Quality Midwifery Care in the Midst of Crisis

Midwifery Capacity Building Strategy for Northern Syria

2017-2021

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United Nations Population Fund (UNFPA)
ATTA
Bihar
CARE
Canadian International Medical Relief Organization (CIMRO)
Health Directorates (Aleppo, Idlep, rural Damascus)
Hand in Hand (HiH)
Human Appeal
Independent Doctors Association (IDA)
International Medical Corps (IMC)
Médecins du Monde (MDM)
Mercy-USA
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Syrian American Medical Society (SAMS)
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Syria Relief and Development (SRD)
Union of Medical Care and Relief Organizations (UOSSM)
Violet
Women and Health Alliance International (WAHA)
World Health Organization (WHO)
World Vision International (WVI)

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ACRONYMS

CRHW	Community Reproductive Health Worker
CPD	Continuing Professional Development
EMOC	Emergency Obstetrical Care
ENC	Essential Newborn Care
HNO	Humanitarian Needs Overview
IDP	Internally Displaced Persons
ICM	International Confederation of Midwives
GBV	Gender Based Violence
MNH	Maternal and Newborn Health
MMR	Maternal Mortality Rate
NMR	Neonatal Mortality Rate
NGO	Non- Governmental Organization
PHC	Primary Health Care
SRH	Sexual Reproductive Health
RCM	Registered Community Midwife
RM	Registered Midwife
RN	Registered Nurse
UNFPA	United Nations Population Fund
WHO	World Health Organization

1. Executive Summary

In areas of Syria reachable though cross-border operations from Turkey, women and girls experience exacerbated restrictions on freedom of movement, due to lack of security but also increasingly conservative gender norms, coupled with early marriage and lack of access to family planning. All of these inter-related factors impact on the women's reproductive health needs, health seeking behaviour and access to health services, ultimately negatively impacting maternal and neonatal health.

At the same time, the health system is seriously challenged and unsuited to the situation of on-going conflict whereby caesarean sections have become commonplace due to 'safety and rapid execution of surgical techniques'. The pre-war Syrian health system was highly specialized, facility-based and centralized, which did not support autonomous normal Midwifery care in either a facility or the community. In fact, many Midwives themselves were unaware of the full range of skills possible under the core competencies of Midwifery practice.

To compensate for the loss of dedicated, qualified maternal health care providers, in particular those with Midwifery competencies, there is a great need of a Midwifery capacity building strategy which will contribute to the rapid availability of health based human resources.

In order to rapidly fill the skills gap and ensure life-saving services whilst also building a workforce that could then be integrated into the health system, UNFPA proposed a multiphase training approach to build a new cadre of health care providers which could eventually become fully trained Midwives per the International Confederation of Midwives (ICM) standards. Rapid Assessment revealed that there are many different approaches to delivery of maternal health amongst humanitarian players engaged in the maternal health emergency response efforts. The different approaches included role confusion about who is a Midwife and what is the basic skill sets included in provision of care.

The Midwifery model of care differs from other types of Maternal and Newborn Health (MNH) care in that the provider - the Midwife, seeks to work in partnership with women, to empower women and help protect and promote normal physiology and process of reproductive health and neonatal care. Midwifery care is always mindful that normality can easily move into compilations and even life threatening events, which the Midwife must be equipped to respond to and deal with effectively and efficiently.

Analysis of the future for Syrian Midwifery points to the need for long -term support for Midwifery capacity building to contribute to improved quality of interventions. The Midwifery and maternal health community will need to utilize common policy, protocol, strategies and interventions. The provision of short course intensive capacity building opportunities for skills will continue to be a cornerstone of care reinforcing baseline skills and assisting with the identification of a pool of future Midwifery leaders.

Strategic partnerships including those with local authorities, civil society, development partners, private sector and communities will be key to the successful implementation of this strategy. All projected activities under the proposed Midwifery Strategic framework guidance will have both in-service and pre-service components. The underlying focus will be to bring all current Midwifery services in line with adjusted trajectory for up-graded Midwifery high quality services during the conflict and in the reconstruction period, which will be in accordance with accepted international standards for Midwifery.

Partnership building and collaboration are the keys to a stronger future for Syrian Midwifery. In order to build upon partnerships in a spirit of collaboration the Midwifery capacity building strategy's guidance document's core vision is

"To expand the coverage of quality, evidence based cost effective, high impact Midwifery services and interventions for maternal, newborn survival within Northern Syria."

This Midwifery capacity building plan has five strategic sub-goals, which are to:

1. Increase access to equitable and high quality MNH services through increased collaboration between education and regulation in the public and private sectors
2. Increase community integration and mobilization for participation in and use of Midwifery based MNH services
3. Contribute to the building of Midwifery capacity at the pre-service and in-service levels of clinical service delivery
4. Support availability of sustainable MNH programming at various levels including the building of regulatory capacity through scope of practice expansion and delineation for Midwifery
5. Strengthen Midwifery and maternal newborn health specific program evaluation for scale up of lessons learnt at national and international level

Due to the deficit of structured guidance on any of the professional pillars of Midwifery education, regulation or association currently present in Northern Syria, as direct result of the conflict, this document leans heavily towards provision of guidance aimed towards the pillar of education. With solid pre-service and in-service education as the foundation of Midwifery care, the additional pillars will be strengthened as the post- conflict reconstruction phase begins.

The Midwifery capacity building strategy begins the process of setting agreed upon minimal standards for Midwifery practice, which are in some cases more stringent than those found prior to the conflict. This is done with the understanding that women and newborns lives are at stake in cases of poor quality of care which may be magnified in the wake of harmful attitudes that believe that any help is good help in a crisis. While the emergency resolutions are in rollout phasing, the Midwifery capacity building strategy hopes to guide the groundwork that is being laid for future Midwifery and maternal newborn intervention.

The underlying belief system is that is more beneficial to maternal health to avoid short cuts that will lead to partial skills which history and lessons learned from other post-conflict settings has proven to be ultimately harmful.

The Midwifery capacity building strategy holds as its key message that Quality Midwifery Care for Syria is and will not be just a quick fix.

Midwifery Capacity Building for Northern Syria Key Message:

"Quality Midwifery is not just a quick fix"

For the purposes of current and future processes a Midwife is defined ONLY as:
"A person who has successfully completed a Midwifery education program that is duly recognized in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice Midwifery and use the title Midwife and who demonstrates competency in the practice of Midwifery." (http://www.internationalMidwives.org)

Core vision:

"To expand the coverage of quality, evidence based cost effective, high impact Midwifery services and interventions for maternal, newborn survival within Northern Syria."

Midwifery Capacity Building Strategy Key Decisions in Brief

1. Emergency Phase Clinical focal areas for technical skill, policy and protocol development
2. Entry Pathways to Basic Midwifery Practice
3. Emergency Phase Temporary Time-limited early exit pathway for Community Practice Midwifery
4. Admission guidelines and criteria for Diploma level Midwifery programs
5. Minimum standards of acceptability in clinical practice for admission to practice
6. Minimum scores or pass-marks for theoretical and clinical practice
7. Validation of need for Competency based CPD for Midwifery providers
8. Standard Job description for Midwives and Midwifery Tutors

All Midwives inclusive of Midwives (RM) and Community Midwives (RCM) upon completion of studies will maintain the ability to work along the home to hospital continuum with the full complement of core Midwifery competencies.

2. Background

Entering into its 6th year, the conflict in Syria continues to affect millions of people and negatively impact the long term and short- term health indicators of the population. In Syria, an estimated 2.8 million women of reproductive age have little to no access to basic health services due to the severe deterioration of the health system and lack of human resources for health. Not only have overall health care services been severely impacted, but the availability of reproductive health services has also dropped dramatically across Syria since 2011. According to the 2016 Humanitarian Needs Overview (HNO), it is estimated that there are currently about 488,000 pregnant women of which at least 45'000 will need Emergency Obstetric Care. The HNO points to a significant number of newborns who could die or suffer permanent disabilities without timely essential interventions including normal newborn care and resuscitation. 1 There has been an estimated increase in maternal morbidity by 40% since the beginning of the conflict. These numbers do not reflect the refugeess who reside in towns or camps in the neighbouring countries bordering Syria who wait to return home after the cessation of conflict.

The targeted attacks on health care facilities and health care workers continue to deplete available health resources. The UNFPA has estimated 58% of public hospitals and 49% of primary health centres are either only partially functional or have closed their doors. The Syrian conflict is considered to be one of the biggest humanitarian crises of the 21st century with far reaching health impact estimated well into the next decade.

The UNFPA endorses 'a safe birth even here' and is the leading global provider of maternity services in the humanitarian sector. Efforts are designed to strengthen capacity, deliver a timely and effective response, and build resilience as part of a continuum of humanitarian and development planning and programming. It is hoped that the conflict will soon reach a resolution, however, the needs of women and girls cannot afford to wait until that future point to begin to be addressed. To date, much of the health based support structures involved in the Syrian crisis have looked towards emergency and trauma based care. With the lack of access to basic MNH /SRH services and the resulting subsequent challenges, the need for a more comprehensive approach to building a structure for Midwifery services is clear.

1 UNFPA 2015. Women and girls in the Syria Crisis: UNFPA Response Facts and Figures.

It is within this framework that cross-border operations seek to assist in the development of clear women-health focus for the future through construction of a Midwifery capacity building plan. This proposed Midwifery Capacity Building strategy aims to provide a framework for addressing maternal, neonatal and child health challenges through an intra-professional multi-stakeholder approach. It is an overarching strategy for the scale up of the response to reduce the current levels of MNH mortality and morbidity and increase the numbers of competent human resources for health, in line with the necessary reconstruction of the Syrian health system. The life cycle approach and continuum of care concept, starting with care from the home environment to health facility, guided the development of this roadmap.

In line with aspects of their past functionality, it is envisioned that the Health Directorates, NGO's and Midwifery educational institutions should play a key role in the coordination and implementation of this Midwifery capacity building plan to ensure high performance and quality care to achieve the anticipated improvements in maternal newborn health outcomes.

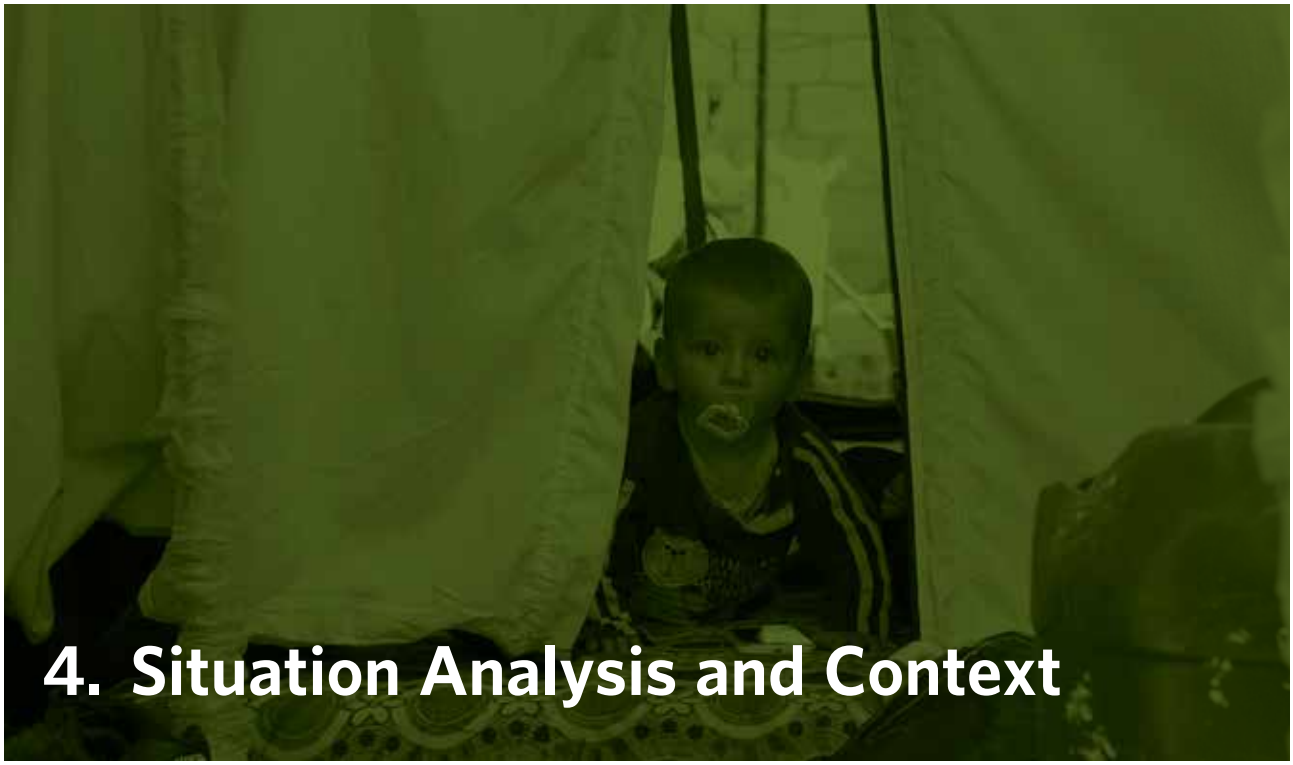
3. Methodology

In order to fully develop this Midwifery strategy, a comprehensive approach was undertaken that was inclusive of desk reviews, meetings with key informants, focus groups, an in-depth clinical services/ basic human resources assessment, and two 2-days participatory workshops, to gather inputs over a 6-months period. Large NGO's and humanitarian actors currently providing maternal health services inside of Syria were initially surveyed to get a glimpse of what is happening at the ground level. With many of the maternity service providers and Midwives currently displaced, either internally or externally, there existed a scarcity of data on the maternal health human resource capability was currently available. Learning from lessons in other contexts about what works and what does not, it was decided in the early phases of developing a capacity building plan that the voices and opinions of the often disenfranchised Midwives and Nurses needed to be heard. This approach of "nothing for Midwives but from Midwives', while adding time to the development process would additionally help to attract and develop a leadership pool to draw upon in the future.

