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SCHOOL OF MEDICINE · NKUA MASTER'S COURSE IN GLOBAL HEALTH - DISASTER MEDICINE

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Table of Contents

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1. Main Point/Takeaway:

The SafeMa project is Education Hubs for Excellence in Midwifery which aims to create a new postgraduate program in Advanced Midwifery Practice in Asia, and it focuses on postgraduate level training, providing advanced courses and guidance in developing research skills necessary to develop innovative new data-driven techniques. The SafeMa hubs are the centers for the development of the midwifery field and will improve midwifery services' quality will increase women's access to midwifery services; consequently, reducing maternal and newborn mortality. However, it requires the necessary practical competencies to deliver quality maternal and neonatal care. They'll support midwives, both students, and professionals at hospitals or health centers. Evidence-based practice and research are the hubs' focus. It will improve midwifery education and care. Hubs will transmit ideas, knowledge, and skills to academics, health organizations, policymakers, and national/international organizations (1).

2. Background:

Midwifery-led care is the most appropriate model to improve maternal and neonatal health in order to meet the Sustainable Development Goals although pregnancy and birth are not seen as normal physiological processes led by midwives. However, the midwifery profession and midwifery models have been impacted by the medicalization of birth (2).

A midwife-led model of care is woman-centered and based on the premise that pregnancy and childbirth are normal life events, and the lead healthcare professional is responsible for the planning, organizing, and delivery of care given to a woman from the initial antenatal visits through care during the postnatal period (3). In addition, this model of care offers the woman counseling, education, and antenatal care based on her specific needs and provides continuous care during labor, birth, and the immediate postpartum period and further support during the postnatal period (4).

3. Evidence:

Midwife-led Care in Low-Income Countries:

Midwife-led care has remarkable impacts on maternal and newborn health outcomes. For instant, women are less likely to have an episiotomy, an epidural, or instrumental birth and less likely to experience preterm birth. Spontaneous vaginal birth is more likely to increase. Preterm birth and the risk of babies dying before 24 weeks of gestation are less likely to be observed. Furthermore, women who received midwife-led care are nearly eight times more likely to be attended at birth by a known midwife but there are no adverse effects compared to other models of care (4).

The first study reported on maternal and newborn health outcomes associated with midwifery care in Uganda. In this cross-sectional descriptive study, 36 of the 76 'midwives' from different educational backgrounds (from health visitors to nurses, registered midwives, and enrolled midwives) were interviewed

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about their educational backgrounds and their uptake of in-service training. Healthcare providers were then observed during ante- and intrapartum care. Women's satisfaction was also assessed in four focus group discussions. The main finding was that midwives could not recall symptoms, signs, or causes of pregnancy complications related to the two most common causes of maternal mortality indicating poor quality of care. Women reported that the staffs were rude and harsh. Midwives blamed women for presenting after complications had already occurred and demanded women pay user fees. Overall, this study lacks rigor as the sample size was small, the method of data analysis was not reported and the findings are not reported systematically. While the authors stated that the study findings could be applied to many units, it is not clear if the findings are transferable to other settings and to care provided by midwives only (5).

The second study in this group focused on the experience of midwives working in midwifery-led units (MLU) in Angola. The researchers interviewed 11 midwives, with most being general nurses with a basic knowledge of maternity care and a few being professionally educated midwives. All were recruited from three maternity units which were part of a program of the Angolan Ministry of Health to improve maternal health and reduce the high maternal mortality rate in the country. The priorities of this program were the establishment of suburban-based midwifery-led maternity units and the empowerment of midwives as autonomous professionals through their education. These MLUs were equipped with essential medicines and staffed with midwives to provide 24-hour/7 days week services, with access to communication and transport systems for referrals. The midwives received incentives of around $US30 per month per midwife. In this model of care, midwives saw themselves as independent but recognized their limitations. The use of the partograph and continuous professional learning was also seen as important. Midwives regarded themselves as trusted among the population through a feeling of "togetherness" but they also mentioned problems with transfer to the next facility with obstetric care (6).

