available evidence to support the practice of obstetrics and clinical care. On the other hand, they must commit to exercising social control so that government agencies are called upon to issue regulations that enable the implementation of the

recommendations contained in the Guidelines, and so that managers and administrators of Benefit Plan Promoters and providers offering maternal care undertake changes to the structure and inter/intra-institutional care processes in order to promote the use of top quality standards of care during labour and childbirth, rendering obstetric violence intolerable. As for the academia, it is very important for undergraduate and graduate students working in pregnancy and delivery care to understand the importance of respecting the autonomy of patients; recognise, understand and respect cultural differences; and safeguard the privacy and dignity of the woman during the gynaecological examination, which must only be performed when absolutely necessary to check the progress of the delivery and not for any other reason. Undergraduate students must be familiar with human rights, sexual and reproductive rights, and the ethical principles that they must bear in mind when providing medical care and, in particular, maternal care. These components must be included in the respective syllabuses, beyond technical and scientific considerations. Obstetric care is besieged by multiple ethical dilemmas, including respect for other peoples, the guarantee of justice and equity, and the exercise of autonomy, which have to be faced by all the players involved. Their existence recognised challenges professionals, administrators, patients and institutions to attenuate the inequities resulting from differential obstetric care quality depending on socioeconomic bracket, healthcare regime or geographic location.

On the other hand, studies are needed to assess compliance with the recommendations of the Guidelines aimed at securing humanised childbirth and eliminating barriers to access, structures and care processes that limit their application in the private realm as well as in the contributive and subsidised healthcare regimes. Studies are also needed to assess indicators that can be used to verify compliance with standards of excellence during labour and childbirth care.

Care of pregnant women during prenatal visits and throughout pregnancy must be one of the processes where evidence derived from clinical research, good practices, experience, solidarity and respect, and the absence of barriers must all converge for the benefit of the product of gestation and the mother. ZERO tolerance for obstetric abuse.

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