Northern Syrian Midwifery Capacity Building Strategy Timeline

Key Informant Interviews with Midwifery Service Providers	May - June 2016
Development of Midwifery Skills/Capacity Assessment tools	June - July 2016
Baseline data collection and assessment on Maternity Care and Training	July 2016
Midwifery Strategy Capacity Building Participatory workshop 1 (Onsite workshop)	August 2016
Virtual consultation for Midwifery Strategy	Sept 2016
Review of Draft Strategy	October - November 2016
Midwifery Strategy Capacity Building Participatory workshop 2 (Virtual and onsite Workshop combined)	Dec 2016
Presentation of Professionalization of the Role of the Midwife at Global and Local	Jan 2017
Review of Final Draft Strategy	
Focus on EMOC and ENC skills with support curriculum, tools and equipment for training Master Trainers at Midwife level	Sept 2016 – April 2017

International frameworks for Midwifery and Nursing, existing regional Midwifery curriculums, policies and strategies were analysed to provide a basis upon which to formulate goals. After the initial structural needs were identified, a series of virtual consultations took place over a 2-month period to confirm basic understanding of the core components and definitions associated with the strategic guidance. With a focus on building a common understanding and providing interim training with protocol advancement at every step, the capacity building strategy was both being built and foundational steps implemented at the same time which is a unique feature specific to the needs of the crisis.



4. Situation Analysis and Context

Since March 2011, over a quarter of a million Syrians have been killed and over one million have been injured. 4.8 million Syrians have been forced to leave the country, and 6.5 million are internally displaced, making Syria the largest global humanitarian crisis.2 In 2016, an estimated 13.5 million people, including 6 million children, are in need of humanitarian assistance. Of these 4.6 million people are in hard-to-reach areas, including close to 500,000 people in besieged areas. The Syrian MMR in 2010 was estimated to be 68 maternal deaths per 100 000 live births.

Since the onset of the conflict in 2011, there has been no reliable data regarding maternal mortality and morbidity rates. Within the context about what is known of war and its negative impact on maternal health from other conflict settings, it can be safely assumed that the MMR & NMR are increasing with the escalation and prolongation of the conflict.

What is known of the Syrian health system prior to the war exists mainly from verbal reports of health care providers practicing at that time frame. The information points to a system that was highly medically specialized with a decreased focus on primary health and normal Midwifery. There was concern over an increasing level of medical intervention in maternity services and professionally segregated, technologically based system.

The health care system3 is currently in a state of chaos with the targeted attacks that continue upon health care workers and facilities. Many health care workers have understandably fled for safety reasons and facilities have been destroyed. Those health care workers that remain are working under deplorable conditions with little support. There are anecdotal reports of Midwives delivering via torch under the rubble of a destroyed infrastructure. Also Midwives have converted parts of their residential dwellings to accommodate the birth processes of women who are afraid or unable to go to a facility to birth for various reasons. This points to a marked psychological change in attitude towards the idea of the professional Midwife attending births in the community setting. Prior to the conflict, there was little support for the idea that a professional Midwife could conduct a homebirth. This setting was considered to be the domain of the 'dhai ' or traditional birth attendant.

2 United Nations Office for the Coordination of Humanitarian Affairs , Syria Crisis; Regional Overview – About the conflict. http://www.unocha.org/syrian-arab-republic/syria-country-profile/about-crisis

3 Kherallah, M., Alahfez, T., Sahloul, Z., Eddin, K. D., & Jamil, G. (2012). Health care in Syria before and during the crisis. Avicenna Journal of Medicine, 2(3), 51–53. http://doi.org/10.4103/2231-0770.102275

Additionally, the number of caesarean sections is increasing exponentially due to the ability to perform a surgical procedure to deliver the infant in a 45 minute or less time frame driven by fear of attacks on health facilities.

Female health care providers in particular are at increased risk due to security concerns and increasingly conservative religious norms, which impact mobility and ability to provide services without the presence of a male escort. The demand for Nursing and Midwifery services remains high with the need far outstripping the supply. Educational facilities for initial and on-going training of Midwives and Nurses are not operational for obvious reasons of resourcing both human, structural and population fluctuations. In the period before the conflict, focus groups point to multiple means to enter into Midwifery practice from vocational to Nurse-Midwife both under health and education with pass rates ranging from 30-50% with no stringent requirements for clinical practice outside of observation and assistance with procedures. Multiple providers with various skill sets function under misuse of the title Midwife, which causes confusion both intra-professionally and publicly.

Despite the challenges, Midwives and Nurses continue to make up the numerical bulk of the health workforce that is providing maternal health services in Syria. All is not lost as several NGO's are able to provide mobile RH services, and new training institutes for Midwifery are in the inception stages. A system of community reproductive health workers has been recently introduced as an interim step and adopted to provide basic community level reproductive health education/awareness with initial success seen in its scale-up. Further dedicated development of Midwifery capacity is required for the health of women and families in this setting.

5. Purpose and Use of Midwifery Capacity Building Strategy Guidance

The purpose of the strategy is to put in place guidance for international, and national, decisions makers, programs, training institutions, and local authorities to be utilized in the assessment, planning, implementation, and monitoring of interventions and activities for Midwifery and maternal health. The northern Syrian Midwifery capacity building guidance framework is in line with the quality maternity care framework 4 and WHO Strategic Directions for Nursing and Midwifery 2016 - 2020. Both of these sources stress the need for quality Midwifery services that are available, accessible, acceptable and feasible to the public receiving maternal health care. The figure below illustrates the conceptual framework that was integral to the development of the

Figure1. WHO Global strategic directions for strengthening nursing and midwifery 2016 – 2020 conceptual framework:

4 Lancet Midwifery series June 2014

The following groups are envisioned to become the primary users of the Midwifery capacity building guidance strategy:

1. Reproductive Heath Cluster agencies and partners
2. Sub-national: governorates and health directorates
3. Midwifery and Nursing Training Institutes
4. Maternal Health workforce (Midwives, Physicians, Nurses)
5. International and National Non-governmental organisations
6. International organisations
7. Development partners /Donor Community
8. Communities receiving care

6. Guiding Principles of the Northern Syrian Midwifery Capacity Building Strategy

The guiding ideologies of the Northern Syrian Midwifery Capacity Building Strategy are the building blocks upon which all decisions related to Midwifery care should made. The core principles embrace the philosophical view of birth as a normal process to be facilitated and are as follows:

- *Equity*

All women, newborns and children, without distinction of religion, ethnicity, political beliefs, geographical situation, economic status, or physical condition – have a right to equal and universal access to maternal health services

- *Integrated Continuum of care in various settings*

All women and newborns should have the highest attainable standard of health; achievable through receiving the best possible care in both the home/community and facility based health care settings

- *Use of Clinical care guidelines, policies and approaches based on available evidence and best practices*

Midwifery care based policies, approaches, and practice should be supported by assessment, research findings, ongoing monitoring and evaluation, lessons learned and global evidence-based norms and standards

- *Midwifery Leadership*

Midwives should be at the forefront of promoting a sense of clinical excellence, stewardship, accountability and transparency in all levels Midwifery services from policy making to bedside care.

- *Humanistic Respectful Maternity Care*

Midwifery care is supported through a human rights lens of compassionate care for both the client and the Midwifery care provider.

7. Overarching Aim and Goals of the Northern Syrian Midwifery Capacity Building Strategy

The core vision of this Midwifery Strategy is:

"To expand the coverage of quality, evidence based cost effective, high impact Midwifery services and interventions for maternal, newborn survival within Northern Syria."

This vision is envisioned to be operationalized through the design and implementation of effective in-service and pre-service strategies delivered across the continuum of home to hospital care in order to reduce MMR and NMR in Syria during the emergency and post –conflict reconstruction period. This strategy will be achieved through a targeted focus on strengthening Midwifery education and regulation through organizational and governmental partnerships.

This Midwifery plan has five strategic sub-goals, which are to:

1. Increase access to equitable and high quality MNH services through increased collaboration between education and regulation in the public and private sectors
2. Increase community integration and mobilization for participation in and use of Midwifery based MNH services
3. Contribute to the building of Midwifery capacity at the pre-service and in-service levels of clinical service delivery
4. Support availability of sustainable MNH programming at various levels including the building of regulatory capacity through scope of practice expansion and delineation for Midwifery
5. Strengthen Midwifery and maternal newborn health specific program evaluation for scale up of lessons learnt at national and international level

The underlying belief system is that is more beneficial to maternal health as a whole to avoid Midwifery human resource development short cuts, which may be ultimately harmful.

8. Emergency Response and Immediate Post-Conflict

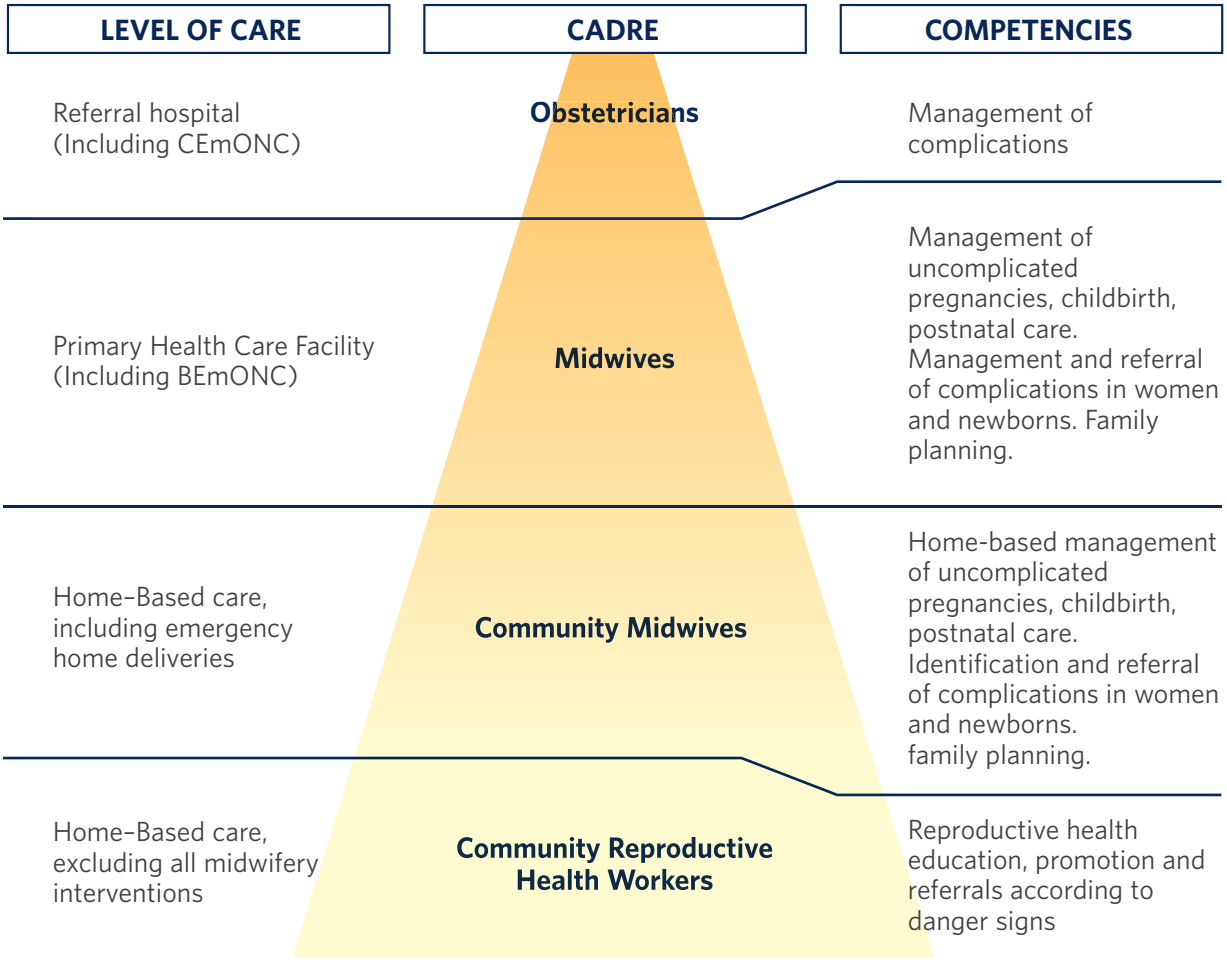
8.1 From Community Midwifery in Emergencies to Midwives in every setting for Normal Birth

With the urgency of need for functional maternal health workers that is currently present as a result of the conflict, it was deemed that a strategy was needed to rapidly build up a core of Midwifery personnel and resource persons. Further reflection of concerned stakeholders in the maternal health arena determined that taking a more intermediate stepwise approach to increasing Midwifery human resources would be most beneficial for the long- term need. Prior to the development of the emergency Midwifery response strategy, stakeholder consultations revealed that professional Midwifery courses offered in Syria varied in length, objectives and course progression. This had led to multi- sectorial and inter- professional confusion about the definition and expected skill set of the functioning Midwife.

With the successful introduction of the newer cadre of Community Reproductive Health workers and the CRHW Master Trainers, it had already been proven that well thought out interim steps to building health workers could work.

