Safe and family-centered maternity hospitals: organizational culture of maternity hospitals in the province of Buenos Aires

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ABSTRACT

Introduction. In 2010, the Safe and Family-Centered Maternity Hospitals initiative was launched in order to transform large public maternity centers into settings where safe practices are implemented and the rights of women, newborn infants and families are warranted. As a result, the paradigm of perinatal care was modified. This article reports on the findings of organizational culture as a component for the implementation of the initiative.

Population and Methods. The sample was selected in a non-probabilistic way and was made up of 29 public hospitals located in the province of Buenos Aires that participated in the initiative. During 2011 and 2012, an anonymous, self-administered survey was completed by members of the Department of Neonatology and the Department of Obstetrics. The survey collected information on three dimensions of the organizational culture: organizational environment, safe practices, and facilitation of change.

Results. A total of 1828 surveys were collected; 51% of survey respondents stated that there is a need to improve communication by having more meetings, while 60% made a positive assessment of various aspects of leadership. Work overload was described as the main cause of conflicts by 60%. Approximately 25% agreed and showed commitment with the initiative of transforming maternity centers. Adherence to practices was dissimilar depending on the practice, but half of survey respondents reported that there were genuine reasons for change.

Conclusions. The assessment of the organizational culture showed that commitment to the Safe and Family-Centered Maternity Hospitals initiative is yet to be consolidated, and the evaluation of leadership is not comprehensive. Work overload and communication failures are the main reasons for conflict.

Key words: *perinatal care, health care quality, patient safety, organizational culture, family-centered care.*

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INTRODUCTION

In Argentina, the quality of health care provided to women during pregnancy, childbirth and postpartum and to newborn infants is still a challenge for health policies given the need to reduce inequalities in the opportunity to access a timely and good quality medical care. Maternal morbidity and mortality and neonatal mortality are still at a level that is unacceptable for a country with the degree of economic and social development of Argentina.[1,2]

Facing the challenge proposed by the Operational Plan to Reduce Maternal and Child Mortality and Mortality of Women and Adolescents established by the United Nations International Children's Emergency Fund (UNICEF), Argentina, the National Ministry of Health of Argentina and ten Provincial Ministries of Health agreed, in 2010, to promote the Safe and Family-Centered Maternity Hospitals (SFCMH) initiative to transform large public maternity centers into settings where safe practices are implemented and the rights of women, newborn infants and families are warranted as part of institutional policy goals.[3,4]

SFCMH is a complex intervention structured around five conceptual themes stating its ethical and political bases: organizational culture; protection of the rights of mother, father and child; participation of family members in the protection and care of mother and child; implementation of safe and effective practices; and strengthening of other initiatives regarding perinatal health promotion.[5]

Organizational culture is a set of codes that guide the behavior and practices of members of an organization, therefore, it impacts processes of change in different ways.[6] The organization's history, together with its members' expectations, motivations and interests, make up the organiza-

tional environment that will react to change and either facilitate or hurdle the implementation of an innovative intervention.[7]

In 2011, the Center for State and Society Studies (*Centro de Estudios de Estado y Sociedad*, CEDES) was invited to design and coordinate an organizational culture assessment instrument for the complex SFCMH intervention, which is made up of several instruments.[8] During 2011 and 2012, the organizational culture was evaluated in 29 maternity hospitals that cater for more than 1000 deliveries in the province of Buenos Aires. The objectives of such assessment were a) to systematize knowledge, appraisals and practices of health teams in relation to SFCMH; b) to identify barriers and facilitators for the implementation of this initiative, and to assess its feasibility; and c) to provide a baseline to monitor changes in the organizational culture of each hospital as the model becomes consolidated.

This article describes the results of the assessment conducted at 29 maternity hospitals to describe the main characteristics of the organizational culture of selected maternity centers.

