



Assessment of provider competence and quality of maternal/newborn care in selected Latin American and Caribbean countries

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ABSTRACT

Objective. To obtain a snapshot of the maternal and newborn care provided by different types of maternal and child health providers in Latin America and the Caribbean (LAC) to 1) better inform advocacy and programmatic strategies and interventions to improve the quality of those services in the region, and 2) determine the need for more rigorous study of the issues.

Methods. A rapid assessment of 83 health workers providing antepartum, intrapartum, and immediate postpartum and newborn care (within two hours of birth) in eight LAC countries was conducted in November and December of 2011. Health workers were observed by two-person expert maternal/newborn clinician teams using pretested forms based on international quality-of-care standards. A total of 105 care encounters were observed, primarily in urban, public, referral-level settings. Providers of care included obstetricians, midwives, generalist physicians, medical residents, registered nurses, auxiliary nurses, and students of medicine, midwifery, and nursing.

Results. Hand washing, as an indicator of quality of antepartum care, was observed in only 41% of the observed encounters. Labor management often lacked certain elements of respectful maternity care across all provider groups. Several clinical tasks of high importance in the identification and prevention of common complications of antepartum, intrapartum, and immediate postpartum/newborn care were not documented as performed during the observation periods. Providers self-reported limited competence (ability to perform to a defined level of proficiency) in manual removal of the placenta, bimanual compression of the uterus, and newborn resuscitation.

Conclusions. The findings suggest that 1) the quality of maternal and newborn care and 2) the competence of maternal and child health providers in the diverse selection of LAC countries that were studied require substantial attention.

Key words

Women's health; quality assurance, health care; maternal and child health; clinical competence; midwifery; Bolivia; Chile; Colombia; Guatemala; Guyana; Honduras; Panama; Peru; Latin America; Caribbean Region.

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The health of women, including mothers, and newborns (NBs) in Latin America and the Caribbean (LAC) is vital for growth and economic development in

each country and the region as a whole. Yet a high number of women and NBs continue to die during the childbearing cycle. The average maternal mortality ratio (MMR) for the LAC region in 2010 was estimated at 88.9 per 100 000 births or 9 500 maternal deaths. These figures represent a decrease of 41% (1) compared to the 1990–2010 period, which is not a sufficient rate of reduction for the region to achieve the Fifth Millennium Development Goal (MDG 5)⁵ target of reducing maternal deaths by 75% by 2015 (2). There were nine (out of 35) LAC countries with MMRs above the regional average (Bolivia, Dominican Republic, Guatemala, Guyana, Haiti, Honduras, Paraguay, Peru, and Suriname). The perinatal mortality rate for the region was 21.3 per 1 000 live births (3) over the same period. The 12 countries with above-average perinatal mortality included Bolivia, Colombia, Dominican Republic, El Salvador, Guatemala, Guyana, Haiti, Honduras, Mexico, Nicaragua, Paraguay, and Suriname.

A strategy for the use of “skilled birth attendants” (SBAs) or “trained personnel” (both terms are used across the region) (4) was adopted in the LAC region more than a decade ago (5, 6). A vital part of the new women’s health agenda for the region (post-2015) is determining if providers considered to be SBAs/“trained personnel” in a given country qualify for that distinction based on competencies (knowledge, skills, and professional behaviors). A substantial body of evidence indicates that having SBAs/“trained personnel” competent in providing high-quality evidence-based maternal and NB care can substantially reduce maternal and neonatal mortality (7–11).

However, many countries in the region use a count of institutional births as a proxy measure for SBAs/“trained personnel” attending a birth, without regard for the qualification of who actually attended the birth. Information on the provision of antepartum (AP) and birth care by SBAs/“trained personnel” is submitted by LAC countries as official data for the basic health indicators for the Americas region published annually by the Pan American Health Organization (PAHO) (1). This information does not include the categories of the providers who actually delivered the care, or

their formal education or competencies. Concern about this information gap is exacerbated by the variation in the definition of SBAs/“trained personnel” across countries. In many countries, the sole criterion for determining if a provider qualifies as a SBA/“trained personnel” is his/her title (“nurse,” “physician,” “midwife,” “auxiliary nurse,” etc.) (12). There is no attempt to determine providers’ credentials or the specific type that are delivering the AP/intrapartum (IP)/immediate postpartum (PP) and NB care (within two hours of birth) (13). In addition, data for different types of providers are often aggregated in the reporting of the results. For example, data for registered nurse (RN) and midwifery personnel are often combined with data for auxiliary personnel, and the term “doctor” often includes all types of physicians—interns, residents, generalists, specialists (e.g., obstetricians (OBs)), etc.