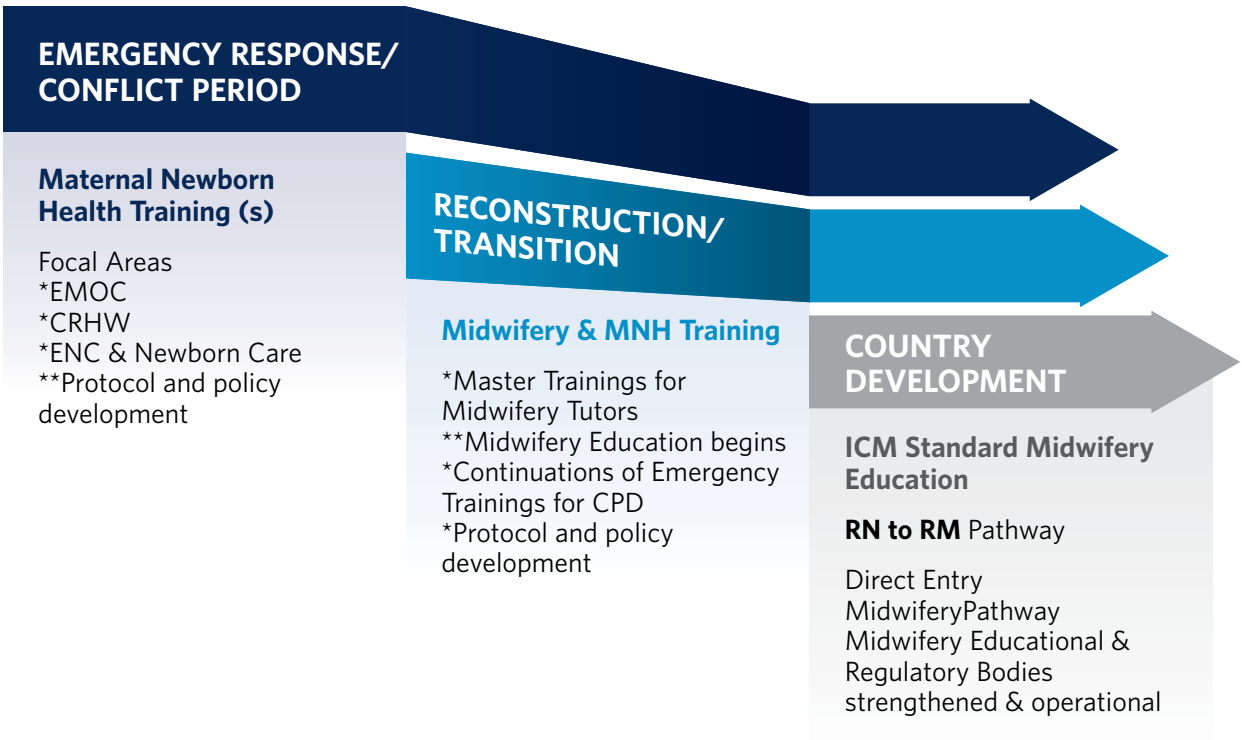
Thus it was decided that a comprehensive stepwise approach to Midwifery training would be taken that allowed for a supported build-up of Midwifery human resources that took into consideration the practicality of providing basic competent 'helpers' in the current situation. Figure 2 illustrates the pyramid of care providers and expectations that was validated through the RH -TWG

Figure 2. Emergency Midwifery Response Human Resources Development Pyramid



The varying levels of maternal newborn health capacity building that are ongoing needed more backing to assist in a smoother transition from emergency response to comprehensive development of Midwifery services. While some of the guidance decisions made may seem non-important when facing current need, there is recognition that there will be an inpouring of maternal health focused assistance particularly with the cessation of conflict. If measures are not taken to stream line and decide upon priorities before this happens, chaotic disjointed educational and service delivery is a huge probability. Figure 2 outlines the pivotal points for the Segway from MISP to comprehensive care. It is for-seen that there should be fluid overlap, as actions taken in the emergency response will support the transition period. For example, making members of allied health such as pharmacist aware that a prescription from a Midwife for select medicines can be filled.

Figure 3. From Emergency Response to Comprehensive Midwifery Care Services



8.2 Staggered Midwifery Capacity Building

The consultative stakeholder group influencing the Midwifery Capacity building strategic guidance universally adopted the ICM global standard 3-year Midwifery training as the ideal model for the future of Syrian Midwifery. To support emergency needs for Midwifery services, this 3 year pre-service training would be modified to allow an time limited temporary exit of "Resident Community Midwives" (RCM) at year 1.5 or after completion of normal Midwifery core courses. This emergency based temporary RCM exit would focus solely on delivering maternal health care in the community and expire as a recognized approach to delivering Midwifery services approximately 5 years after the official cessation of conflict.

The initial Midwifery core courses would be focused on the basic sciences, humanities, normal birth and normal women's health processes. The Resident Community Midwife upon successful completion of theoretical and clinical examination would be allowed to practice within the outside/ home community setting or within a basic health care facility with referral structure within a system of oversight and supervision. The RCM scope of practice would be limited to normal cases within a strict guideline of normal care with early recognition and referral to higher levels of care.

A temporary practice certificate would be issued by the educational institution in collaboration with the functional Health Directorate to cover the immediate emergency and years 5 immediately following. The certificate would only be issued with successful course completion and passing of exit exam with 70% set as the minimum standard pass rate.

Understanding the need for ongoing support, Resident Community Midwives would be expected to undergo quarterly periodic peer review, keep a logbook of cases/procedures for audit and expected to enrol for the last year of diploma level Midwifery training within 3 years after the cessation of conflict. For all intents and purposes, the RCM would continue to be counted a registrant/extern of her supervising educational institution. The educational institute would be expected to maintain close contact with the RCM through the tutors providing external support through fore-mentioned periodic visitation and clinical audit.

Full additional licensing examination would be expected from the RCM as per the norm with successful completion of the 3rd year of Midwifery school theoretical and clinical components. The full course of recommended modules for diploma level Midwifery would be completed with the option of a Bachelor's degree in a 4th year given as educational institutions and programs progress.

For currently practicing RN's wishing to transition into Midwifery practice, there would be no option given other than the recommended 18-month post-basic Nurse to Midwifery training. In other words, the currently practicing RN's would not be eligible to undergo the emergency based RCM route to Midwifery practice. It was felt strongly by stakeholders that there was little desire to further deplete the already low numbers of RN's in the medical surgical units by pulling them into maternity care.

It is clearly understood within members of the medical, Midwifery and nursing community that many births are taking place within the home setting without the reliable support of a professional Midwife or skilled birth attendant. This reality was true both in the past and in the present scenario of Syria. With the current restricted movement of women imposed by the conflict, multiple anecdotal reports give rise to identifying a greater than ever need for and acceptance of community based Midwifery services. Thus, the supported presence in communities of the Resident Community Midwife could assist in improving the safety of normal birth services and provide an access point into the formal maternal new born health care system when referral is needed.

8.3 Resident Community Midwife (RCM) -Functionality

The Resident Community Midwife is designed to mainly work independently within the community setting. It is envisioned that she will work strictly according to globally accepted guidelines of normalcy and rapid referral. If indicated or required by the health system the RCM may work in a primary health centre, or basic Midwifery centre to admit, manage and provide the required full scope of normal Midwifery care only. She is expected to provide birth registration and/or related documentation in line with routine health information management and vital statistics registration systems. The resident community Midwives will have full autonomy to demonstrate professional skills with normal women of reproductive age.

In order to function fully, the resident community Midwife's scope of practice will include, but is not limited to, skills and prescription of a limited formulary of specific obstetrical, well woman's health care, and family planning drugs in relation to the WHO and Syrian Essential medicines list.

Every RCM entering into community-based practice will have demonstrated completion of 40 normal deliveries and concurrent essential newborn care as evidenced by recording clinical information in a logbook as a minimum standard of care.

This clinical expectation component will be the minimum expected for the Midwifery candidate to be allowed to sit for the examination of the temporary exit strategy. The candidate will not be allowed into community-based practice until the clinical component is completed regardless of completion of the theoretical coursework.

The RCM is expected at minimum to be able to independently

1. Provide normal antenatal and birth care
2. Prescribe basic medicines such as prenatal vitamins, anti-infective, and commonly used utero-tonics
3. Order laboratory studies and sonograms and or have access/authority to refer to laboratory/diagnostic services
4. Admit or discharge normal patients from an in-patient lowest level health facility such as a PHC
5. Refer to and consult with specialists
6. Have access to emergency back-up services.

In comparison with the RM, the emergency response RCM will have a more intensive focus on maternal and immediate newborn health only. The broader family and public health focus of Midwifery would be expected to be added through coursework during the final 3rd year of Midwifery training program to complete ICM standard competencies.

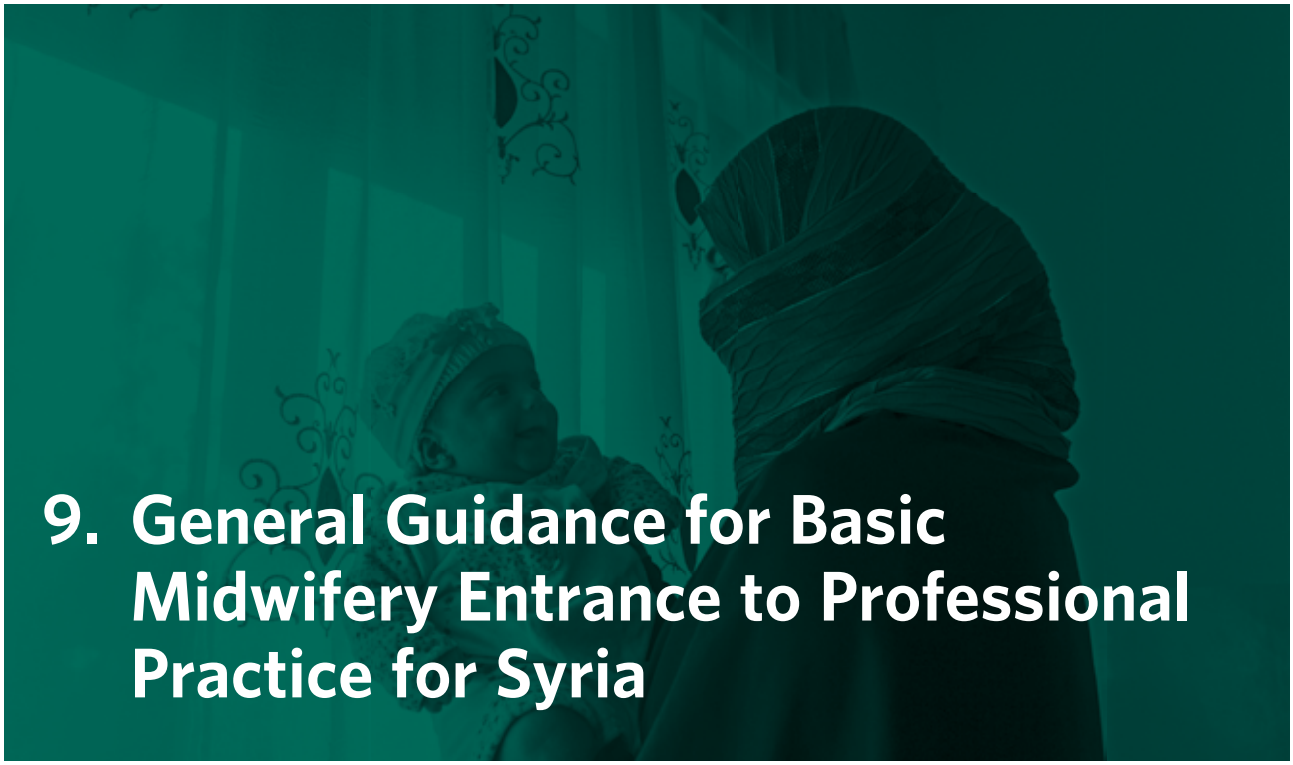
Comparative Competencies for Time-limited- Northern Syria Resident Community Midwife Emergency Strategy

Standard ICM Registered Midwife (3 Years Education)	**Resident Community Midwifery (1.5 Years Education Emergency Response)**
Competency 1: Midwives have the requisite knowledge and skills from obstetrics, neonatology, the social sciences, public health and ethics that form the basis of high quality, culturally relevant, appropriate care for women, newborns, and childbearing families.	**Competency 1:** Midwives have the requisite knowledge and skills from obstetrics, neonatology, the social sciences, public health and ethics that form the basis of high quality, culturally relevant, appropriate care for women, and newborns.
Competency 2: Midwives provide high quality, culturally sensitive health education and services to all in the community in order to promote healthy family life, planned pregnancies and positive parenting.	**Competency 2:** Midwives provide high quality, culturally sensitive health education and basic services to all in the community in order to promote healthy and planned pregnancies.
Competency 3: Midwives provide high quality antenatal care to maximize health during pregnancy that includes early detection and treatment or referral of selected complications.	**Competency 3:** Midwives provide high quality antenatal care to maximize health during pregnancy that includes **early detection with immediate referral of complications.**
Competency 4: Midwives provide high quality, culturally sensitive care during labor, conduct a clean and safe birth and handle selected emergency situations to maximize the health of women and their newborns.	**Competency 4:** Midwives provide high quality, culturally sensitive care during normal labor, and conduct a clean and safe birth and manage only the major immediate complications/ emergencies that may be associated with delivery and immediate postpartum.
Competency 5: Midwives provide comprehensive, high quality, culturally sensitive postpartum care for women.	**Competency 5:** Midwives provide **basic**, high quality, culturally sensitive postpartum care for normal women.
Competency 6: Midwives provide high quality, comprehensive care for the essentially healthy infant from birth to two months of age.	**Competency 6:** Midwives provide high quality, comprehensive care for the **healthy infant from birth to 1 week of age.**
Competency 7: Midwives provide a range of individualized, culturally sensitive abortion-related care services for women requiring or experiencing pregnancy termination or loss that are congruent with applicable laws and regulations and in accord with national protocols.	**Competency 7** **Not applicable for Resident Community Midwife.**

Figure 4. Suggested Minimal Mandatory Modular coursework for Direct Entry RM Progression

Clinical coursework* will be integrated from the initial semester of Midwifery to fully combine theory and practice skills**

Figure 5. Suggested Minimal Mandatory Modular coursework for RN to RM Progression



9. General Guidance for Basic Midwifery Entrance to Professional Practice for Syria

In order to encourage continued growth of the Midwifery workforce, the Northern Syrian Midwifery strategy will allow more for more than one entry path to Midwifery practice. The strategy is designed to allow for two basic pathways for entry into Midwifery practice, which will capture different populations of candidates subsequently enriching the human resource and future leadership pool through diversity of age and life experiences. The pathways are designed to maintain the integrity of the profession while encouraging an attitude of lifelong learning. The pathways support the understanding the Midwifery and Nursing are two separate disciplines. There may be areas of overlap between the two professions but the competencies required for safe Midwifery practice are independent of those learned in a Nursing course of study.