POPULATION AND METHODS

Based on a review of the literature, a conceptual framework based on three constructs was developed: *organizational environment*, which refers to leadership, internal communication, predisposition to change and conflict management dimensions; *practices*, which refer to the implementation of safe and effective practices, participation in and respect for rights, and adherence to the Mother and Child Friendly Hospital (MCFHI) initiative, which is one of the steps in the SFCMH initiative; and *facilitation of change*, which refers to regulations that govern perinatal care and the hospital's commitment to change.[7,9]

A cross-sectional design with quantitative and qualitative data collection techniques was implemented. This article reports on the results of the quantitative component. The sample was selected in a non-probabilistic way and was made up of 29 tertiary care public hospitals (IIIA and IIIB) of the province of Buenos Aires and participating in the SFCMH initiative (*see Annex 1* in electronic format version), located in nine of the twelve health regions of Buenos Aires. In 2012, these 29 maternity hospitals catered for 78 919 deliveries, which account for 28% of all births in Buenos Aires (282 031 live births in 2012), with an average of 2721 births (range: 701-5498).[10,11] Maternity centers were selected jointly by the Ministry of Health of the province of Buenos Aires and UNICEF. All selected hospitals agreed to participate in the study. Field work was conducted over a two-year period (2011 and 2012) until completing assessments in all selected maternity hospitals.

The survey was self-administered and anonymous, and included 29 questions with categorical answer options and Likert scales. The survey was tested to assess its internal logic,

TABLE 1. *Characteristics of survey respondents (n = 1828)*

Characteristic	*Number of participants (%)*
Department	
Neonatology	677 (37%)
Obstetrics	987 (53%)
Other	73 (4%)
Does not answer	91 (5%)
Sex	
Female	1480 (81%)
Male	238 (13%)
Does not answer	110 (6%)
Profession	
Nurse	677 (37%)
Obstetricians/Obstetrics residents	402 (22%)
Neonatologists/Neonatology residents	238 (13%)
Midwives	274 (15%)
Others	146 (8%)
Does not answer	92 (5%)
Professional experience (years)	
≤30	227 (12%)
31-35	228 (13%)
36-40	243 (13%)
41-45	214 (12%)
46-50	207 (11%)
>50	278 (15%)
Does not answer	431 (24%)
Professional experience (years)	
<2179	(10%)
2-5	203 (11%)
6-10	257 (14%)
11-15	221 (12%)
16-20	272 (15%)
21-25	203 (11%)
>25	239 (13%)
Does not answer	254 (14%)
Years of experience in the hospital	
<2	302 (17%)
2-5	238 (13%)
6-10	243 (13%)
11-15	243 (13%)
16-20	186 (10%)
21-25	150 (8%)
>25	122 (7%)
Does not answer	344 (19%)

wording of questions, and validity of answer categories. The survey was then distributed among health care staff members working in the Department of Neonatology and the Department of Obstetrics, together with an informed consent form and an envelope. Those who agreed to participate completed the survey, placed it in the envelope and deposited the envelope in a sealed box located in each department. Survey questions were divided into five thematic focuses: basic information on survey respondents, dynamics and functioning of the Department, practices, institutional policies regarding the SFCMH initiative, and training needs.

Surveys were edited and entered into a database using the SIPE win software.[12] Analysis was based in single frequencies and double-entry tables. Answers were analyzed by department, except for questions on practices, which were considered as a whole. This was decided because, according to the SFCMH initiative, mother and child should be assisted by trained personnel, regardless of whether they work in one department or the other.

RESULTS

A total of 1828 surveys were collected, which accounted for a 60% response rate (37%-95%; mean: 62%). *Table 1* shows the profile of survey respondents.

For the purpose of this article, the most relevant assessment results obtained from the self-administered survey were selected. Material analysis focused on key aspects of the three constructs. For *organizational environment*, analysis covered leadership, communication and conflicts. At least half of survey respondents made a positive evaluation of four out of the seven leadership qualities regarding their heads of department, with better agreements observed in the Department of Neonatology. Among options describing leadership included in the survey, "allowing team members to freely express their ideas" and "taking into account any problem occurring at the department" were positively evaluated in both departments, especially in the Neonatology unit (*Table 2*).

In terms of communication, 40% considered that decisions regarding the department were

TABLE 2. *Organizational environment - leadership assessment by department*

Leadership quality	Department	Strongly agree and agree (%)	Neither agree nor disagree (%)	Disagree and strongly disagree (%)	Does not know, does not answer (%)
1	Obstetrics	58	12	26	4
	Neonatology	67	11	17	5
2	Obstetrics	56	31	7	6
	Neonatology	67	23	5	6
3	Obstetrics	55	30	8	7
	Neonatology	71	21	6	7
4	Obstetrics	49	37	8	6
	Neonatology	57	33	5	6
5	Obstetrics	46	38	10	6
	Neonatology	71	21	6	7
6	Obstetrics	46	39	10	6
	Neonatology	56	33	6	5
7	Obstetrics	43	36		7
	Neonatology	53	31	8	7

Leadership qualities:
1: All team members are able to freely express their ideas to the head of department.
2: The head of department takes into account any problem occurring at the department.
3: The head of department encourages and supports proposals for change aimed at improving patient care.
4: Ideas and proposals made by the team are considered by the head of department.
5: The head of department works cooperatively with department staff members in order to carry out adequate changes within the department.
6: Team members trust decisions made by the head of department.
7: Team members are able to question decisions made or actions taken by the head of department.