The third study conducted in Nepal used an unpaired comparison method that compared intrapartum care of a midwife-led model of care versus a consultant-led model of care (Rana et al. 2003). It showed that care provided by midwives was more cost-effective, especially because there were fewer interventions such as unnecessary cesarean sections: the care was less resource intensive, less costly, and as safe and effective compared with physician-led care (Rana et al. 2003). However, although women in both groups were identified as "low risk", the findings should be treated with caution as the study was not randomized. The study defined midwife-led care as care by auxiliary nurse-midwives supervised by a nurse with nine months of midwifery training who worked at the site of the data collection as a midwife (7).

The fourth study was conducted in Ethiopia in 2017 by Sheferaw looked at the provision of care by midwives and others in public health facilities in terms of quality with a focus on respectful care. Midwives, nurses, doctors, and health officers were observed while caring for 240 women in 28 health centers during labor and childbirth. Physical abuse, verbal abuse, absence of privacy during examination, and abandonment were measured. Compared to doctors, nurses, and medical officers, midwives provided higher levels of respectful maternity care, although reasons for their better performance are unclear. As the study examined one important aspect of midwife-led care (respectful care), it will be jointly discussed with similar studies later (8).

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4. Discussion and Recommendation:

According to evidence-based research in midwifery-led care in low-income countries, several studies have shown a positive relationship between midwifery-led care and the outcome of mather and newborn health. These results have several strengths to support the national initiative of midwifery-led care. Likewise, in 2016 WHO published a recommendation on midwifery lead care which highlights that midwife needs continuing training and education should be assessed. If midwives receive well-trained, women will get wide access to a sufficient number of midwives with reasonable caseloads. And therefore, the prevalence of maternal and newborn mortality will decrease in the world (9).

The journey to this stage of development in maternity services in Cambodia has been a long one, and fraught with many difficulties including a weak national maternity care policy and a lack of official support for local maternity services. Midwife-led care should be engaged by women and other stakeholders to wisely promote the development and sustainable implementation of this model in Cambodia. Particularly for further development and maintain this model. Likewise, Vietnam has encountered similar problems and challenges. The midwifery workforce is lacking in quantity, weak in quality, and unbalanced in structure. The midwifery system still has many limitations in terms of qualifications, most of them have not been trained in patient care management. In addition, the midwifery training system has not been standardized. Lack of midwifery teachers, practice facilities are still limited, and a specialized training system has not been developed. Moreover, care practice techniques have not been standardized and developed into standard protocols. Comprehensive care has just begun, and basic care for patients is still entrusted to family members. Rural midwifery work and home care have not been developed. The important thing is that there is not yet a complete policy system. Lack of policies to attract careers and no focus on comprehensive investment, especially financial investment for midwifery majors.

As can be seen both countries, Cambodia and Vietnam have similar challenges, therefore, some recommendations are suggested to take into consideration. One of the foremost is to consolidate the organizational system and develop human resources by establishing the National Midwifery Advisory Council: to advise the Ministry of Health on policies and standards for midwifery practice as a basis for training, monitoring, testing, evaluation, commendation, and utilization. Central hospitals, provincial hospitals, hospitals of ministries, and branches with obstetric departments must have midwives in charge of care. And, medical centers of districts, provincial cities have a Nursing-Midwifery Department - in charge of care work and ensuring the ratio of 1 doctor to 2 midwives for 2 hospital beds.

Secondly, improving policies and laws by developing and supplementing the responsibilities and duties for midwives to suit the rank of civil servants. Identify the working relationship between midwives and other specialties in the health sector such as formulating the Ordinance on Nursing and Midwifery Practice.

Thirdly, training and scientific research should be improved such as planning the network and upgrading training schools to form a midwifery training system throughout the country, reaching the same standards as other countries in the region. Standardize the teaching staff as midwives in training schools. Prioritize training the core group of teachers. Research and develop training programs that are continuous and continuous between levels of study and training duration. Training masters and doctorates in Midwifery

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at home and abroad. Research and apply scientific-technological advances and theory of Midwifery applied to practice in Vietnam and Cambodia.

In addition, it is crucial to invest in a policy. The financial investment for midwifery work includes the state budget, international aid, and other sources. Leaders of Ministries and Departments of Health annually set aside a budget for midwifery activities.