Observing that several countries with high percentages of care (AP and birth) attributed to SBAs/“trained personnel” had mortality statistics higher than the regional averages, the LAC Regional Task Force on Maternal Mortality Reduction (*Grupo de Trabajo Regional para la Reducción de la Mortalidad Materna*, GRT) decided to carry out an initial assessment to obtain a better understanding of the reasons for this counter-intuitive result. The objective of the assessment was to obtain a snapshot of maternal and NB care provided by different types of maternal and child health providers in the LAC region to 1) better inform advocacy and programmatic strategies and interventions to improve the quality of those services in the region, and 2) determine the need for more rigorous study of the issues.

MATERIALS AND METHODS

Study design

A rapid assessment of 83 health workers who were providing AP, IP, and immediate PP and NB care in eight countries in the LAC region was conducted to determine which types of providers were actually delivering the care (based on titles and credentials) and which elements of quality and competence in their caregiving could be observed and thus used as study indicators.

Health authorities from the eight countries—six of the higher-mortality

countries in the region (Bolivia, Colombia, Guatemala, Guyana, Honduras, and Peru) and two with more favorable health statistics (Chile and Panama)—were invited and agreed to participate in the assessment.

Ethical considerations

Because the assessment was designed as a mixed-method survey as a practical means for answering basic questions on quality of care, rather than for research purposes, human subjects review board approval was not solicited. Formal administrative authorization for the conduct of the rapid assessment was provided by the United Nations Population Fund (UNFPA) LAC regional office. Ethical guidelines for conduct of observational assessments were followed. Informed consent, and a protocol for intervention by the expert observers in the event that life-threatening complications arose during the period of observation, were obtained from both the health providers who volunteered to participate in the study and the women under their care.

A direct observation approach using expert clinicians as observers of care was selected for documenting health provider credentials and practices. Administrative approval was obtained from the relevant authorities (e.g., ministers of health) in each of the eight countries that were invited and agreed to participate in the study.

Country selection for the study was based on the authors’ aim to collect data on a diverse array of models for the provision of childbearing care (described in detail elsewhere (14)) in settings with sufficient geographic and health facility diversity (Box 1). The facilities where health providers could be observed in each country were selected by country officials. Providers at those facilities volunteered to participate after listening to the description of the purpose of the observations.

Instruments

Standardized observation tools were developed for purposes of this assessment by a panel of experts who used international standards and guidelines (15–18) to develop assessment criteria for each of the four clinical practice areas: 1) first AP visit; 2) follow-up AP

⁵ “Improve maternal health.”

BOX 1. Country selection criteria

- Ministry of Health officials willing to cooperate with project staff
- Different models of childbirth care available
 - Traditional midwifery and institutional obstetric care—Guatemala
 - Institutional obstetric care and certified traditional birth attendants—Bolivia, Honduras, and Panama
 - Institutional and community professional midwifery with obstetric team model—Chile, Guyana, and Peru
 - Institutional obstetric care, limited institutional and community professional midwifery, and/or midwifery in development—none
 - Institutional obstetric care without professional midwifery care—Colombia
- Geographic diversity (i.e., rural and urban areas)
- Health facility diversity (i.e., community (“health posts”), district/referral hospitals, public and private facilities)

visits; 3) labor management; and 4) birth, and immediate PP and NB care. The tools were based on seven observable quality-of-care indicators directly linked to health outcomes for mothers or NBs and explicitly cited in the WHO/FIGO/ICM⁶ scope of practice for SBAs (4, 19). The tools also included indirect measures of ethical approaches to service delivery, such as respectful maternity care (20).