N.B.: In order to facilitate reading the table, the following categories were grouped: "strongly agree" and "agree", "disagree" and "strongly disagree", "does not know" and "does not answer".

communicated in a way that did not warrant that everyone involved was informed. Fifty-one percent agreed that regular meetings were necessary to improve communication, while 36% considered that communication would improve if there were more communication channels available between team members and heads of department; 34% considered that communication would improve with more open debates on routine topics and cases; and 33% considered that it would improve if more technical updates on specific cases were provided (*Table 3*).

In terms of conflicts, work overload was the cause of conflict according to 60% of survey respondents, while communication problems were the cause for half of respondents (54% in the Department of Neonatology, 45% in the Department of Obstetrics). To a lesser extent, competition among professionals (36%), how decisions regarding task organization were

TABLE 3. *Dynamics and functioning of the Department of Obstetrics and the Department of Neonatology - communication variable*

"Information, changes or important decisions are reported…" (choose up to two statements)	**Number of references (%)** **Total N= 1828 (100%)**	**Obstetrics N= 976 (53%)**	**Neonatology N= 683 (37%)**
Orally at meetings where not necessarily all staff members are present	731 (40%)	400 (41%)	273 (40%)
Through informal exchanges	668 (36%)	429 (44%)	239 (35%)
Orally, by the head of department at a meeting so that they are conveyed to the entire team	475 (26%)	224 (23%)	191 (28%)
On a board or bulletin board that is clearly visible to all staff members	347 (19%)	176 (18%)	150 (22%)
Through a written note hand-delivered to all staff members	238 (13%)	117 (12%)	96 (14%)
On a board or bulletin board that is not clearly visible to all staff members	128 (7%)	78 (8%)	68 (10%)
"Situations that may improve communication and decisions at your department…" (choose up to two statements)	**Number of references (%)** **Total N= 609 (100%)**	**Obstetrics N= 346 (57%)**	**Neonatology N= 218 (36%)**
Regular meetings with all team members aimed at improving efficiency and communication	311 (51%)	180 (52%)	113 (52%)
A greater number of communication channels between team members and heads of department	219 (36%)	128 (37%)	70 (32%)
Technical updates on how to manage cases	201 (33%)	121 (35%)	65 (30%)
More open debates on topics and cases managed routinely	207 (34%)	104 (30%)	85 (39%)
Communication is adequate and does not require improvements	30 (5%)	17 (5%)	11 (5%)

TABLE 4. *Dynamics and functioning of the Department of Obstetrics and the Department of Neonatology - conflict variable*

"Common causes of conflict within your department" (choose up to three statements)	**Number of references (%)** **Total N= 1828 (100%)**	**Obstetrics N= 976 (53%)**	**Neonatology N= 683 (37%)**
Work overload	1097 (60%)	556 (57%)	444 (65%)
Communication problems within the team	877 (48%)	439 (45%)	369 (54%)
Communication problems or competition among health professionals	658 (36%)	361 (37%)	239 (35%)
How decisions regarding task organization are made	494 (27%)	303 (31%)	150 (22%)
Favoritism by heads of department	439 (24%)	264 (27%)	137 (20%)
Workload distribution	475 (26%)	254 (26%)	178 (26%)
Clinical case management	311 (17%)	176 (18%)	116 (17%)
Distribution of training opportunities outside the department	329 (18%)	146 (15%)	143 (21%)
Labor union issues	110 (6%)	49 (5%)	48 (7%)

made (27%), workload distribution (26%) and favoritism by heads of department (24%) were also perceived as a source of conflict (*Table 4*).

Regarding *facilitation of change*, only 31% in the Department of Obstetrics and 42% in the Department of Neonatology considered that most staff members in their department agreed with transformation towards the SFCMH model, and only 29% in the Department of Neonatology and 21% in the Department of Obstetrics indicated that their department was absolutely committed to this process of change. Lastly, 69% and 51% of survey respondents in each department, respectively, indicated that there were genuine reasons to implement the initiative (*Table 5*).