The pathways to Midwifery practice are as follows:

1st: 3 year direct entry pathway of high school graduates
2nd: Entrance into Midwifery practice of the of Registered Nurse

Both cadres would be known a Registered Midwives upon completion of studies and fulfilment of licensing requirements.

The broad acceptance of two separate but equal pathways will allow for an increased number of persons to be able to enter the profession while maintaining basic standards for Midwifery care as clinical requirements for graduation would be the same. It is anticipated that the two pathways will bridge and share common curricular content, clinical sites and resources for teaching.

9.1 Registered Nurse to Registered Midwife- Pathway 18 month full time Midwifery training

This pathway is designed for the practicing nurse who has already completed a basic nursing program and wishes to further her Midwifery specific education course. In order to be eligible to bridge into a post nursing completion Midwifery program, the Registered Nurse must fulfil the basic requirements of:

1. Completion of high school
2. Age not less than 17
3. Present formal documentation attesting to professional designation as a Registered Nurse
4. Pass baseline entrance examination
5. Complete educational institution admission specific requirements
6. Present statement of good health and physical fitness
7. Ability to understand written English & Arabic and write in English

Additionally the candidate must:

- Commit to course completion
- Be willing to undergo end of course licensing examination
- Be willing to work both at the community level and within available facilities in places where maternal and neonatal health services may not be readily available

All RN presenting for acceptance to Midwifery training will be expected to undergo a rigorous basic examination process without exception. The mandatory equivalence/entry examination of current nurses wishing to bridge into Midwifery is anticipated to cover the social sciences, humanities, basic first aid, and core nursing knowledge and be inclusive of skills such as vital signs and therapeutic communication.

The expected minimum pass rate for both theoretical and clinical components of the examination is set at 60%. The entrance examination will be set in collaboration, by a collective of representatives of the educational institutions.

If the RN is unsuccessful in her attempt to pass the entrance examination she may be given one attempt to remediate her performance. If a second attempt at the 18 month training entrance examination is unsuccessful, the RN will be expected to undertake the full 3 year Midwifery training should she wish to continue to pursue a career as a Midwife.

Considering the context of massive displacement that has been a result of the conflict, allowance will be made for the RN who does not possess a copy of her License/Registration. If such an RN without documentation of education/licensure wishes to enter into the Midwifery program, she may present the signed sworn testimonial of 3 registered/licensed health care professionals attesting to practice as a health care professional prior to presentation for entry to the Midwifery program. This testimonial inclusive of full name/contact information of sworn health professionals can be accepted in lieu of presentation of formal licensing document.

9.2 Direct Entry Midwifery 3 year Diploma level

This pathway is designed for the candidate who has never undergone any training in Midwifery independent of completion of coursework in another field of study. In order to be eligible for an admission to a direct entry Midwifery program, the candidate must fulfil the basic requirements of

1. Completion of high school
2. Age not less than 17
3. Pass baseline entrance examination (if required)
4. Complete educational institution specific admission requirements
5. Present statement of good health and physical fitness
6. Has ability to understand written English & Arabic and write in English

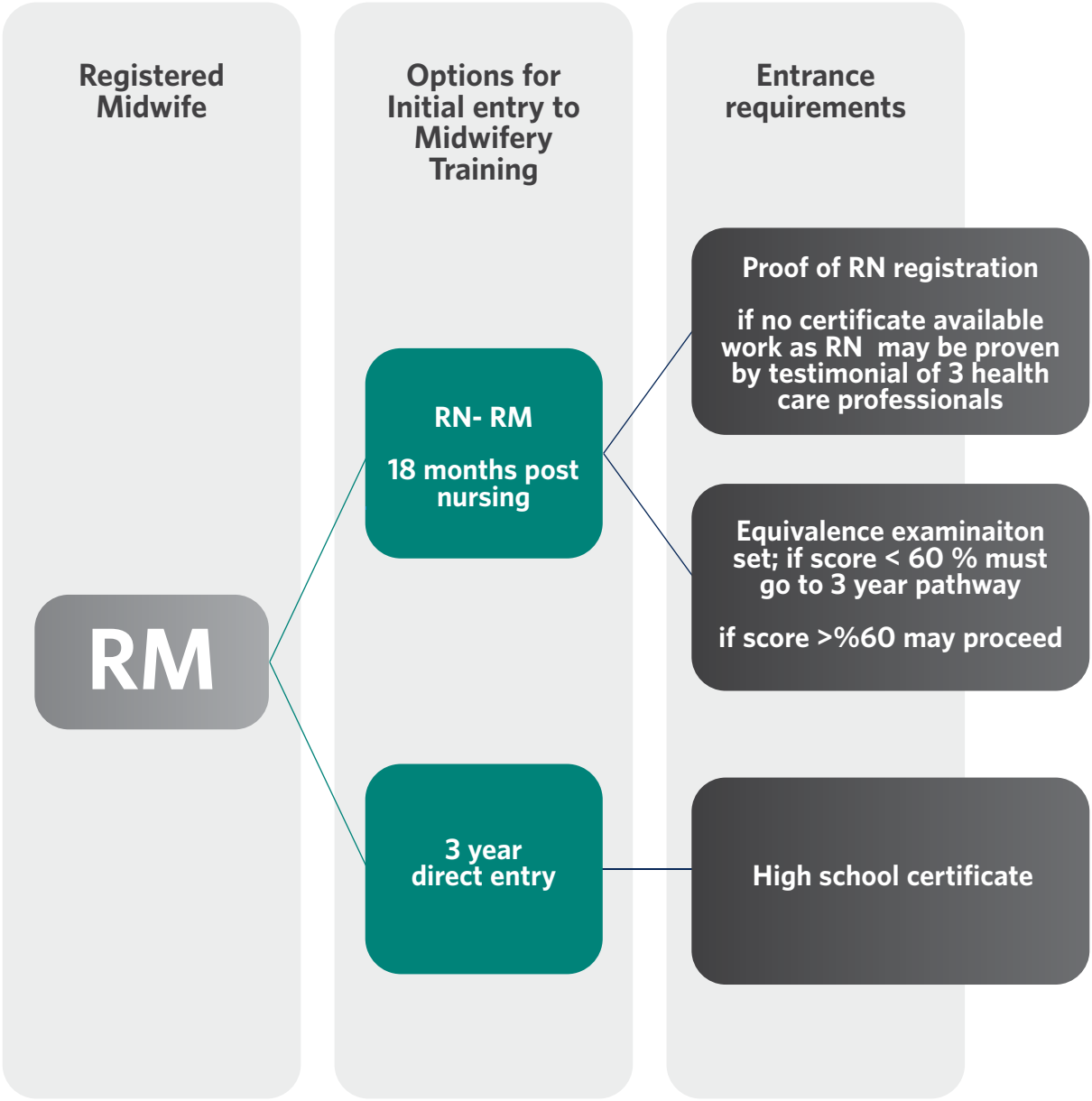
Additionally the candidate must:

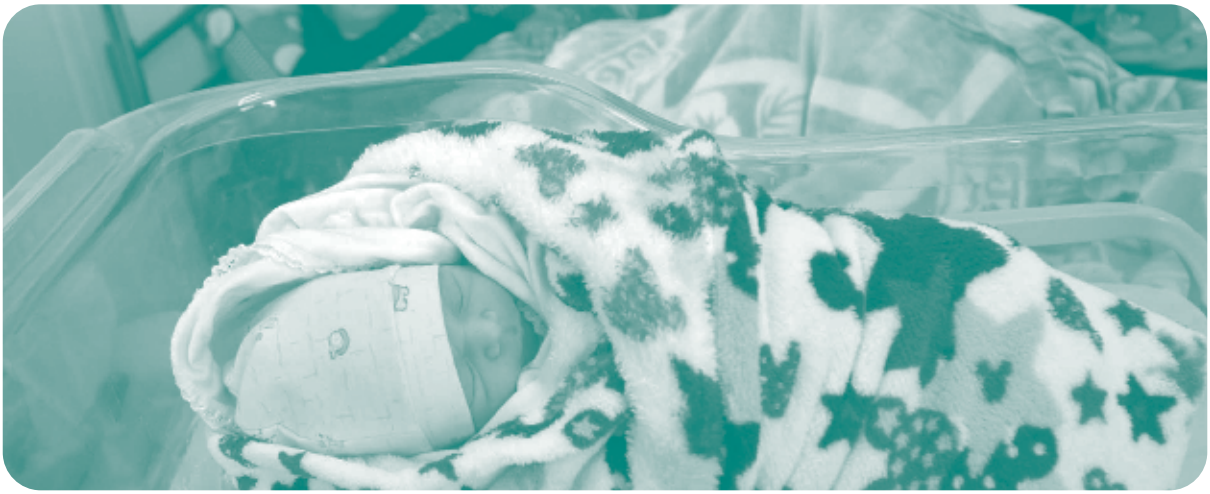
- Commit to course completion
- Be willing to undergo end of course licensing examination
- Be willing to work both at the community level and within available facilities and in places where maternal and neonatal health services may not be readily available

There will be the minimum expectation of completion of a high school certificate for anyone presenting for entry into the Midwifery program. If greater than 5 years have passed since completion of high school without any further commencement of higher education, an equivalency examination may be required of the candidates.

There will be no discrimination based upon advanced age, pregnancy or marital status imposed upon anyone desiring entry to Midwifery training programs according to either direct entry or registered nurse pathway.

Figure 6. Pathways to Midwifery Practice





9.3 Graduation requirements for all Midwifery Candidates

Regardless of entry pathway to formal Midwifery training, the expected minimum requirements for graduation will be a 70% score in coursework. This will be tabulated in separate scoring for mandatory theoretical and clinical coursework.

A candidate will be given no more than 2 chances to remediate any failing mark in any overall course grade. The candidate may not progress to the next phase of training if end of year combined competency based examinations have not been successfully passed at the 70 % rate

There will be required Documentation via logbook to support clinical cases covered during the course of training. In order to present for graduation or release from program as interim RCM the clinical expectation will be for the independent performance of

- 50 normal vaginal deliveries
- No minimum for separate FP visits
- No minimum for abnormal cases.

Upon completion the educational institute will offer a certificate attesting to the individual completion of standard requirements.

9.4 Regulation Licensing of Midwives in Emergency

Regulation of Midwifery practice is a function to offer public protection and safety. As there is no formal mechanism for licensing of Midwives in the emergency context there is a heavier reliance on professional ethics in relation to those performing skills in the maternal health arena.

Validation of truth in prior learning and fitness to practice lies currently with the employing agency or organization who assume responsibility and liability for any malpractice.

In order to provide a baseline for minimum expected capacity and scope of practice for Midwives in this context a standard job description outlining the expected scope of practice for Midwives has been developed. It is recommended that the adoption of standardized job description to be used in the hiring of Midwives for clinical and educational practice. This document can also be used as a benchmark for self-assessment in care providers to assist with identification of learning needs to remediate any lacking areas of competency.

10. Role of Midwifery Educational Institutions

The educational institutions will play a vital role in the enforcement of minimally acceptable standards for Midwifery Training.

In addition to adherence to admission criteria for Midwifery students, the educational institutes are expected to adhere to the basic guidance set forth in the job description for Midwifery Faculty (Annex 3).

The recommended ratio of Midwifery Tutors to Midwifery students is 1:10 for the educational institutes. There is the additional expectation of a fully functional skill laboratory complete with materials specifically for low risk Midwifery/maternal health care along with Midwifery specific textbooks for core course reference materials.

The educational institutes commit to the extension of any existing 2 year Midwifery programs to become 3 year ICM standard Midwifery programs with expected re-alignment of course requirements content to facilitate fulfilment of this standard.

Adaptation of competency based teaching /learning approach for all pre-service and in-service Midwifery training. This style will encourage the health care professional to seek to understand exactly what are the expected outcome(s) of learning and take responsibility for one's learning. In the both the short and long term this will result in a cadre of motivated critically thinking professionals who are better able to provide care.

While no formal accreditation of schools exists, transparency and collaboration of educational institutes will be encouraged through co –development and sharing of standard documents and student assessment tools such as logbooks. The spirit of collaboration and transparency will also reduce duplication efforts while supporting consistency of overall approach within the professional institutes. This will simultaneously reduce the strain on diminished midwifery educational human resources for health.

Midwifery Educational Institutes are strongly encouraged to develop a network to use limited human resources effectively to co- develop standard learning objectives, documents, assessment tools and record-keeping systems such as log-books.

The educational institution shall indicate clearly the length and structure of theoretical and clinical learning of students specifying clearly the hours of theory, clinical practice and settings with a ratio of 60 % clinical practice and 40% theoretical knowledge as the standard.

The Midwifery curriculum must be relevant to philosophy, health needs of the society, and local and global trends, fundamental scientific knowledge that is applied to Midwifery and adult learning principles based on ICM Core competencies for Midwifery practice.

11. Continuing Professional Development

Given the rapid pace of developments in maternal health care, it is imperative that all Midwives continue to update their knowledge and skills on a regular basis. There are many benefits for each Midwife as a result of participating in continuing professional development (CPD). The benefits can include a broadening of knowledge base, the acquisition of new skills and services, and increased professional satisfaction. Routine updating of one's knowledge and skills serves as a model for Midwives and demonstrates the value attributed to life-long learning. Facilities and organizations employing Midwives who are regularly updated see benefits in increased patient satisfaction leading to increased use of services and decreases in incidents of concern or debilitating sentinel events.

CPD acknowledges varying learning styles among professionals and includes a wide range of formal and informal learning activities .The key principles behind CPD are that it is:

1. Is self-directed
2. Is based on learning needs identified by the individual
3. Builds on an individual's existing knowledge and experience
4. Links an individual's learning to their practice

Hence the Midwifery Strategy for Northern Syria supports a system of documented CPD within each clinical and academic site employing Midwives.

The strategy supports a system of routine CPD that is

1. Competency and evidence based
2. Integrates Theory and practice
3. Uses Standardized validated packages of learning such as lifesaving skills for Midwives in both the emergency and reconstruction context.