Expert clinician observers were asked to provide two opinion ratings: 1) summative (on the quality of care provided) and 2) informed (on the demonstrated competency of the provider in performing the care that was observed). Given that the current project was time-limited, it was anticipated that the observers would not have the opportunity to observe management of complications. Therefore, individual providers were asked to self-report whether they had the competence and authorization to carry out the nine essential lifesaving skills for maternal and NB care defined by WHO (16). The tools were pretested in September 2011 at clinical sites in Panama.

Procedures

Two-person expert maternal/NB clinician observer teams were selected for each country depending on the availability of OBs, midwives, nurse consultant, and/or physicians with obstetric training. Team members received orientation on the use of the study instruments and were assessed in person and virtually

for their inter-rater reliability in the use of the tools. The observations took place from 21 November to 21 December 2011.

Data were analyzed using SPSS (SPSS, Inc., Chicago, Illinois, United States) with descriptive statistics, including frequencies and cross-tabulations. Individuals were grouped with similarly credentialed providers for some of the assessments to generate a sufficient sample size for analysis. The assessment was not sufficiently powered for use of inferential analyses.

RESULTS

Providers and settings

A total of 83 health care providers agreed to be observed in the eight countries studied. There was remarkable

heterogeneity across the countries in 1) titles and roles of the health providers, 2) health infrastructure, and 3) models of care, affirming the success of the authors’ efforts to include a diverse group of countries in the study.

The health facilities included in the assessment were primarily urban (93%), public (96%), and referral-level (96%). A total of 11 (13%) of all participating providers were observed in community clinics without maternity beds, and six (7%) providers were observed in community clinics with maternity beds. Guyana was the only country where rural facilities were included in the study.

A total of 105 care encounters were observed. Table 1 shows the distribution of the provider categories by country. As shown in the table, only 39 (47%) of the providers (OBs and midwives) qualified as SBAs according to the global definition. In most countries in the LAC region, SBAs/“trained personnel” also include generalist physicians and RNs with training in AP care and birth (1). It could not be determined, in the assessment, if this latter group of providers receives education in every skill listed in the SBA scope of practice. The observed health providers had been working in their respective settings for an average of 6.7 years (range: 1 day to 36 years).

Observed AP care was provided by all categories of providers, whereas observed labor management only included care provided by midwives (a total of 10), OBs (nine), generalist physicians (five), an OB resident, and nine provid-

TABLE 1. Categories of providers observed in rapid assessment of competence and quality in maternal/newborn care, Latin America, November–December 2011

Country	Midwife	OB ^a	Generalist physician	OB resident	AN ^b /RN ^c	Medical student/intern	Midwife student	RN student	Other
Bolivia	1	4	2	2	1 / 0	–	–	–	–
Chile	7	–	–	–	–	1	–	–	–
Colombia ^d	–	5	4	–	–	–	–	–	–
Guatemala ^e	–	3	1	1	4 / 0	1	–	–	1
Guyana ^f	4	–	1	–	–	–	2	–	–
Honduras ^g	–	1	4	1	1 / 0	3	–	–	–
Panama	1	2	7	–	0 / 1	2	1	1	–
Peru	10	1	–	2	–	–	–	–	–
Total	23	16	19	6	6 / 1	7	3	1	1

^a OB: obstetrician.

^b AN: auxiliary nurse.

^c RN: registered nurse.

^d Colombia’s model for labor/birth care involves physician/OB care of women in labor and their deliveries, with ANs providing immediate postpartum (PP) and newborn (NB) care (within two hours of birth).

^e Guatemala’s model of intrapartum care includes ANs (for labor, PP/NB care, and occasionally birth). In urban settings, physicians or residents provide birth care.

^f MEDEX program personnel in Guyana are trained in midwifery so were added to the midwife category for analysis.

^g Honduras observations included two patients with two providers each (one for birth and one for PP/NB care).

⁶ World Health Organization/International Federation of Gynaecology and Obstetrics (*Fédération internationale de gynécologie et d’obstétrique*)/International Confederation of Midwives.