To account for *practices in place*, the survey asked for respondents' opinion on practices aimed at protecting the rights of women and newborn infants, and warranting that they are safe and effective.

Figure 1 shows a sample out of 50 practices related to women care during pregnancy, childbirth and postpartum and newborn infant care. These practices were selected because they are considered more significant and relevant in relation to the purpose of this article.

Results show that practices related to warranting rights, such as information on humanized childbirth or the chance to choose the position assumed during childbirth, occurred at a low rate (30%), and only 25% considered that they were desirable and feasible. Moreover, "allowing women to be accompanied during labour" was reported by 17% as a practice that was always in place, and only 22% identified it as desirable and feasible. On their side, safe practices, such as low-risk pregnancies attended by midwives and promotion of hand washing, were reported as always occurring only by half of survey respondents. However, half of respondents indicated that they always encouraged the participation of mothers and fathers in newborn infant care at the Neonatology Department, and practices related to MCFHI–promotion of breastfeeding and skin-to-skin contact– showed to be highly institutionalized and were in place at a higher rate.

DISCUSSION

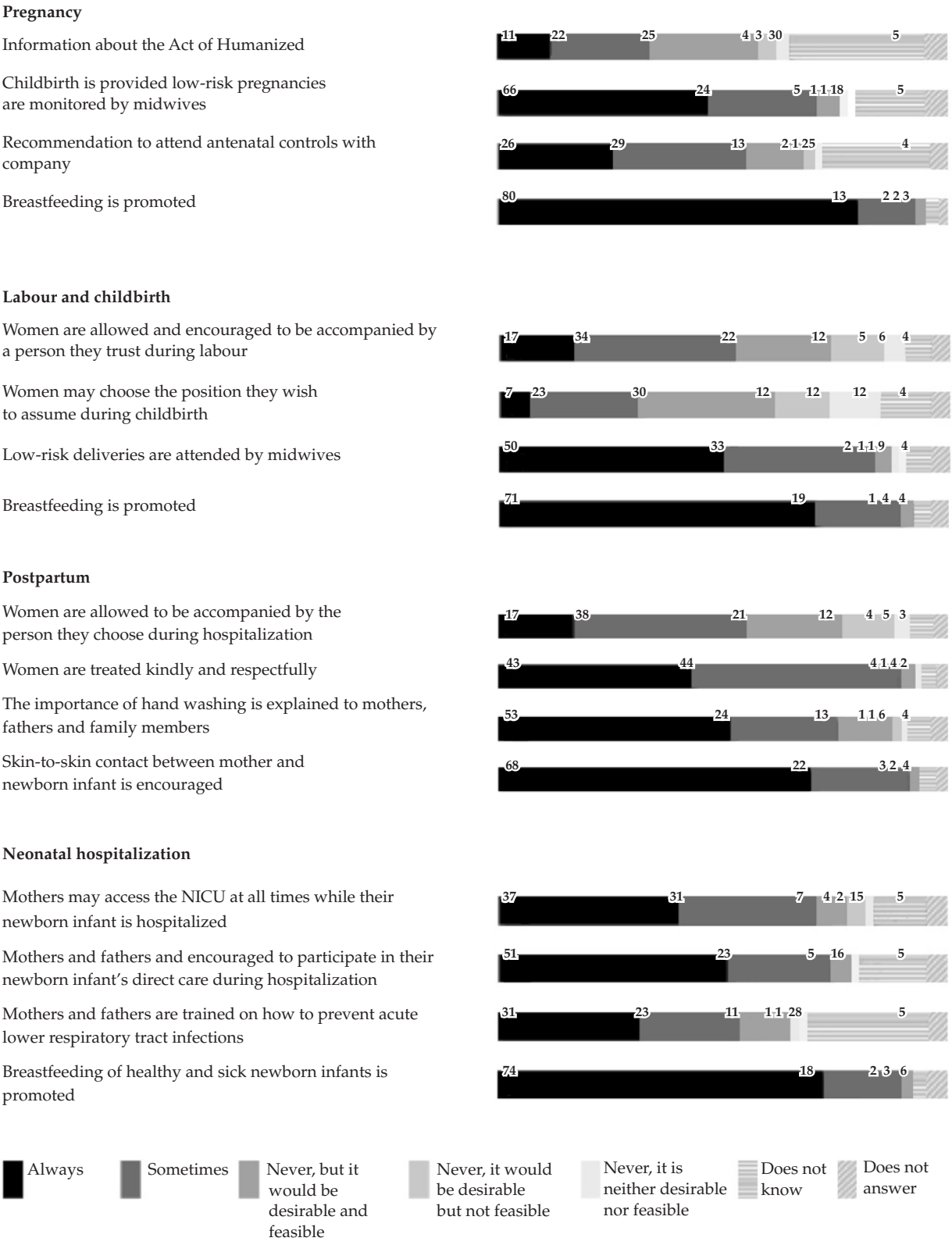
Although indicators of the perinatal health process show a wide coverage of antenatal care and institutionalized childbirth attended by trained personnel, several studies conducted in the past few years have demonstrated the scarce implementation of cost-effective interventions in Argentina.[13] Interventions aimed at protecting the rights of health care users, which have been legitimized by our legal framework (Humanized Childbirth Act and Patients' Rights Act), are also scanty.[14-17]