Moreover, standardization of care practices should be developed. For instance, completing and progressing to develop national standards on "Technical procedures for taking care of mothers and babies in hospitals"; Completing and progressing to develop a national standard on "Practice against infection in hospitals and the community"; and building models - illustrative projects on comprehensive care to research and apply widely in hospitals and pilot models of midwifery care in the community and at home.

Besides, it is vital to expand international cooperation in the field of midwifery. this can be done by enlisting the help of international organizations in terms of techniques, means, and funding for midwifery work. Cooperation and exchange with other countries in the fields of scientific research, study, visit, conferences, and seminars on midwifery work. Also, participate in international organizations specializing in midwifery in the region and the world.

Lastly, ensuring life, material, and spiritual for midwives is important to minimize the problem. We can use diverse and effective media to increase awareness about the role of midwives. It is proposed that the government use the salary scale for midwives, equivalent to the salary scale of other specialties with the same training level and training time. Supplementing the standard of noble titles for midwives in the general titles of the medical profession. also, providing additional allowances for midwives.

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5. Conclusion:

Midwifery-led care is the most appropriate model of care for childbearing women because it provides safe and high-quality care and is associated with more efficient use of resources and improves outcomes. We need SafeMa Hubs for sustainability and to thrive more professionally for improving the midwifery field in Cambodia as a whole. UHS strongly believes that we will be able to keep working on developing this hub to be better.

Furthermore, the midwife's job is to provide prenatal care and advice to pregnant women, detect common physiological disorders and devise specific care plans for each case. This is also the person who directly monitors the progress of the labor, taking care of the basic physiological needs of the pregnant woman. At the same time, sympathize, share and create a sense of security for pregnant women, helping pregnant women pass labor smoothly. The woman who gives birth is also the one who detects complications and abnormal signs at the earliest to promptly handle complications that happen to pregnant women. This department is also responsible for preparing and assisting doctors in difficult cases, requiring the use of complicated procedures, maintaining care as well as restoring and improving the health of pregnant women after giving birth. With professional skills, Midwives optimally support doctors in reproductive health care. In the community, midwives play an important role in counseling, disease prevention, and health education for women as well as other members of the community, in the family, performing health-related care. Annual fertility or gynecological examination. In addition, midwives also undertake reproductive health care, annual gynecological examinations, family planning, and menopause care, this job includes prenatal education and preparation of Basic and advanced for women before motherhood. They can also perform some common obstetrical procedures such as: sucking to regulate menstruation, placing contraceptive devices, examining, and detecting gynecological infections, etc. that role is especially important in places where there is no doctor.

Lastly, investment in midwifery education such as the SafeMa project has been undertaken at national and regional levels for capacity building in higher education to address the specific need or problems regarding maternal and newborn health in Cambodia and Vietnam. Undoubtedly, the SafeMa midwifery postgraduate course on Advanced Midwifery Practice would support the recommended policy on midwifery-led care. The key intervention to promote this policy is strengthening midwifery skills through competency-based training to increase the quality and coverage of antenatal care, skilled birth attendance, and postnatal care.

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References

1. SafeMa Project. 2019.

2. Renfrew MJ, McFadden A, Bastos MH, Campbell J, Channon AA, Cheung NF, et al. Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care. 2014;384(9948):1129-45.

3. Sandall J, Soltani H, Gates S, Shennan A, Devane DJCdosr. Midwife-led continuity models versus other models of care for childbearing women. 2016(4).

4. International Confederation of Midwives. Midwifery Led Care, the First Choice for All Women. 2017.

5. Kaye DJEAmj. Quality of midwifery care in Soroti district, Uganda. 2000;77(10).

6. Pettersson KO, Svensson ML, Christensson KJM. The lived experiences of autonomous Angolan midwives working in midwifery-led, maternity units. 2001;17(2):102-14.

7. Rana TG, Rajopadhyaya R, Bajracharya B, Karmacharya M, Osrin DJHP, Planning. Comparison of midwifery-led and consultant-led maternity care for low risk deliveries in Nepal. 2003;18(3):330-7.

8. Sheferaw ED, Bazant E, Gibson H, Fenta HB, Ayalew F, Belay TB, et al. Respectful maternity care in Ethiopian public health facilities. 2017;14(1):1-12.

9. WHO. WHO recommendation on midwife-led continuity of care during pregnancy. WHO Reproductive Health Library. 2021.

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