TABLE 2. Observed quality of antepartum (AP) care by provider category in rapid assessment of maternal/newborn care, Latin America, November–December 2011

Providers by category (total number)	Greets patient respectfully	Provides respectful care throughout	Maintains privacy and confidentiality	Solicits questions and concerns	Provides information and counseling	Washes hands before and after care	Uses clean equipment
	Number of providers demonstrating quality of AP care (%)						
Midwives and OBs ^a (16)	16 (100)	15 (94)	13 (81)	14 (88)	15 (94)	10 (63)	15 (94)
Generalist physicians and OB residents (15)	15 (100)	15 (100)	11 (73)	10 (67)	11 (73)	3 (20)	12 (80)
Other (3)	3 (100)	3 (100)	2 (67)	3 (100)	2 (67)	1 (33)	2 (67)
Total providers (<i>n</i> = 34)	34 (100)	33 (97)	26 (76)	27 (79)	28 (82)	14 (41)	29 (85)

^a OBs: obstetricians.

TABLE 3. Observed quality of intrapartum (IP) care by provider category in rapid assessment of maternal/newborn care, Latin America, November–December 2011

Providers by category (total number)	Greets and treats woman respectfully	Maintains privacy and confidentiality	Encourages support companion	Provides information to woman	Provides supportive care and pain relief	Washes hands before and after care
	Number of providers demonstrating quality of IP care (%)					
Midwives and OBs ^a (19)	15 (79)	9 (47)	2 (11)	9 (47)	13 (68)	6 (32)
Generalist physicians and OB residents (6)	5 (83)	2 (33)	0 (0)	2 (33)	5 (83)	1 (17)
Other (9)	3 (33)	2 (22)	3 (33)	1 (11)	4 (44)	4 (44)
Total providers (<i>n</i> = 34)	23 (68)	13 (38)	5 (15)	12 (35)	22 (65)	11 (32)

^a OBs: obstetricians.

ers from the “Other” category (primarily auxiliary nurses (ANs) and medical or nursing students). The observation teams in Guatemala and Honduras noted that nursing and medical students often provided care without supervision.

Providers of care during births assisted with a mean of 93.7 births in the six months prior to the study (“last six months”), ranging from 35 (for ANs) to 164 births (for OBs). Some of the 37 encounters observed for the combined clinical care area of birth plus immediate PP/NB care involved a team approach.

Quality of care

Table 2 shows findings related to the observed quality of care provided during AP visits (initial and follow-up). The overall mean time spent by providers of AP care in a given setting was 30.4 minutes (range: 5–96 minutes). Findings for the aggregate provider groups (i.e., all observations for a particular indicator combined) ranged from 20% (for washing hands) to 100% (for one or more of the seven quality-of-care indicators⁷). A substantial number of the indicators were observed 50% or less of the time.

Six quality-of-care indicators⁸ were selected for observation of labor management (Table 3). The highest ratings for observed quality of care for all six indicators were for 1) greeting and treating the woman respectfully and 2) providing supportive care and pain relief. The lowest quality ratings were for 1) washing hands before and after care and 2) other elements of respectful maternity care, such as encouraging a support companion, and providing information to the woman.

Three quality-of-care indicators were identified for IP and PP/NB care: 1) maintaining clean technique during birth (observed in 81% of the deliveries); 2) treating the woman with respect (observed 65% of the time); and 3) promoting maternal–infant bonding (observed in only 46% of the observed encounters).

The expert observer teams provided their summative expert opinions about

⁷ Greets patient respectfully, provides respectful care throughout, maintains privacy and confidentiality, solicits questions and concerns, provides information and counseling, washes hands before and after care, uses clean equipment.

⁸ Greets and treats woman respectfully, maintains privacy and confidentiality, encourages support companion, provides information to woman, provides supportive care and pain relief, washes hands before and after care.

the quality of care offered by each category of provider, based on the observations conducted in each clinical area. The dichotomous ratings indicated that 75% of providers for initial AP visits and 52% of those for follow-up AP visits were providing good-quality care, according to the experts’ summative opinions for all discrete clinical task indicators (not shown). Less than half (44%) of all providers received a positive rating for good-quality care for labor management and only 41% received a positive rating for good quality for IP and PP/NB care.