TABLE 5. *Facilitation of change dimension*

Facilitation of change	Department	Yes, absolutely committed (%)	Yes, partially (%)	No (%)	Does not know, does not answer (%)
Your department is undergoing a process of change towards the implementation of the SFCMH initiative	Obstetrics	21	51	15	13
	Neonatology	29	50	11	11
		Most of the department staff agrees (%)	***Only part of the department staff agrees (%)***	***Only a minority agrees (%)***	***My department staff agrees, but there is no support from other departments (%)***
Degree of agreement to become a SFCMH	Obstetrics	31	29	13	4
	Neonatology	42	21	6	7
		There are genuine reasons to implement the SFCMH initiative (%)	***I am not sure this change is necessary (%)***	***The SFCMH model does not apply to our hospital (%)***	***Nobody has explained to me why this change is necessary (%)***
Opinion regarding reasons to implement the SFCMH model	Obstetrics	51	9	20	12
	Neonatology	69	4	6	13

SFCMH: Safe and Family-Centered Maternity Hospital.

FIGURE 1. *Selected practices in relation to pregnancy, childbirth, postpartum and neonatal hospitalization*

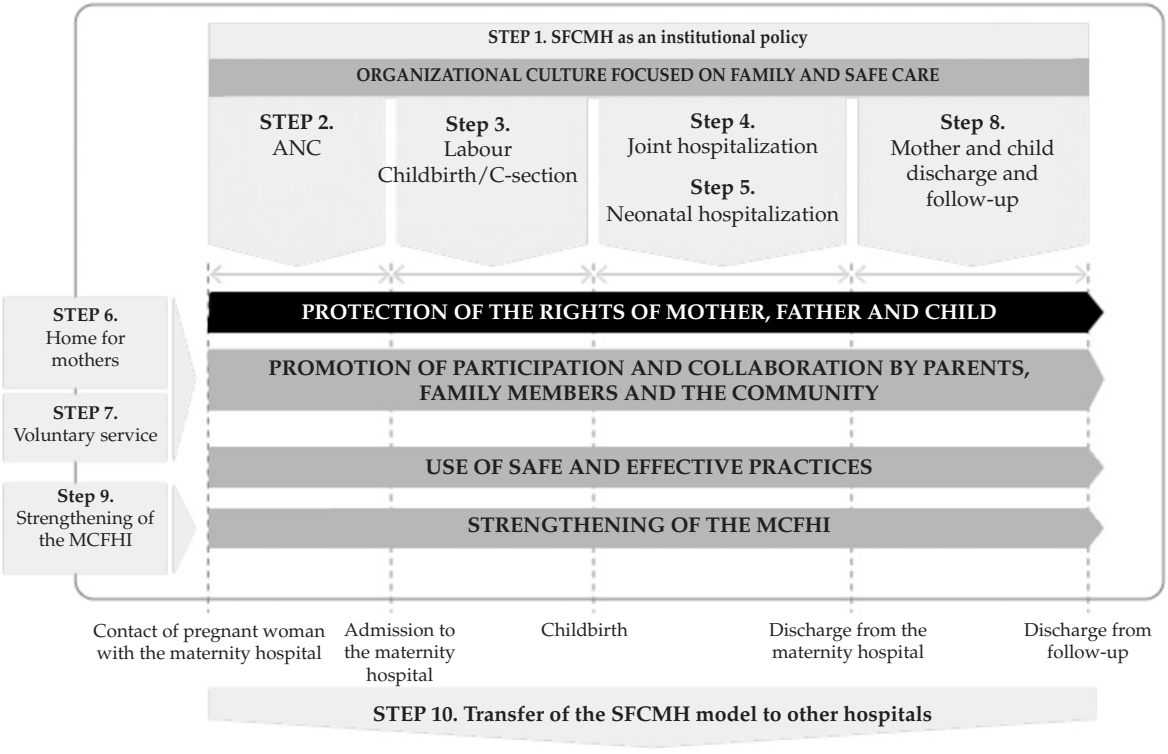


The implementation of the ten steps that make up the SFCMH initiative includes institutional commitment and conveyance of the model to other hospitals, as well as practices that are safe and protect pregnant women´s rights in every stage of their care, from the first contact with the health system to the discharge of their newborn infants (*Figure 2*). Institutional commitment is key because it states a political decision and will to warrant a safe and family-centered care. In this regard, actions undertaken should aim at improving management, training, coordination, communication and team work. A review of values and practices by health teams is also promoted so that change becomes feasible and institutional commitment is maintained. In spite of the documented benefits of this perinatal care model, its principles and practices have not been fully adopted so far.[9,18]

Difficulties in the adoption of innovative organization and health care models have been extensively analyzed in the literature.[7,19] Such analyses indicated that it is necessary to be aware of the organizational culture every time the implementation of a new intervention is considered,[20] because such knowledge allows to identify barriers and facilitators of change, assess its feasibility and design strategies to promote and maintain it, and also assess its results and impact on work processes and relationship within the organization. It also allows to identify the strengths of the organizational culture, making their capitalization possible in favor of proposed changes.[18]

The development of an assessment of the organizational culture is also in line with recommendations made by specialists in organizational change. Michie, et al. emphasize

FIGURE 2. *Thematic focuses and steps for the implementation of the Safe and Family-Centered Maternity Hospitals initiative*