CPD offerings should be objectively based as opposed to ad-hoc and were resources allow, a designated person should be placed as a focal point for the coordination of CPD and Clinical Skills.

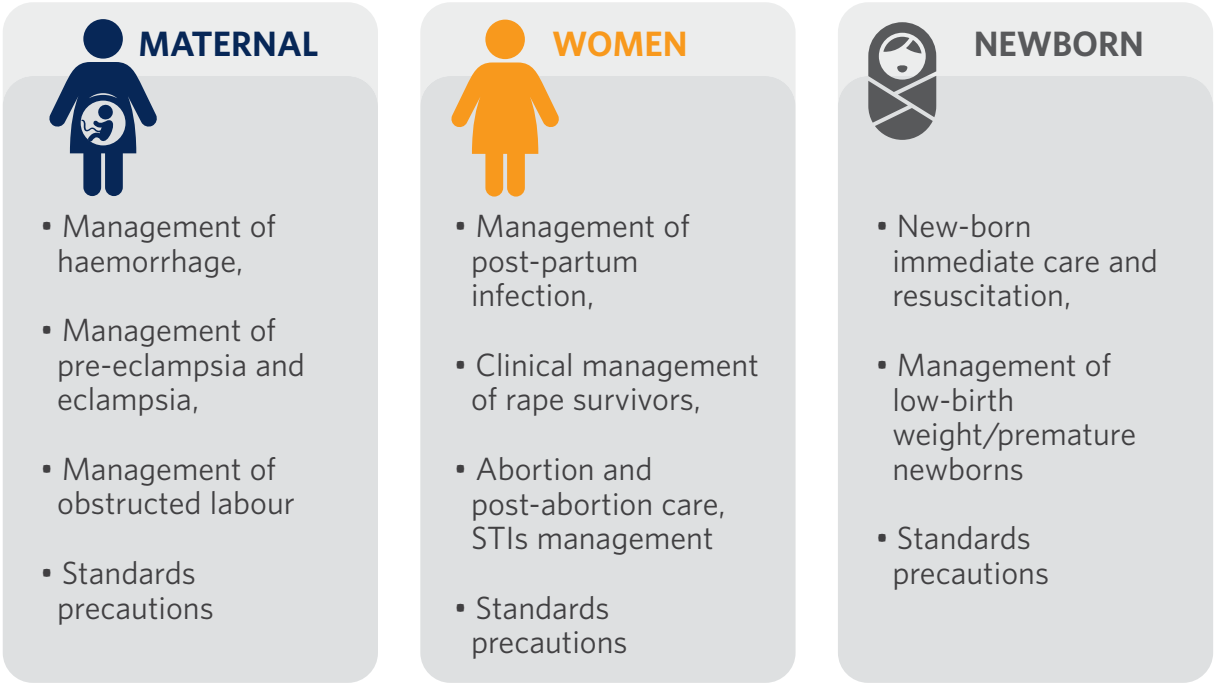
Participation in CPD activities should be counted as a condition of continued employment with a minimum recommended hours per year of 30.

Bearing in mind the current conflict context in Syria, online, interactive, culturally aware training packages (with audiovisual in English & Arabic language, are recommended in the emergency phase for Midwives, Midwifery tutors and Midwifery students who may not be able to attend face- to- face training sessions.

In the context of the current crisis and emergency needs, certain areas for maternal newborn CPD have been agreed upon through consultative process as a part of the Midwifery capacity building strategy. These areas are to be prioritized by all partners to upgrade the existing skill set of maternal health providers who are providing services on the ground using competency based approaches. The list representing the urgent needs covers the areas of practice that are common to Midwifery based care for women of reproductive age.

1. Management of haemorrhage,
2. Management of pre-eclampsia and eclampsia,
3. Management of post-partum infection,
4. Management of obstructed labour,
5. Clinical management of rape survivors,
6. Abortion and post-abortion care,
7. STIs management
8. New-born immediate care and resuscitation,
9. Management of low-birth weight/premature newborns,
10. Standards precautions (crosscutting for all core maternal newborn care components)

Figure 7. Agreed Upon Emergency Response CPD and Standard Protocol Priority Areas



The long-term impact of the importance to quality Midwifery practice of CPD cannot be underestimated. Competency based CPD achievements stemming out of the emergency response will have contributed to the safe maternal health practices. Hence, in the reconstruction phase the Midwifery capacity strategy states the need for a formal regulated CPD policy be developed that is a recognized part of licensing and fitness to practice requirements for Midwives.

12. Actionable Items from Strategic Framework Guidance for Partner development

In order to assist with the operationalization of the Midwifery capacity building strategic framework each of the sub -goals has been expanded into select recommended actions to achieve the overarching vision.

1. Increase access to equitable and high quality MNH services through increased collaboration between education and regulation in the public and private sectors

a. Development of functional network of maternal health institutes and organizations to address major maternal newborn health issues

b. From the inception design any new or upcoming Midwifery programs or professional development systems to be in line with global guidance and ICM standard definitions of 18 month post basic RN or 3 year Diploma level Midwifery

c. Standardization of key definitions related to Midwifery and Midwifery services inclusive of those use in education/training and regulation

d. Design/Implementation of Minimal Clinical Standards for each approved clinical/service delivery site

e. Facilitation of cross border/regional validation of norms related to Midwifery education, practice and regulation to encompass current and future projected workforce needs

2. Increase community collaboration, integration and mobilization for participation in and use of Midwifery based MNH services

a. Coordination of training programs within NGO and governmental structures for knowledge and resource sharing

b. Adaptation of Community Midwifery to include full scope of public health, primary and preventative care as routine practice for all Midwives

c. Community awareness and outreach for 'What is a Midwife' and 'What can a Midwife do"

d. Development of recruitment strategies to attract candidates into Midwifery practice

e. Development of Communication and advocacy strategy for public awareness and up take of Midwifery services in community and facility

3. Building of Midwifery capacity at the pre-service and in-service levels of clinical service delivery

a. Development and adoption of standard job descriptions for Midwives
b. Preparation of contextualized versions of protocols and job aids to align with international standards
c. Draft of main clinical guidelines for common maternal health areas of focus
d. Determine critical areas in need of immediate pre-service curriculum support
e. In service clinical provider focus and training on normal Midwifery and emergency obstetrical care with inclusion of maternal mental health

4. Ensuring availability of sustainable quality MNH programming at various levels including the building of regulatory capacity through scope of practice delineation for Nursing and Midwifery

a. Nurse/Midwife to be allocated at Ministry/Directorate of Health levels to account for Nursing/Midwifery Services specifically
b. Identification of focal person for Nursing/Midwifery at each referral hospital or organization to form a committee representing Nursing and Midwifery needs
c. Establishment of ongoing continuous professional development processes to upgrade existing Midwives in line with updates in best maternal health practices
d. Leadership training to begin at entry point to Nursing and Midwifery to provide a platform and to give possible career pathway potential
e. Establish Linkages between all levels of the health system for N & M to partner additionally with the Ministry of Health and the Ministry of Education

5. Strengthen MNH program evaluation for scale up of lessons learnt at National and international level

a. Dissemination plan for Midwifery material /curriculums developed by partners
b. Development of centralized repository to 'hold forms'/ guidelines/protocols/ Midwifery human resource
c. Establishment of advocacy and communication plan

Key general activities are recommended to support the Midwifery capacity building process which cover each of the sub-goals: These general activities are as follows:

1. Information and dissemination seminars and orientations on core Midwifery competencies
2. Standardized competency based Training (s) on prioritized areas
3. Sharing of evidence based best clinical and educational practices
4. Supportive supervision and peer review of maternal health providers

13. Current and Future Roles and Responsibilities

The implementation of the Northern Syrian capacity building plan for Midwifery is expected to be a joint collaborative effort in which all of the stakeholders who have currently been identified will continue to actively participate. As new stakeholders are identified, there is the expectation that each new actor in Midwifery and maternal health will be brought into line with the vision for Midwifery care through targeted advocacy and communication. As a part of the Midwifery community building process, it is the responsibility of each person with the knowledge of the minimum expectations of the strategy to impart the vision of the strategy to the new partners.

Specific roles and responsibilities may overlap in the provision of various methods of support for Midwifery for design of integrated versus parallel structures. The focus will always be placed on further strengthening of the maternal health system and internalized individual ownership to expand coverage of quality, evidence based cost effective, high impact Midwifery services and interventions for maternal, newborn survival within Northern Syria.

In the short- term emergency phases it is envisioned that the RH Technical working group will play the role of premier coordination entity.

13.1 Reproductive Health Working-Group (RH-WG)

The sector working groups is the technical entity for humanitarian actors and donors to coordinate and discuss programs and projects within the sector of Midwifery. The RH-WG will serve as a key entity for technical experts to review and discuss reproductive health and Midwifery program planning, implementation, and monitoring. This group will function in consultative role and be accessible to all stakeholders providing MNH services.

13.2 Specific Roles and Responsibilities of NGO/Partner Organizations

The NGO/Partner organizations have undertaken a vital role in the provision of direct maternal health services and it is anticipated that the numbers of actors in the NGO arena will continue to increase with the cessation of conflict. In order to avoid threats to the provision of clinical quality in addressing the needs gap, it is proposed that all NGO's will adhere to a common framework which includes the following:

I. The NGO/organization must present to the RH Technical Working group and attempt to register with the Directorate of Health (where operational) in the province where the Midwifery services are proposed

II. The NGO/organization must ensure registration/license all health care service providers who are proposed to provide any training or clinical service delivery. This includes any foreign volunteers who must provide

III. Inform the RH Cluster and MOH/DOH of any proposed or planned trainings, including content

IV. Commit to competency based educational modalities

V. Advocate, and promote, operationalization of the Midwifery capacity strategic plan and advocate for policies that facilitate MNH programs and services at the national and organizational level

VI. Advocate for women's empowerment in MNH care-seeking and FP decision-making and implement mechanisms to expand male involvement in MNH and FP

VII. Advise the government on resource mobilization for MNH services and monitor their use to support implementation of the MNH road map

VIII. Build the capacity of providers to ensure that the services they provide align to standards and quality of care in the MOH's MNH, and FP protocols and guidelines

IX. Facilitate and support research on MNH and FP, document best practices, disseminate and apply the results to clinical care

X. Assist with the development and keep updated standards, protocols and guidelines for care and services in the provision of MNH and FP at all levels of the health care system

XI. Provide support for maternal death audits

13.3 Ministry of Health/Directorate of Health

The Ministry of Health and Syndicate will provide the oversight for the entirety of the Midwifery capacity building strategic framework and will be an active participant at every level. The future expected role of the MOH will intersect greatly with its identified past function and is anticipated to include core function in the following areas

Licensing

I. Setting of Licensing Examinations for Midwifery

II. Marking of Licensing Examinations for Midwifery

III. Issuance of results of licensing examinations for Midwifery

Accreditation

I. Clinical Facility accreditation

II. Educational Institute accreditation

Clinical Practice

I. Provide oversight and approval of any protocols/guidelines that are produced by Association branch of Syndicate

II. Supervision of clinical practice sites

13.4 Syndicate for Health Professionals

The Syndicate for health professionals in Syria has functional similarity to the expanded role of a professional association for health professionals. Functioning in the past as a mandatory membership body, the syndicate provides a forum for the network of health care workers.

It is anticipated that the Midwifery specific division of the syndicate will guide the formation of protocols for specialized areas in maternal health which will be updated regularly according to the best available evidence from reputable bodies in healthcare.

The syndicate will also play a role in

I. Labour issues

II. Disciplinary action

III. Enforcement of code of conduct

IV. Continue with other functions as decided

13.5 Monitoring and Evaluation

Monitoring and evaluation of the process and outcomes of the strategic plan, are critical to track interventions implementation, inform decision-making, and increase accountability toward the beneficiaries. Monitoring of this strategic plan will rely on routine data generated through reporting systems of the HMIS (present and future), maternal and neonatal death audit reports, verbal autopsy reports, and rigid documentation from the Midwifery educational institutions among others.

The RHC/ TWG will conduct a periodic review of key MNH data sources and reports to ensure that needed information is being obtained. At each level, data will be analysed, interpreted, and used to inform further decision-making and planning that is responsive to the expressed needs of the Midwives and maternal health workers.

14. Conclusions

The challenges present for the Syrian Nursing and Midwifery profession are very similar to those faced by the global Nursing and Midwifery professions. These include lack of trained educators and staff, lack of infrastructure/supplies, inadequate access to information and negative views of the profession. These problems however, are exacerbated exponentially by the realities of war.

For the purposes of furthering Midwifery capacity building, the strategy will be utilized as and initial roadmap to achieve the target of improved Midwifery services in the current and immediate post-conflict rebuilding. After the validation of the proposed strategy, detailed time-bound approach will be taken to identify the priority strategic objectives for the year 2017-2021.

Based on the identified strategic priorities, interventions and validated decisions that have been made such as admission criteria, graduation criteria and job description with embedded scope of practice framework, a comprehensive annual action plan can be developed. The next step action planning, can indicate actions to be taken by various stakeholders under the vision and sub-goals of this strategy.

Linkages between partners should be prioritized to encourage a higher degree of free flowing information and sharing of resources is highly encouraged. However, main required resources of all stakeholders have already been identified to be:

- Technical Midwifery led support to build the internal capacity of Midwives and Midwifery
- Financial support to develop human resources, infrastructure, equipment, supplies, transport and support to achieve the Strategy's interventions.
- Policy and planning systems for retention of Midwives in the profession, recruitment in to the profession and supervisory systems
- Career ladder and pathway specific to Midwifery
- Provide clear guidelines of deployment and utilization of Certified and Registered Midwives working autonomously and clearly define their scope of practice

sThis is a living guidance document, which will be continually adapted to local context and supplemented as information becomes available on the true Midwifery HRH situation within Syria. This Midwifery strategy is underscored in the commitment of the maternal health stakeholders to function as a cohesive body to improve Midwifery and maternal health care. It is acknowledged that this guidance for Midwifery capacity building can only be as successful as the implementing partners enforcing it.