Competency of care

A total of 156 performance indicators (clinical tasks) across AP, IP, and PP/NB clinical areas were included in the observational assessment of provider performance. The clinical tasks (some of which were repeated in one or more clinical areas) involved the use of skills or behaviors related to assessment, diagnosis, and/or management of normal pregnancy, plus five specific PP/NB complications that occurred at a high frequency in the LAC region. These included hypertensive disorders of pregnancy, vaginal bleeding, anemia,

bacteriuria, and syphilis. The expert observers documented whether they could affirm that the providers inquired about or attended to each of the specific clinical tasks that comprised the indicators.

The clinical tasks most often omitted (i.e., documented in less than one-half of the observations) during provision of AP services included inquiring about certain factors in the prior pregnancy history (contraceptive use, history of pregnancy-induced hypertension, and history of vaginal bleeding) and problems that had occurred since the previous visit.

During labor management, the providers were documented as noting the status of membranes and using sterile technique for rupture of membranes in only 50% of observed care encounters. Partograph use was documented for only 37% of patients in labor. There was a policy endorsing the use of active management of third stage of labor in all but one of the countries studied, but across all providers in all countries only 15% deferred cutting and clamping the cord until pulsation had stopped.

A two-hour period of maternal and NB monitoring, including assessment of maternal and NB vital signs and maternal fundal status at least every 15 minutes, was documented in only 27% of PP/NB observations. Skin-to-skin maternal–NB contact and the promotion of early breastfeeding were documented in less than one-third of the care encounters.

The observer teams also provided their expert opinion on provider competency based on what they observed in the clinical setting, scoring them as either “competent” or “needs improve-

ment.” A “needs improvement” rating indicated the provider did not perform all clinical tasks for a particular skill, according to the recommended international guidelines or standards (16, 18). Generalist MDs were rated as “needs improvement” in 0% of tasks for labor management and IP and PP/NB care but 44% of tasks for AP visits. OBs received that rating for 18% of tasks for IP and PP/NB care and 50% of tasks for AP visits. Providers in the “Other” category received that summative rating for 8% of tasks for IP and PP/NB care to 50% of tasks for follow-up AP visits. Professional midwives received the “needs improvement” rating for 9% of tasks for AP visits but only 20% of tasks for labor management—the best overall performance achieved among all types of providers across all clinical areas.

Self-reported competence. Table 4 provides a snapshot of what the providers observed in this assessment thought about their own ability to perform any of nine lifesaving obstetric and newborn skills (starting an IV, prescribing or administering antibiotics, prescribing or administering a uterotonic, prescribing or administering magnesium sulphate, performing forceps or vacuum delivery, performing manual removal of the placenta, performing manual vacuum aspiration, performing bimanual uterine compression, and conducting NB resuscitation).

Of special concern, according to the self-reported ratings, was the low level of competence related to 1) manual removal of the placenta, 2) bimanual compression of the uterus, and 3) NB

resuscitation reported by all categories of providers managing labor—three of the nine skills designated as lifesaving. Physicians, OBs, and midwives were authorized to perform these skills in each of the countries studied. Midwives did not have authorization to perform assisted vaginal delivery or manual vacuum aspiration, in any of the eight countries studied, so the proportions of those procedures reported in Table 4 are for OB self-report only.

DISCUSSION

The profile of the health provider categories represented in this rapid assessment appears to be consistent with research by Pettersson & Stone (14) that documented midwifery services in the LAC region. In three countries studied in this assessment (Colombia, Guatemala, and Honduras), there are no professional midwives, so the observations in those countries were of generalist physicians, OBs, and auxiliary nursing personnel. In Chile, Guyana, and Peru, professional midwives provide the majority of childbearing care, so the providers who volunteered to be observed were predominantly midwives.

Many recent studies (10, 21–24) have attempted to determine the importance of SBAs in reducing maternal mortality. These studies did not use the same definition of SBAs (4), however, so it is difficult to compare their findings. This same discordance in language was evident in the LAC region, and in this study, where in both cases the term “trained personnel” seemed interchangeable with “SBAs,” with no data on specific educa-

TABLE 4. Self-report of competence in nine lifesaving skills by provider category in rapid assessment of maternal/newborn care, Latin America, November–December 2011

