Reorganization of perinatal care in Greenland

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ABSTRACT
Introduction. September 2000 the planning of a major reform of health services was launched aimed at improving perinatal care and decreasing perinatal mortality and morbidity. The activities became effective from January 2002. Methods. A new organization plan was developed, a special medical record was designed for perinatal care and training programs for health workers in perinatal care were instituted, including basic ultrasound scan for gestational age. Professional guidelines for perinatal care were distributed countrywide, stipulating that at risk pregnancies should be referred for delivery to Queen Ingrid’s Hospital, as well as offering treatment suggestions for various complications. Results. There was a marked improvement in the referral rate for at risk pregnancies and consequently a sharp rise in the share of at risk patients in Queen Ingrid’s Hospital, calling for extra resources to be allocated. However, the rate for instrumental deliveries remained low at the special unit at the same time as the rural health care centres were relieved of the burden of high-risk deliveries. Discussion. Transferring women for delivery, in many cases leaving their families for a substantial amount of time, undoubtedly has psychosocial implications. Will the impact of the programme on perinatal mortality and morbidity make up for these costs? Will we be able to reduce the rate of instrumental deliveries in the rural health care centres as well as the number of acute - and very costly - evacuations of patients by chartered aircraft? The questions are many - we hope to provide some answers.

Keywords: perinatal care, perinatal mortality, obstetric management, midwife, delivery, high-risk deliveries, risk pregnancies, partogram

INTRODUCTION
In September 2000 the planning of a major reform of health services was launched aimed at improving perinatal care and decreasing perinatal mortality and morbidity.

Variation in the practice of identifying and referring at risk patients from the rural districts for specialist treatment at the main hospital in Nuuk was identified as a major problem.

Furthermore, there was a shortage of district midwives due to recruitment problems and the standard of the medical records regarding perinatal care was not acceptable.

METHODS
A new organization plan (Figure 1) was developed, handing over the responsibility for perinatal care management and recruitment of midwifery staff to the Obstetric management comprising the chief obstetrician and the chief midwife. The midwifery staff consists of a chief midwife responsible for the allocation of district midwives in cooperation with the Management of Rural Health, a senior midwife in charge of the special unit, a clinical instructor, 6 staff midwives and 10 district midwives. In districts where there is no district midwife - or during her time off – perinatal care is undertaken by nurse’s aids with special training.

A special medical record was designed for perinatal care facilitating a high standard of record keeping with a built-in checklist, and introducing the partogram as an instrument for high awareness during the process of delivery. Training programmes for health workers in perinatal care were instituted, including basic ultrasound scan for gestational age. Professional guidelines for perinatal care were distributed countrywide, stipulating that at risk pregnancies should be referred for delivery
RESULTS

There was a marked improvement in the referral rate for at risk pregnancies - 2000: 11.6%, 2001:13.7%, 2002: 23% (Figure 2) - and consequently a sharp rise in the share of at risk patients in Queen Ingrid’s Hospital, calling for extra resources to be allocated. Forty-six of the referred patients did not present any problems but had a normal spontaneous delivery (31%)  

However, the rate for instrumental deliveries at the special unit remained low at the same time as the rural health care centres were relieved of the burden of high-risk deliveries.

The number of Caesarean sections in the districts was 22 (3.9%), 7 of them elective, 15 acute. Nine (1.6%) vacuum extractions were performed, the total share of instrumental deliveries being 5.5%.

There were 15 cases of perinatal death, of which 7 were stillborn in 6 deliveries. Three died during the first 24 hours after delivery and 5 died on day 2 – 7.

According to the office of the Chief Medical Officer’s "Public Health Status Year 2002" the perinatal mortality rate declined from 25 in 1990 to 20 in 2000 and was 17 in 2002.

The corresponding figures from Denmark are 10, 8 and 6.

The number of acute - and very costly - evacuations of patients by chartered aircraft has decreased from 33 in 2001 to 22 in 2002.

DISCUSSION

There are no doubt psychosocial implications when women are transferred for delivery, in many cases leaving their families for a substantial amount of time. During 2002 only 10 pregnant women refused to be referred, indicating that the perinatal care programme is well understood and accepted by the public.

The perinatal care programme has started out well and in the future we hope to have the financial foundation needed to employ district midwives in all rural health districts in order to secure and further expand the quality of perinatal care.

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