KEY MESSAGE:

"Quality Midwifery is not just a quick fix"

Annexes

Annex 1: Recruitment Basics for Admission to Registered Midwifery Training Program

RN to RM Bridge Program Admission Criteria

1. Completion of high school
2. Age not less than 17
3. Present formal documentation attesting to professional designation as a Registered Nurse
4. Pass baseline entrance examination
5. Complete educational institution admission specific requirements
6. Present statement of good health and physical fitness
7. Ability to understand written English & Arabic and write in English

Additionally the candidate must:
Commit to course completion
Be willing to undergo end of course licensing examination
Be willing to work both at the community level and within available facilities in places where maternal and neonatal health services may not be readily available

Direct entry 3- years Diploma in Midwifery Admission Criteria

1. Completion of high school
2. Age not less than 17
3. Pass baseline entrance examination (if required)
4. Complete educational institution specific admission requirements
5. Present statement of good health and physical fitness
6. Has ability to understand written English & Arabic and write in English

Additionally the candidate must:
Commit to course completion
Be willing to undergo end of course licensing examination
Be willing to work both at the community level and within available facilities and in places where maternal and neonatal health services may not be readily available

IMPORTANT NOTE: There will be no discriminatory practices in admission practices based upon marital status, pregnancy or advanced age

Annex 2: Midwife Job Description

JOB TITLE: Midwife

OBJECTIVES

To contribute to the improvement in the quality of Midwifery Services, by providing clinical Midwifery leadership for health services ensuring that women and their families are at the centre of health care service delivery in every setting along the home to hospital continuum of care.

JOB SUMMARY

The Midwife in education, research or clinical practice has overall responsibility for providing women and family health services under the following domains according to the ICM Competencies for Midwifery practice:

- Primary care
- Basic Gynaecologic and family planning services
- Preconception care
- Care during pregnancy and childbirth
- Postpartum care
- Care of the normal newborn during the first 28 days of life
- Treatment of male partners for sexually transmitted infections

The Midwife has the responsibility of ensuring high standards of care so that the needs of women and their families are continuously maintained. The scope of clinical duties may vary from practice site to practice site and it is the responsibility of the Midwife to practice safely within her scope of practice and level of skill and training competency. The Midwife is expected to function autonomously in the arena of normal women's and new-born health while engaging actively in early screening and referral systems for the potentially high risk client. In collaboration with members of a multi-disciplinary team, the Midwife is responsible for delivery of health care services, basic risk management, implementation of clinical and educational guidelines, and management of complaints.

MAIN DUTIES AND RESPONSIBILITIES

In the area of Clinical Leadership, the Midwife should:

- Demonstrate excellent transformational leadership skills, as well as detailed knowledge of Midwifery and contemporary maternity care
- Be accountable for continuously improving the quality of women-centred care and Midwifery services
- Safeguard high standards of evidence based Midwifery practice and promote clinical excellence.
- Promote a holistic high quality Midwifery service that promotes childbirth as a normal physiological life event
- Supervise/mentor Midwives and students as required
- Demonstrate excellence in documentation and data management systems
- Be able to communicate with women about highly complex, sensitive and emotionally challenging issues, for example in instances of, sexually based violence, neonatal death/ miscarriage, foetal abnormality, and gender based violence,

- Demonstrate appropriate leadership skill in conflict resolution, problem solving and people management when dealing with stressful and difficult situations.

In the area of Risk management the Midwife should:

- Work collaboratively with the multidisciplinary team, to identify, to develop, to implement and to evaluate action plans to mitigate against risks within the clinical area

In the area of Clinical guidelines the Midwife should:

- Work within existing guidelines for clinical practice in both the national and international arena where local clinical practice guidelines do not exist
- Ensure that the philosophy, policies, procedures and standards of care for maternity service are appropriately maintained and implemented
- Work to develop Midwifery clinical care pathways, policies and procedures

In the cross cutting areas of logistics and infection control, the Midwife should:

- Ensure that all clinical equipment within use are serviced and in working order
- Ensure systems are in place for the cleaning and monitoring of equipment.
- Lead and influence the control and prevention of hospital acquired infection within defined area of responsibility.
- Work actively towards compliance with standard Infection control policies

In the area of professional practice and educational development the Midwife should:

- Under no circumstances divulge protected information of a confidential nature by any means to any unauthorised persons while on or off duty
- Contribute to the planning and evaluation of the pre and post registration Midwifery educational process
- Ensure that the quality of mentorship and assessment of Midwifery peers and student Midwives within maternity services are evidenced and high quality
- Promote a work culture that encourages the ethos that everyone can overtly learn from each other and share best practice strategies
- Create an environment that is challenging, stimulating and supportive of individuals in promoting life long learning for the improvement of patient care.
- Take responsibility for her own personal and professional development and continual learning
- Ensure personal and professional knowledge and skills meet the requirements of the post and that they are in line with current practice.

NOTE

The duties and responsibilities outlined in this job description although comprehensive are not definitive and you may be required to perform other duties as outlined by the individual organizational structure.

Annex 3: Midwifery Clinical Faculty Job Description

JOB TITLE: Midwifery Clinical Faculty

Midwifery faculty/tutors play an integral role in the ongoing development of the Midwifery profession. As such, candidates desirous of a role as Midwifery faculty are expected to show a strong commitment to Midwifery education and demonstrated commitment to student learning. The ideal Midwifery faculty candidate will also demonstrate a willingness to take a leadership role in areas of educational and clinical professional expertise.

Midwifery faculty members are held to the overview and job description of the Midwife in addition to the following faculty role specific expectations.

General Roles and Responsibilities of Midwifery instructors/faculty are:

- Innovative instruction in a variety of classroom, clinical and clinical laboratory settings
- Participation in curriculum/course development, evaluation and revision.
- Development and delivery of student-centreed experiences that promote learning
- Planning learning experiences with intent of assisting students in meeting course/ curriculum outcomes
- Participation in evaluation of student learning and performance
- Willingness to continuously integrate new patient care content into teaching/learning strategies
- Ability to facilitate the learning of a diverse student population including people of all ages from academically, culturally and economically diverse backgrounds
- Provision of lectures and clinical instruction to motivate students to actively participate in their educational process
- Preparation of formative and timely feedback to students regarding their clinical, lab and classroom performance
- Identification and referral of students for tutoring and remediation when appropriate
- Utilization wherever possible, of teaching methods which combine to make communication, critical thinking, and an attitude of lifelong learning concepts relevant across the Midwifery curriculum

MINIMUM/MANDATORY EDUCATION AND EXPERIENCE REQUIREMENTS:

- Bachelor's Degree in Midwifery or Nursing (basic requirement) Masters Degree or Masters in Public Health highly desired
- Minimum of 2 years' clinical experience
- Willingness to undertake specific course to specialize in pedagogical learning within 2 years of employment if not already a part of prior educational experience
- Ability to travel locally to assist students with clinical components of program
- Up to date Registration with accredited Nursing and Midwifery Council
- Work experience related to obstetric, paediatric, community or mental health nursing beneficial
- Demonstrated ability to work effectively in an innovative team environment where change is the norm
- Experience using a variety of teaching and assessment techniques – including the use of technology to enhance student success
- Experience in implementing techniques of critical thinking in the classroom and in clinical settings.

Annex 4: International Confederations Essential Competencies for Midwifery Practice

2010 Revised 2013

PREFACE

The International Confederation of Midwives (ICM) is a federation of midwifery associations representing countries across the globe. The ICM works closely with the World Health Organization, all United Nations agencies, and governments in support of safe motherhood and primary health care strategies for the world's families. ICM takes the leadership role in development of the definition of the midwife, and the delineation of the midwifery scope of practice (the essential competencies). ICM also promotes standards and guidelines that define the expected structure and context of midwifery pre-service education programs; provides guidance for the development of regulations for midwifery practice; and assists countries to strengthen the capacity of midwifery associations and to develop leaders of the midwifery profession worldwide.

Throughout this document the term "competencies" is used to refer to both the broad statement heading each section, as well as the knowledge, skills and behaviours required of the midwife for safe practice in any setting. They answer the questions "What is a midwife expected to know?" and "What does a midwife do?" The competencies are evidence-based.

The majority of the competencies are considered to be basic or core, i.e., those that should be an expected outcome of midwifery pre-service education. Other items are designated as additional knowledge or skills. Additional skills are defined as those that could be learned or performed by midwives under either of two circumstances: a) midwives who elect to engage in a broader scope of practice and/or b) midwives who have to implement certain skills to make a difference in maternal or neonatal outcome. This allows for variation in the preparation and practice of midwives throughout the world, depending on the needs of their local community and/or nation.

The competencies are written in recognition that midwives receive their knowledge and skills through several different educational pathways. They can be used by midwives, midwifery associations, and regulatory bodies responsible for the education and practice of midwifery in their country or region. The essential competencies are guidelines for the mandatory content of midwifery pre-service education curricula, and information for governments and other policy bodies that need to understand the contribution that midwives can make to the health care system. The Essential Competencies for Basic Midwifery Practice is complemented by ICM standards and guidelines related to midwifery education, regulation and clinical practice.

The Essential Competencies for Basic Midwifery Practice is a living document. The competency statements undergo continual evaluation and amendment as the evidence concerning health care and health practices emerges and evolves, and as the health care needs of childbearing women and families change.

KEY MIDWIFERY CONCEPTS

There are a number of key midwifery concepts that define the unique role of midwives in promoting the health of women and childbearing families. These include:

- partnership with women to promote self-care and the health of mothers, infants, and families;
- respect for human dignity and for women as persons with full human rights;
- advocacy for women so that their voices are heard and their health care choices are respected;
- cultural sensitivity, including working with women and health care providers to overcome those cultural practices that harm women and babies;
- a focus on health promotion and disease prevention that views pregnancy as a normal life event; and
- advocacy for normal physiologic labour and birth to enhance best outcomes for mothers and infants.

SCOPE OF MIDWIFERY PRACTICE

The scope of midwifery practice used throughout this document is built upon the ICM international Definition of the Midwife which recognises the midwife as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility, and to provide care for the newborn and infant. This care includes preventative measures, the promotion of normal physiologic labour and birth, the detection of complications the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.
The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care. A midwife's role as advocate for evidence-based midwifery practices can also be valuable in advancing public health policy regarding women's health and maternal and child health care.
A midwife may practise in any setting including the home, community, hospitals, clinics or health units.

International Confederation of Midwives

Essential competencies for basic midwifery practice 2010

COMPETENCY IN SOCIAL, EPIDEMIOLOGIC AND CULTURAL CONTEXT OF MATERNAL AND NEWBORN CARE

COMPETENCY # 1: Midwives have the requisite knowledge and skills from obstetrics, neonatology, the social sciences, public health and ethics that form the basis of high quality, culturally relevant, appropriate care for women, newborns, and childbearing families.

Knowledge
BASIC
The midwife has the knowledge and/or understanding of...

- the community and social determinants of health (e.g., income, literacy and education, water supply and sanitation, housing, environmental hazards, food security, disease patterns, common threats to health)
- principles of community-based primary care using health promotion and disease prevention and control strategies
- direct and indirect causes of maternal and neonatal mortality and morbidity in the local community and strategies for reducing them
- methodology for conducting maternal death review and near miss audits
- principles of epidemiology, community diagnosis (including water and sanitation), and how to use these in care provision
- methods of infection prevention and control, appropriate to the service being provided
- principles of research, evidenced-based practice, critical interpretation of professional literature, and the interpretation of vital statistics and research findings
- indicators of quality health care services
- principles of health education
- national and local health services and infrastructures supporting the continuum of care (organization and referral systems), how to access needed resources for midwifery care
- relevant national programs (provision of services or knowledge of how to assist community members to access services, such as immunization and prevention or treatment of health conditions prevalent in the country)
- the concept of alarm (preparedness), resources for referral to higher health facility levels, communication and transport [emergency care] mechanisms

- the legal and regulatory framework governing reproductive health for women of all ages, including laws, policies, protocols and professional guidelines
- human rights and their effects on health of individuals (includes issues such as domestic partner violence and female genital mutilation [cutting])
- advocacy and empowerment strategies for women
- local culture and beliefs (including religious beliefs, gender roles)
- traditional and modern health practices (beneficial and harmful)
- benefits and risks of available birth settings (birth planning)
- strategies for advocating with women for a variety of safe birth settings

Professional Behaviours
BASIC
The midwife...

- is responsible and accountable for clinical decisions and actions
- acts consistently in accordance with professional ethics, values and human rights
- acts consistently in accordance with standards of practice
- maintains/updates knowledge and skills, in order to remain current in practice
- uses universal/standard precautions, infection prevention and control strategies, and clean technique
- behaves in a courteous, non-judgmental, non-discriminatory, and culturally appropriate manner with all clients
- is respectful of individuals and of their culture and customs, regardless of status, ethnic origin or religious belief
- maintains the confidentiality of all information shared by the woman; communicates essential information between/among other health providers or family members only with explicit permission from the woman and compelling need
- works in partnership with women and their families, enables and supports them in making informed choices about their health, including the need for referral or transfer to other health care providers or facilities for continued care when health care needs exceed the abilities of the midwife provider, and their right to refuse testing or intervention
- works collaboratively (teamwork) with other health workers to improve the delivery of services to women and families

Skills and/or abilities
BASIC
The midwife has the skill and/or ability to...

- engage in health education discussions with and for women and their families
- use appropriate communication and listening skills across all domains of competency
- assemble, use and maintain equipment and supplies appropriate to setting of practice
- record and interpret relevant findings for services provided across all domains of competency, including what was done and what needs follow-up
- comply with all local reporting regulations for birth and death registration
- take a leadership role in the practice arena based on professional beliefs and values

ADDITIONAL
The midwife has the skill and/or ability to...

- assume administration and management tasks and activities, including quality and human resource management, appropriate for level of health facility and midwifery scope of practice
- take a leadership role in policy arenas

COMPETENCY IN PRE-PREGNANCY CARE AND FAMILY PLANNING

COMPETENCY # 2: Midwives provide high quality, culturally sensitive health education and services to all in the community in order to promote healthy family life, planned pregnancies and positive parenting.