Providers by category (total number)	Start IV ^a	Prescribe or administer antibiotics	Prescribe or administer uterotonic	Prescribe or administer magnesium sulphate	Perform forceps or vacuum delivery	Perform manual removal of the placenta	Perform manual vacuum aspiration	Perform bimanual uterine compression	Conduct newborn resuscitation
	(Number of providers reporting current competence (%))								
Midwives and OBs ^b (37)	30 (81)	36 (97)	37 (100)	36 (97)	13 (35)	21 (57)	13 (35)	27 (73)	19 (51)
Generalist physicians and OB residents (25)	21 (84)	24 (96)	23 (92)	24 (96)	6 (24)	19 (76)	10 (40)	18 (72)	13 (52)
Other (14)	13 (93)	13 (93)	12 (86)	10 (71)	0 (0)	4 (29)	1 (7)	4 (29)	5 (36)
Total providers (n = 76 ^c)	64 (84)	73 (96)	72 (95)	70 (92)	19 (25)	44 (58)	24 (32)	49 (64)	37 (49)

^a IV: intravenous therapy.

^b OBs: obstetricians.

^c Two self-assessments were missing from the Midwives & OBs group and five self-assessments were missing from the “Other” group for a total of 76 completed self-assessments out of a total of 83 persons observed.

tion or competencies that would correspond to SBA scope of practice.

In addition, these published studies often aggregate a variety of health professional categories (doctors, midwives, and nurses), so it is difficult to determine what impact they have, as distinct cadres, on the reduction of maternal and neonatal mortality and morbidity. The recent report by Homer et al. (25) clearly points to the potentially positive impact of the use of fully skilled midwives in the provision of maternal and NB care. Other studies support the potential impact on increasing skilled birth attendance that could be achieved through strengthening the midwifery workforce (26).

Quality of care

The quality-of-care items that need improvement across all categories of health providers that were observed included the psychosocial elements of privacy, encouraging a support companion, providing information on the progress of labor, and supporting maternal–NB bonding and breastfeeding. The lack of immediate and continued monitoring of both the mother and NB after the birth was also notable. Belizán et al. (27) noted that the provision of woman- and family-centered care, which included a focus on its cultural, emotional, and social aspects, were among the goals for maternal and perinatal care established for the LAC region.

Competency of care

Being skilled means that the provider is competent to carry out a package of interventions that have been defined as essential interventions for high-quality maternal and NB care (18). The definition of competence used in this assessment was drawn from the ICM Glossary of Terms (28) and based on an extensive literature review by Fullerton et al. (29). As defined in the ICM glossary, health provider competence is “the combination of knowledge, psychomotor, communication and decision-making skills that enable an individual to perform a specific task to a defined level of proficiency” (28). The defined level of proficiency is measured against clinical standards, and, as the observation team for this assessment found, such standards were often not met.

For clinical indicators that only corresponded to small numbers of providers, aggregate groupings were used to present the findings. The clinical areas with the lowest levels of demonstrated competency across several of the aggregate groups included history-taking during AP visits and some stages of labor management, especially for prior complications of pregnancy, and assessment of current signs of hypertension in pregnancy and anemia. Use of the partograph and immediate PP/NB care were the clinical areas of concern in IP care. High-volume settings and use of lesser-skilled staff (and those who were completely unqualified, in some observations) almost certainly contributed to the low levels of quality and competence noted in the observations (30, 31).

Self-reported competence. Many health providers reported some clinical tasks that they were authorized and had the knowledge to carry out but for which they lacked a specific skill at the time of the study. One possible explanation for the low level of competence reported in these cases is lack of experiences that would maintain their skills, as noted in the work of Janakiraman et al. (31), especially in low-volume rural sites. Another explanation may be that in high-volume sites there are often certain types of providers who perform specific specialized functions, limiting opportunities for other providers to build and/or maintain certain skills. Facility or environment-of-care factors may also have affected poor performance, as noted in other reports (22, 32). For whatever reason(s), nine of the 14 providers in the “Other” category with a self-reported lack of skill in managing life-threatening conditions were caring for women in labor and at birth. Ongoing enhancement, monitoring, and evaluation of SBA/“trained personnel” competency is a fundamental responsibility of the health systems that engage these providers’ services (33).