Source: Larguía M, González MA, Solana C, Basualdo MN, Di Pietrantonio E, Bianculli P, Ortiz Z, Cuyul A, Esandi ME. Maternidad segura y centrada en la familia (MSCF) con enfoque intercultural. Conceptualización e implementación del modelo. 2da ed. Buenos Aires: UNICEF, Fundación Neonatológica, Maternidad Sardá, Ministerio de Salud de la Nación; 2012.

Abbreviations used in the figure:
SFCMH: Safe and Family-Centered Maternity Hospital.
ANC: antenatal care.
MCFHI: Mother and Child Friendly Hospital initiative.

the usefulness of this type of assessment to model interventions, explain hurdles in their implementation and design strategies to maintain processes of change.[21]The organizational culture instrument is a key component in the SFCMH initiative for two reasons. Firstly, because it was an unprecedented experience that questioned those who are directly responsible for care about critical aspects of their work environment. Secondly, because it generated contextual information on barriers and facilitators of organizational change and of behaviors and practices required by the SFCMH initiative.

Results obtained in this study show that the implementation of the SFCMH initiative is in its early stage given that not all recommended practices have been fully incorporated in everyday practice. Some practices have been accepted more widely than others, and hospitals appear to be more open to introducing changes in some of the initiative's steps and thematic focuses than in others. Such lack of synchronicity between acceptance and adoption of a package of new practices is foreseeable, especially in relation to complex interventions. Fixen, et al. have made a thorough description of the steps in the processes of implementing an organizational change.[22] Such framework of reference helps to understand the "natural" uneven acceptability and adherence to certain practices and behaviors. For example, some practices, such as breastfeeding promotion, have a level of acceptability and compliance close to the SFCMH parameters, while others, such as choosing the position assumed during childbirth, are still far from becoming institutionalized. However, one of the strengths of the SFCMH initiative is that it recognizes the variety of settings where changes proposed by the model should be implemented.

These results are consistent with those of other studies conducted in 2008, which also reported an uneven compliance with recommended practices and observed organizational and behavioral barriers resulting from the typical inertia of institutional "customs and traditions".[18,23]

This assessment of organizational culture has revealed problems in the different dimensions of the organizational environment of hospitals. Although such problems are relatively well-known, they had not been analyzed in a systematic, objective and participative manner. Detected problems allow to conclude that it is particularly essential to establish better coordination procedures among health teams and to improve internal communication, review leadership modalities and strengthen teamwork skills.