Knowledge
BASIC
The midwife has the knowledge and/or understanding of...

- growth and development related to sexuality, sexual development and sexual activity
- female and male anatomy and physiology related to conception and reproduction
- cultural norms and practices surrounding sexuality, sexual practices, marriage and childbearing
- components of a health history, family history and relevant genetic history
- physical examination content and investigative laboratory studies that evaluate potential for a healthy pregnancy
- health education content targeted to sexual and reproductive health (e.g., sexually transmitted infections, HIV, newborn and child health)
- basic principles of pharmacokinetics of family planning drugs and agents
- culturally acceptable and locally available natural family planning methods
- contemporary family planning methods, including barrier, steroidal, mechanical, chemical and surgical methods of contraception, mode of action, indications for use, benefits and risks; rumours and myths that affect family planning use
- medical eligibility criteria for all methods of family planning, including appropriate timeframes for method use
- methods and strategies for guiding women and/or couples needing to make decisions about methods of family planning
- signs and symptoms of urinary tract infection and sexually transmitted infections commonly occurring in the community/country
- indicators of common acute and chronic disease conditions specific to a geographic area of the world that present risks to a pregnant woman and the foetus (e.g., HIV, TB, malaria) and referral process for further testing and treatment including post-exposure preventive treatment
- indicators and methods for advising and referral of dysfunctional interpersonal relationships, including sexual problems, gender-based violence, emotional abuse and physical neglect
- principles of screening methods for cervical cancer, (e.g., visual inspection with acetic acid [VIA], Pap test, and colposcopy)

Skills and/or abilities
BASIC
The midwife has the skill and/or ability to...

- take a comprehensive health and obstetric, gynaecologic and reproductive health history
- engage the woman and her family in preconception counselling, based on the individual situation, needs and interests
- perform a physical examination, including clinical breast examination, focused on the presenting condition of the woman
- order and/or perform and interpret common laboratory tests (e.g., hematocrit, urinalysis dip-stick for proteinuria)
- request and/or perform and interpret selected screening tests such as screening for TB, HIV, STIs
- provide care, support and referral or treatment for the HIV positive woman and HIV counselling and testing for women who do not know their status
- prescribe, dispense, furnish or administer (however authorized to do so in the jurisdiction of practice) locally available and culturally acceptable methods of family planning
- advise women about management of side effects and problems with use of family planning methods
- prescribe, dispense, furnish or administer (however authorized to do so in the jurisdiction of practice) emergency contraception medications, in accord with local policies, protocols, law or regulation
- provide commonly available methods of barrier, steroidal, mechanical, and chemical methods of family planning
- take or order cervical cytology(Pap) test

ADDITIONAL
The midwife has the skill and/or ability to...

- use the microscope to perform simple screening tests
- insert and remove intrauterine contraceptive devices
- insert and remove contraceptive implants
- perform acetic acid visualization of the cervix and interpret the need for referral and treatment
- perform colposcopy for cervical cancer screening and interpret the need for referral and treatment

COMPETENCY IN PROVISION OF CARE DURING PREGNANCY

COMPETENCY # 3: Midwives provide high quality antenatal care to maximize health during pregnancy and that includes early detection and treatment or referral of selected complications.

Knowledge
BASIC
The midwife has the knowledge and/or understanding of...

- anatomy and physiology of the human body
- the biology of human reproduction, the menstrual cycle, and the process of conception
- signs and symptoms of pregnancy
- examinations and tests for confirmation of pregnancy
- methods for diagnosis of an ectopic pregnancy
- principles of dating pregnancy by menstrual history, size of uterus, fundal growth patterns and use of ultrasound (if available)
- components of a health history and focused physical examination for antenatal visits
- manifestations of various degrees of female genital mutilation (cutting) and their potential effects on women's health, including the birth process
- normal findings [results] of basic screening laboratory tests defined by need of area of the world, (e.g., iron levels, urine test for sugar, protein, acetone, bacteria)
- normal progression of pregnancy: body changes, common discomforts, expected fundal growth patterns
- implications of deviation from expected fundal growth patterns, including intrauterine growth retardation/restriction, oligo- and polyhydramnios, multiple foetuses
- foetal risk factors requiring transfer of women to higher levels of care prior to labour and birth
- normal psychological changes in pregnancy, indicators of psychosocial stress, and impact of pregnancy on the woman and the family
- safe, locally available non-pharmacological substances for the relief of common discomforts of pregnancy
- how to determine foetal well-being during pregnancy including foetal heart rate and activity patterns
- nutritional requirements of the pregnant woman and foetus
- health education needs in pregnancy (e.g., information about relief of common discomforts, hygiene, sexuality, work inside and outside the home)
- basic principles of pharmacokinetics of drugs prescribed, dispensed or furnished to women during pregnancy
- effects of prescribed medications, street drugs, traditional medicines, and over-the-counter drugs on pregnancy and the foetus
- effects of smoking, alcohol abuse and illicit drug use on the pregnant woman and foetus
- the essential elements of birth planning (preparation for labour and birth, emergency preparedness)
- the components of preparation of the home/family for the newborn
- signs and symptoms of the onset of labour (including women's perceptions and symptoms)
- techniques for increasing relaxation and pain relief measures available for labour

- signs, symptoms and potential effects of conditions that are life-threatening to the pregnant woman and/or her foetus, (e.g., pre-eclampsia/eclampsia, vaginal bleeding, premature labour, severe anaemia, Rh isoimmunisation, syphilis)
- means and methods of advising about care, treatment and support for the HIV positive pregnant woman including measures to prevent maternal-to-child transmission (PMTCT) (including feeding options)
- signs, symptoms and indications for referral of selected complications and conditions of pregnancy that affect either mother or foetus (e.g., asthma, HIV infection, diabetes, cardiac conditions, malpresentations/abnormal lie, placental disorders, pre-term labour, post-dates pregnancy)
- measures for prevention and control of malaria in pregnancy, according to country disease pattern, including intermittent preventive treatment (IPT) and promotion of insecticide treated bed nets (ITN)
- pharmacologic basis of de-worming in pregnancy (if relevant to the country of practice)
- the physiology of lactation and methods to prepare women for breastfeeding

Skills and/or abilities
BASIC
The midwife has the skill and/or ability to...

- take an initial and ongoing history each antenatal visit
- perform a physical examination and explain findings to the woman
- take and assess maternal vital signs including temperature, blood pressure, pulse
- assess maternal nutrition and its relationship to foetal growth; give appropriate advice on nutritional requirements of pregnancy and how to achieve them
- perform a complete abdominal assessment including measuring fundal height, lie, position, and presentation
- assess foetal growth using manual measurements
- evaluate foetal growth, placental location, and amniotic fluid volume, using ultrasound visualization and measurement (if equipment is available for use)
- listen to the foetal heart rate; palpate uterus for foetal activity and interpret findings
- monitor foetal heart rate with Doppler (if available)
- perform a pelvic examination, including sizing the uterus, if indicated and when appropriate during the course of pregnancy
- perform clinical pelvimetry [evaluation of bony pelvis] to determine the adequacy of the bony structures
- calculate the estimated date of birth
- provide health education to adolescents, women and families about normal pregnancy progression, danger signs and symptoms, and when and how to contact the midwife
- teach and/or demonstrate measures to decrease common discomforts of pregnancy
- provide guidance and basic preparation for labour, birth and parenting
- Identify variations from normal during the course of the pregnancy and institute appropriate first-line independent or collaborative management based upon evidence-based guidelines, local standards and available resources for:

– low and or inadequate maternal nutrition
– inadequate or excessive uterine growth, including suspected oligo- or polyhydramnios, molar pregnancy

- elevated blood pressure, proteinuria, presence of significant oedema, severe frontal headaches, visual changes, epigastric pain associated with elevated blood pressure
- vaginal bleeding
- multiple gestation, abnormal lie/malpresentation at term
- intrauterine foetal death
- rupture of membranes prior to term
- HIV positive status and/or AIDS
- hepatitis B and C positive

• prescribe, dispense, furnish or administer (however authorized to do so in the jurisdiction of practice) selected, life-saving drugs (e.g., antibiotics, anticonvulsants, antimalarials, antihypertensives, antiretrovirals) to women in need because of a presenting condition

• identify deviations from normal during the course of pregnancy and initiate the referral process for conditions that require higher levels of intervention

COMPETENCY IN PROVISION OF CARE DURING LABOUR AND BIRTH

COMPETENCY #4: Midwives provide high quality, culturally sensitive care during labour, conduct a clean and safe birth and handle selected emergency situations to maximize the health of women and their newborns.

Knowledge
BASIC
The midwife has the knowledge and/or understanding of...

• physiology of first, second and third stages of labour

• anatomy of foetal skull, critical diameters and landmarks

• psychological and cultural aspects of labour and birth

• indicators of the latent phase and the onset of active labour

• indications for stimulation of the onset of labour, and augmentation of uterine contractility

• normal progression of labour

• how to use the partograph (i.e., complete the record; interpret information to determine timely and appropriate labour management)

• measures to assess foetal well-being in labour

• measures to assess maternal well-being in labour

• process of foetal passage [descent] through the pelvis during labour and birth; mechanisms of labour in various foetal presentations and positions

• comfort measures in first and second stages of labour (e.g., family presence/assistance, positioning for labour and birth, hydration, emotional support, non-pharmacological methods of pain relief)

• pharmacological measures for management and control of labour pain, including the relative risks, disadvantages, safety of specific methods of pain management, and their effect on the normal physiology of labour

• signs and symptoms of complications in labour (e.g. bleeding, labour arrest, malpresentation, eclampsia, maternal distress, foetal distress, infection, prolapsed cord)

• principles of prevention of pelvic floor damage and perineal tears

• indications for performing an episiotomy

- principles of expectant (physiologic) management of the 3rd stage of labour
- principles of active management of 3rd stage of labour
- principles underpinning the technique for repair of perineal tears and episiotomy
- indicators of need for emergency management, referral or transfer for obstetric emergencies (e.g., cord prolapse, shoulder dystocia, uterine bleeding, retained placenta)
- indicators of need for operative deliveries, vacuum extraction, use of forceps or symphisiotomy (e.g., foetal distress, cephalo-pelvic disproportion)

Skills and/or abilities
BASIC
The midwife has the skill and/or ability to...

- take a specific history and maternal vital signs in labour
- perform a focused physical examination in labour
- perform a complete abdominal assessment for foetal position and descent
- time and assess the effectiveness of uterine contractions
- perform a complete and accurate pelvic examination for dilatation, effacement, descent, presenting part, position, status of membranes, and adequacy of pelvis for birth of baby vaginally
- monitor progress of labour using the partograph or similar tool for recording
- provide physical and psychological support for woman and family and promote normal birth
- facilitate the presence of a support person during labour and birth
- provide adequate hydration, nutrition and non-pharmacological comfort measures during labour and birth
- provide pharmacologic therapies for pain relief during labour and birth (in appropriate birth settings)
- provide for bladder care including performance of urinary catheterization when indicated
- promptly identify abnormal labour patterns and initiate appropriate and timely intervention and/or referral
- stimulate or augment uterine contractility, using non-pharmacologic agents
- stimulate or augment uterine contractility, using pharmacologic agents (in appropriate birth settings
- administer local anaesthetic to the perineum when episiotomy is anticipated or perineal repair is required
- perform an episiotomy if needed
- perform appropriate hand manoeuvres for a vertex birth
- perform appropriate hand manoeuvres for face and breech deliveries
- clamp and cut the cord
- institute immediate, life-saving interventions in obstetrical emergencies (e.g., prolapsed cord, malpresentation, shoulder dystocia, and foetal distress) to save the life of the foetus, while requesting medical attention and/or awaiting transfer
- manage a cord around the baby's neck at birth
- support expectant (physiologic) management of the 3rd stage of labour
- conduct active management of the 3rd stage of labour, following most current evidence-based protocol

- inspect the placenta and membranes for completeness
- perform fundal massage to stimulate postpartum uterine contraction and uterine tone
- provide a safe environment for mother and infant to promote attachment (bonding)
- estimate and record maternal blood loss
- inspect the vagina and cervix for lacerations
- repair an episiotomy if needed
- repair 1st and 2nd degree perineal or vaginal lacerations
- manage postpartum bleeding and haemorrhage, using appropriate techniques and uterotonic agents as indicated
- prescribe, dispense, furnish or administer (however authorized to do so in the jurisdiction of practice) selected, life-saving drugs (e.g., antibiotics, anticonvulsants, antimalarials, antihypertensives, antiretrovirals) to women in need because of a presenting condition
- perform manual removal of placenta
- perform internal bimanual compression of the uterus to control
- perform aortic compression
- identify and manage shock
- insert intravenous line, draw blood for laboratory testing
- arrange for and undertake timely referral and transfer of women with serious complications to a higher level health facility, taking appropriate drugs and equipment and arranging for a companion care giver on the journey, in order to continue giving emergency care as required
- perform adult cardio-pulmonary resuscitation

ADDITIONAL
The midwife has the skill and/or ability to...

- perform vacuum extraction
- repair 3rd and 4th degree perineal or vaginal lacerations
- identify and repair cervical lacerations

COMPETENCY IN PROVISION OF CARE FOR WOMEN DURING THE POSPARTUM PERIOD

COMPETENCY # 5: Midwives provide comprehensive, high quality, culturally sensitive postpartum care for women.