Recommendations

The findings from this observational assessment suggest a number of areas of concern related to the quality of maternal and NB care and the competence of providers. These concerns will be communicated to each country studied, along with the study limitations described below. Recommenda-

tions from this assessment that will be incorporated into these discussions include: 1) all countries in the LAC region should use the same definition of SBAs/“trained personnel” so that monitoring progress in achieving the target indicators for MDGs 4⁹ and 5, and those established for the post-2015 agenda (34), is both valid and reliable within and across countries; 2) each LAC country/health facility would benefit from periodic assessment of maternal/NB care provider competency and should strongly advocate and facilitate partnership with educational institutions and government health authorities to provide periodic updates of knowledge and skills for all health personnel; and 3) human resource development and deployment strategies need to consider the availability of health providers skilled in the specific services that are needed. Advocacy and programmatic strategies for improving the quality of maternal/NB care are planned by the LAC GTR, and future LAC work plans supported by donors should address strengthening the maternal and child health workforce in the region through both pre-service and in-service education and regulation (35).

Limitations

Limitations of this study include its small sample size, for both LAC countries and number of participants, which restricted the analysis to descriptive methods. However, the fact that low levels of performance of several critical maternal and child health skills were observed among participants who volunteered to be observed indicates that the study methodology was likely not restricted by the observer effect.

Conclusions

The impetus for carrying out this rapid assessment of selected indicators of good-quality maternal and NB care and the related competence of health providers came from a concern in the LAC region that several countries who report high levels of SBAs/“trained personnel” providing AP care and attending births had mortality statistics higher than the average for the region in 2010.

⁹ “Reduce child mortality.”

The findings suggested that the quality of the maternal and NB care and the competence of the maternal and child health providers in the diverse selection of LAC countries that were studied require substantial attention.

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Conflicts of interest. None.

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RESUMEN

Evaluación de la competencia de los proveedores y la calidad de la atención materna y del recién nacido en países de América Latina y el Caribe

Objetivo. Obtener una visión panorámica de la atención materna y del recién nacido prestada por diferentes tipos de proveedores de salud materno-infantil en América Latina y el Caribe para 1) fundamentar mejor las estrategias e intervenciones de promoción de la causa y programáticas con objeto de mejorar la calidad de esos servicios en la región, y 2) determinar la necesidad de estudios más rigurosos sobre estos temas.

Métodos. En noviembre y diciembre del 2011, se llevó a cabo una evaluación rápida de 83 trabajadores sanitarios que prestaban atención antes del parto, intraparto, y posparto inmediata y del recién nacido (durante las dos horas posteriores al parto) en ocho países de América Latina y el Caribe. Los trabajadores sanitarios fueron observados por equipos de dos clínicos expertos en atención materna y del recién nacido mediante el empleo de instrumentos previamente puestos a prueba y basados en estándares internacionales de calidad de la atención. Se observaron 105 encuentros de atención que tuvieron lugar principalmente en centros de atención urbanos, públicos y de derivación. Los proveedores de atención fueron obstetras, parteras, médicos generalistas, médicos residentes, personal de enfermería titulado, personal auxiliar de enfermería, y estudiantes de medicina, partería y enfermería.

Resultados. El lavado de las manos, como indicador de la calidad de la atención antes del parto, solo se observó en 41% de los encuentros observados. El manejo del parto a menudo carecía de ciertos elementos de atención respetuosa a la maternidad en todos los grupos de proveedores. Durante los períodos de observación, no se pudo comprobar la realización de diversas tareas clínicas de alta importancia para detectar y prevenir las complicaciones comunes de la atención antes del parto, intraparto, y posparto inmediata y del recién nacido. Los proveedores autotificaron limitada competencia (capacidad para operar a un nivel definido de habilidad) en la extracción manual de la placenta, la compresión bimanual del útero y la reanimación del recién nacido.

Conclusiones. Los resultados indican que 1) la calidad de la atención materna y del recién nacido y 2) la competencia de los proveedores de salud materno-infantil en los países de América Latina y el Caribe estudiados requieren considerable atención.

Palabras clave

Salud de la mujer; garantía de la calidad de atención de salud; salud materno-infantil; competencia clínica; tocología; Bolivia; Chile; Colombia; Guatemala; Guyana; Honduras; Panamá; Perú; América Latina; región del Caribe.