Findings also confirm that an uneven adherence to practices is critical when implementing a new model of care, because behavioral and organizational changes required by a set of new practices are especially complex, and also because each hospital should face its own barriers and take advantage of its own idiosyncratic strengths.

This assessment has the power to generate an informed reflection on barriers and facilitators that influence the implementation of a new model of care, thereby providing an opportunity for health teams to look at themselves in their own "mirror" and develop solutions as part of their individual and collective responsibilities so as to strengthen the opportunities resulting from the paradigm shift. This assessment provided contextual information on the institutional environment and on the willingness and adherence of health teams to take on the set of practices proposed by the initiative. In addition, it allowed to provide a baseline for each maternity hospital; therefore, this assessment not only allowed to get to know the institutional scenario where the initiative was to be implemented, but also allowed each maternity hospital to identify its own weaknesses and strengths, and be more prepared to carry out related interventions and monitor changes. Even with the limitations inherent to a self-administered survey (subjects' self-perception and potential bias from those who proposed themselves to complete the survey), results reflect an unprecedented diagnosis of the situation that looks to promote similar projects in the future that may have a larger coverage.

CONCLUSIONS

The assessment of the organizational culture conducted in 29 maternity hospitals located in the province of Buenos Aires showed that commitment of hospital members to the SFCMH initiative is yet to be consolidated. Although positive, leadership assessment is not comprehensive, and communication requires a better institutionalization of reporting mechanisms. Work overload, on one side, and failures in communication, on the other side, are perceived as the major sources of conflict. Being aware of the real situation of the organizational culture at health facilities implies the ethical commitment of implementing necessary changes.■

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Annex 1

MATERNITY HOSPITALS WHERE ORGANIZATIONAL CULTURE WAS ASSESSED

In 2011 **(between July 14th and September 30th):**

Hospital Interzonal General de Agudos Dr. José Penna - Bahía Blanca
Hospital Interzonal General de Agudos San José - Pergamino
Hospital Interzonal General de Agudos San Felipe - San Nicolás
Hospital Zonal General de Agudos Dr. Enrique Erill - Escobar
Hospital Zonal Gobernador Domingo Mercante - José C. Paz
Hospital Materno Infantil Comodoro Meisner - Pilar
Hospital Zonal General de Agudos Magdalena Villegas de Martínez - Tigre
Instituto Maternidad Santa Rosa - Vicente López
Hospital Zonal General de Agudos Virgen del Carmen - Zárate
Hospital Zonal General de Agudos Dr. Arturo Oñativia - Almirante Brown
Hospital Zonal General de Agudos Evita Pueblo - Berazategui
Hospital Sofía T. de Santamarina - Esteban Echeverría
Hospital Interzonal General de Agudos Evita - Lanús
Hospital Interzonal General de Agudos Vicente López y Planes - General Rodríguez
Hospital Zonal General de Agudos Héroes de Malvinas - Merlo
Hospital Zonal General de Agudos Dr. Carlos Bocalandro - Tres de Febrero
Hospital Zonal Especializado Materno Infantil Argentina Diego - Azul
Hospital Interzonal Especializado de Agudos y Crónicos Dr. Alejandro Korn - Melchor Romero
Hospital Zonal de Agudos Simplemente Evita – González Catán

In 2012 **(between August 8th and December 3rd):**

Hospital Zonal General de Agudos Lucio Meléndez - Almirante Brown
Hospital Zonal General de Agudos Alberto Eurnekian - Ezeiza
Hospital Interzonal General de Agudos Luisa C. de Gandulfo - Lomas de Zamora
Hospital Zonal General de Agudos Dr. Isidoro Iriarte - Quilmes
Hospital Zonal General Mariano y Luciano de la Vega - Moreno
Hospital Interzonal Especializado Materno Infantil Don Victorio Tetamanti - Mar del Plata
Hospital Interzonal General de Agudos Dr. Diego Paroissien - La Matanza
Hospital Municipal Dr. Raúl Larcade - San Miguel
Hospital Zonal General de Agudos Mi Pueblo - Florencio Varela
Hospital Interzonal General de Agudos Gral. San Martín - La Plata