Knowledge
BASIC
The midwife has the knowledge and/or understanding of…

- physical and emotional changes that occur following childbirth, including the normal process of involution
- physiology and process of lactation and common variations including engorgement, lack of milk supply, etc
- the importance of early breastfeeding for mother and child
- maternal nutrition, rest, activity and physiological needs (e.g., bowel and bladder) in the immediate postpartum period

- principles of parent-infant bonding and attachment (e.g., how to promote positive relationships)
- indicators of subinvolution (e.g., persistent uterine bleeding, infection)
- indicators of maternal breastfeeding problems or complications, including mastitis
- signs and symptoms of life threatening conditions that may first arise during the postpartum period (e.g., persistent vaginal bleeding, embolism, postpartum pre-eclampsia and eclampsia, sepsis, severe mental depression)
- signs and symptoms of selected complications in the postnatal period (e.g., persistent anaemia, haematoma, depression, thrombophlebitis; incontinence of faeces or urine; urinary retention, obstetric fistula)
- principles of interpersonal communication with and support for women and/or their families who are bereaved (maternal death, stillbirth, pregnancy loss, neonatal death, congenital abnormalities)
- approaches and strategies for providing special support for adolescents, victims of gender-based violence (including rape)
- principles of manual vacuum aspiration of the uterine cavity to remove retained products of conception
- principles of prevention of maternal to child transmission of HIV, tuberculosis, hepatitis B and C in the postpartum period
- methods of family planning appropriate for use in the immediate postpartum period (e.g., LAM, progestin-only OCs)
- community-based postpartum services available to the woman and her family, and how they can be accessed

Skills and/or abilities
BASIC
The midwife has the skill and/or ability to...

- take a selective history, including details of pregnancy, labour and birth
- perform a focused physical examination of the mother
- provide information and support for women and/or their families who are bereaved (maternal death, stillbirth, pregnancy loss, neonatal death, congenital abnormalities)
- assess for uterine involution and healing of lacerations and/or repairs
- initiate and support early breastfeeding (within the first hour)
- teach mothers how to express breast milk, and how to handle and store expressed breast milk
- educate mother on care of self and infant after childbirth including signs and symptoms of impending complications, and community-based resources
- educate a woman and her family on sexuality and family planning following childbirth
- provide family planning services concurrently as an integral component of postpartum care
- provide appropriate and timely first-line treatment for any complications detected during the postpartum examination (e.g., anaemia, haematoma maternal infection), and refer for further management as necessary
- provide emergency treatment of late post-partum haemorrhage, and refer if necessary

ADDITIONAL
The midwife has the skill and/or ability to...

- perform manual vacuum aspiration of the uterus for emergency treatment of late post-partum haemorrhage

COMPETENCY IN POSTNATAL CARE OF THE NEWBORN

COMPETENCY# 6: Midwives provide high quality, comprehensive care for the essentially healthy infant from birth to two months of age.

Knowledge
BASIC
The midwife has the knowledge and/or understanding of...

- elements of assessment of the immediate and subsequent condition of newborn (including APGAR scoring system, or other method of assessment of breathing and heart rate)
- principles of newborn adaptation to extrauterine life (e.g., physiologic changes that occur in pulmonary and cardiac systems)
- basic needs of newborn: established breathing, warmth, nutrition, attachment (bonding)
- advantages of various methods of newborn warming, including skin-to-skin contact (Kangaroo mother care)
- methods and means of assessing the gestational age of a newborn
- characteristics of low birth weight infants and their special needs
- characteristics of healthy newborn (appearance and behaviours)
- normal growth and development of the preterm infant
- normal newborn and infant growth and development
- selected variations in the normal newborn (e.g., caput, moulding, mongolian spots)
- elements of health promotion and prevention of disease in newborns and infants (e.g., malaria, TB, HIV), including essential elements of daily care (e.g., cord care, nutritional needs, patterns of elimination)
- immunization needs, risks and benefits from infancy through young childhood
- traditional or cultural practices related to the newborn
- principles of infant nutrition, feeding cues, and infant feeding options for babies (including those born to HIV positive mothers)
- signs, symptoms and indications for referral or transfer for selected newborn complications (e.g., jaundice, haematoma, adverse moulding of the foetal skull, cerebral irritation, non-accidental injuries, haemangioma, hypoglycaemia, hypothermia, dehydration, infection, congenital syphilis)

Skills and/or abilities
BASIC
The midwife has the skill and/or ability to...

- provide immediate care to the newborn, including drying, warming, ensuring that breathing is established, cord clamping and cutting when pulsation ceases
- assess the immediate condition of the newborn (e.g., APGAR scoring or other assessment method of breathing and heart rate)
- promote and maintain normal newborn body temperature through covering (e.g., blanket, cap), environmental control, and promotion of skin-to-skin contact
- begin emergency measures for respiratory distress (newborn resuscitation; suctioning in case of airway obstruction), hypothermia, hypoglycaemia
- give appropriate care including kangaroo mother care to the low birth weight baby, and arrange for referral if potentially serious complications arise, or very low birth weight
- perform a screening physical examination of the newborn for conditions incompatible with life
- perform a gestational age assessment
- provide routine care of the newborn, in accord with local guidelines and protocols (e.g., identification, eye care, screening tests, administration of Vitamin K, birth registration)
- position infant to initiate breast feeding within one hour after birth and support exclusive breastfeeding
- recognize indications of need, stabilize and transfer the at-risk newborn to emergency care facility
- educate parents about danger signs in the newborn and when to bring infant for care
- educate parents about normal growth and development of the infant and young child, and how to provide for day-to-day needs of the normal child
- assist parents to access community resources available to the family
- support parents during grieving process for loss of pregnancy, stillbirth, congenital birth defects or neonatal death
- support parents during transport/transfer of newborn or during times of separation from infant (e.g., NICU admission)
- support and educate parents who have given birth to multiple babies (e.g., twins, triplets) about special needs and community resources
- provide appropriate care for baby born to an HIV positive mother (e.g., administration of ARV and appropriate feeding)

COMPETENCY IN FACILITATION OF ABORTION-RELATED CARE

COMPETENCY #7: Midwives provide a range of individualised, culturally sensitive abortion-related care services for women requiring or experiencing pregnancy termination or loss that are congruent with applicable laws and regulations and in accord with national protocols.

Knowledge
BASIC
The midwife has the knowledge and/or understanding of...

- policies, protocols, laws and regulations related to abortion-care services
- factors involved in decisions relating to unintended or mistimed pregnancies
- family planning methods appropriate for use during the post-abortion period
- medical eligibility criteria for all available abortion methods
- care, information and support that is needed during and after miscarriage or abortion (physical and psychological) and services available in the community
- normal process of involution and physical and emotional healing following miscarriage or abortion
- signs and symptoms of sub-involution and/or incomplete abortion (e.g., persistent uterine bleeding)
- signs and symptoms of abortion complications and life threatening conditions (e.g., persistent vaginal bleeding, infection)
- pharmacotherapeutic basics of drugs recommended for use in medication abortion
- principles of uterine evacuation via manual vacuum aspiration (MVA)

Skills and/or abilities
BASIC
The midwife has the skill and/or ability to...

- assess gestational period through query about LMP, bimanual examination and/or urine pregnancy testing
- inform women who are considering abortion about available services for those keeping the pregnancy and for those proceeding with abortion, methods for obtaining abortion, and to support women in their choice
- take a clinical and social history to identify contraindications to medication or aspiration abortion
- educate and advise women (and family members, where appropriate), on sexuality and family planning post abortion
- provide family planning services concurrently as an integral component of abortion-related services
- assess for uterine involution; treat or refer as appropriate
- educate mother on care of self, including rest and nutrition and on how to identify complications such as haemorrhage
- identify indicators of abortion-related complications (including uterine perforation); treat or refer for treatment as appropriate

ADDITIONAL
The midwife has the skill and/or ability to...

- prescribe, dispense, furnish or administer drugs (however authorized to do so in the jurisdiction of practice) in dosages appropriate to induce medication abortion
- perform manual vacuum aspiration of the uterus up to 12 completed weeks of pregnancy

ICM DEFINITIONS

Ability: The quality of being able to perform; a natural or acquired skill or talent

Attitude: A person's views (values and beliefs) about a thing, process or person that often leads to positive or negative reaction

Behaviour: A person's way of relating or responding to the actions of others or to an environmental stimulus

Competence: 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.

Competency (midwifery): A combination of knowledge, professional behaviour and specific skills that are demonstrated at a defined level of proficiency in the context of midwifery education and practice.

Knowledge: A fund of information that enables an individual to have confident understanding of a subject with the ability to use it for a specific purpose

Skill: Ability learned through education and training or acquired by experience, to perform specific actions or tasks to a specified level of measurable performance

Task: A specific component of a larger body of work

Annex 5: Participants List Consultative Midwifery Strategy Building Workshop

August 15-16, 2016
Facilitator Pandora Hardtman RN,CNM

	Name	Title	Organization
1	Nadine Cornier	RH Advisor – Co-Lead RH W G	UNFPA
2	Hani Al Ashawe	RH Manager – Co-Lead RH W G	PAC
3	Mormon Sayed issa	Medical Manager	ATTA
4	Ali Ahmad	Health Officer	Bihar
5	Mohamed ElFeraly		CARE
6	Mustafa abboud	Health coordinator	CIMRO
7	Abd Arrahman Alomar	Advocacy Coordinator	Health D. Idlep
8	Ahmad Abe Lyila		Health D. Aleppo
9	Samer Bydoun RN		Health D. rural Damas
10	Mohammad Alabbas	Field Medical Coordinator	HiH
11	Amjad Qwatly	Senior Programme Coordinator	Human Appeal
12	Ghufran Abdularahman	MCH Coordinator	IDA
13	Salah Alsafadi		IDA
14	Abdulbaki Mahmoud	RH Manager	IMC
15	Yahya Rahhal	Deputy Medical Coordinator	MDM
16	Husnie Alkailani	Health and nutrition specialist	Mercy-USA
17	James Fahey	Programme Officer	Mercy-USA
18	Qutaibah Shehab	Medical Manager	MSF
19	Mohamad Sheik Ibrahim	Health Coordinator	Orient for Human Relief
20	Moaz ALgajer		QRCS
21	Sara Alhelali	Health Awareness and Quality Control	QRCS
22	Ahmad Aldorra	Quality Control Officer	SAMS
23	Bashir Tajaldin	Programme Manager	SAMS
24	Ronida Ali		SAMS
25	Mohammad Amer Bashir	Health advisor	Save the Children
26	Amer Bashir	Health Advisor	SCI
27	Feras Fares	RH Manager	SEMA
28	Issa AL Ahmad		Shafak
29	Amani Kanjo	RH Project Coordinator	SRD
30	Loai Khamis	Programme Associate	UNFPA
31	Roxana Ali	PHC Deputy	UOSSM
32	Ahmad Aldaif	Health Program Officer	Violet
33	Hatem Gibran		WAHA
34	Camilo Valderama	Health Cluster Lead	WHO
35	Hussein Assaf	Health Coordinator	WVI
36	Adnan Altirkawi		Independant

Annex 6: Participants List Consultative Midwifery Strategy Participatory Workshop II

Dec 15-16, 2016
Facilitator Pandora Hardtman RN,CNM

	Name	Organization	Title	Location	Participation
1	Nadine Cornier	UNFPA	RH Advisor – Co-Lead RH W G	Gaziantep	Physical
2	Hani Al Ashawe	PAC	RH Manager - Co-Lead RH W G	Gaziantep	Physical
3	Hussam Alkhellow	HiH	Medical Coordinator	Gaziantep	Physical
4	Qutybah Shehab	Relief Int	RH Coordinator	Gaziantep	Physical
5	Amer Heluani	Relief Int	Field health Coordinator	Gaziantep	Physical
6	Yasser Barodi	Violet	Health Coordinator	Antakya	Physical
7	Ramdan Manlla Ali	SEMA	Institute Manager	Antakya	Physical
8	Ahmad Al Dorra	SAMS	Snr. Officer Quality	Gaziantep	Physical
9	Amer Bashir	SC	Health Advisor	Antakya	Physical
10	Muaaz ALGHAJAR	QRC	HC	Gaziantep	Physical
11	Feras Fares	SEMA	RH Coordinator	Gaziantep	Physical
12	Naima kalla Shakar	Independent	NA	Gaziantep	Physical
13	Zakria AlAhmad	SEMA	Educ./Training manager	Gaziantep	Physical
14	Issa Alahmad	Shafak	RH Officer	Gaziantep	Physical
15	Amani Kanjo	SRD	Project Coordinator	Gaziantep	Physical
16	Hatem Jobran	WAHA	Medical Coordinator	Gaziantep	Physical
17	Nisreen Hamrah	HiH	Midwife	Atmeh-Idleb	Physical
18	Safwan Alchalati	SBOMS	Education Manger	Gaziantep	Physical
19	Enaam Krakiesh	Health Directorate	MW Trainer	Idleb	Skype
20	Bushra khattab	HiH	GYN	Idleb	Skype
21	Huda Al Abıed	IDA	Midwife	Idleb	Skype
22	Ayouish Abd Alal	Shafak	MW	Idleb Ariha	Skype
23	Aminah Zidan	PAC	Midwife	Idleb	Skype
24	Abeer Dani	QRC	Midwife	Kansafra-idleb	Skype
25	Faten Haj Ahmed	QRC	Nurse	Kansafra-idleb	Skype
26	Fatoom Al Nassan	QRC	Midwife	Kansafra-idleb	Skype
27	Halima Haj Ali	QRC	Midwife	Kansafra-idleb	Skype
28	Jamella Al Mustafa	QRC	Midwife	Kansafra-idleb	Skype
29	Ruba Shiek Mohamed	QRC	Midwife	Kansafra-idleb	Skype
30	Shatha Al Mustafa	QRC	Midwife	Kansafra	Skype
31	Aminah Al Mer'e	SEMA	Midwife	Idleb	Skype

	Name	Organization	Title	Location	Participation
32	Nahed Mousa	SEMA	Midwife	Idleb	Skype
33	Najwa Haskour	SEMA	Midwife	Idleb	Skype
34	Hema Hamido	SRD	Nurse	Idleb	Skype
35	Marah Harami	SRD	Midwife	Idleb	Skype
36	Oqba DOGHIM	SRD		Idleb	Skype
37	Fatema Eid	IDA	Midwife	Killis	Skype
38	Ghofran Abdulrahman	IDA	RH Coordinator	Gaziantep	Skype
39	Mervat Allwan		Nurse	Idleb	Skype
40	Raghdaa Salam			Ariha-Idleb	Skype
41	Sobhia Khateb	QRC	Midwife	Kansafra	Skype
42	Hashem Darwish	QRC	Head of Health Dept.	Gaziantep	Physical