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Empowering midwives in the United Arab Emirates

Grace Edwards, Philidah Seda

ORIGINAL

Introduction

Considerable efforts have been made to increase women's access to quality midwifery care around the world. The World Health Organization (WHO) identifies midwives as *'the most appropriate and cost effective healthcare professional to provide care in normal pregnancy and childbirth'* (WHO 2009). A growing body of evidence demonstrates that midwifery care is associated with more efficient use of resources and improved outcomes when provided by midwives who are educated, trained, licensed, and regulated. A recent Cochrane review revealed many benefits of midwifery care, including reduction in the use of regional analgesia, fewer episiotomies, fewer instrumental births, and women feeling more in control and involved in their birthing experience (Sandall *et al* 2016). However, previous research by one of the authors (GE) found that the role of the midwife in the United Arab Emirates (UAE) was poorly understood with many women feeling that they were safer with care from a doctor (Edwards 2014, Edwards *et al* 2014).

This paper describes an initiative to reestablish the midwife as the expert in normality and create a supportive environment whereby midwives can practise to the full extent of their education and license within the government hospitals in Abu Dhabi.



Grace Edwards (left), demonstrating emergency breech

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Background

On average, 20,000 births a year take place across the large, culturally-diverse health system in the UAE. Despite high rates of diabetes, anaemia and grand-multiparity, over two thirds of births are normal vaginal deliveries. The government hospitals in Abu Dhabi are managed by an organisation called SEHA (which is *health* in Arabic). SEHA manages 12 government hospitals and 64 clinics across the whole of Abu Dhabi. Five of these hospitals are situated in the western region, which is a very remote desert region, providing care to small desert communities.

In order to standardise care and encourage evidenced practice, SEHA established a number of service line councils consisting of key clinicians from each of the SEHA hospitals. One of these service lines was Obstetrics and Gynaecology. Initially, the council was almost exclusively physician-led, but both authors played key roles in expanding midwifery presence on the council and were able to influence and educate the group about midwifery-specific issues. A subcommittee consisting of lead midwives from each of the government hospitals was established to identify and address areas of midwifery practice that were felt not to be based on the best available evidence. This subcommittee was called the Midwifery and Nursing Advisory Group (MNAG)

Developing a shared model of care

Communications between the MNAG group members revealed that midwifery practice varied from facility to facility. In some facilities, midwives practised to the full scope of their qualification, providing comprehensive antenatal, intrapartum and postnatal care to mothers and babies, including delivery and suturing as necessary. In other facilities, midwives cared for the woman during labour, but were not allowed to conduct the delivery (unless precipitous). This was predominantly due to the model of care established in those particular facilities. Over the years, many midwives have 'deskilled' (lost midwifery skills) as they were not practising to their full scope. In order to bridge the gap, a structured midwifery upskilling programme was warranted.

A deeper investigation by MNAG revealed that the main contributing factor for variations in midwifery practice was workforce challenges. Other contributing factors were as follows:

1. variations in obstetric model of care across the system
2. variations in midwifery scope of practice across the system
3. no clear referral path for low-risk women to gain access to midwifery services.

Because of the strong medical model prevalent in many of the hospitals, it was recognised that it was too early in the development of midwifery practice

to establish a midwifery-led model. However, the concept of a shared model of care where the midwife was seen as the expert in normal birth and the physician as the expert in complicated birth, with both professions working together, was embraced by the group.

The authors seized this opportunity and utilised the PESTLE model (www.professionalacademy.com) to identify internal and external factors that may impact our ability to develop and standardise a shared model of care. The PESTLE model is a marketing and business model that is very useful for identifying and addressing challenges which may affect the planning and implementation of a new strategy or project. PESTLE is an acronym which stands for:

Political factors

Economic factors

Social factors

Technical factors

Legal factors

Environmental factors

Using this structure helped us to identify the following issues:

Political factors

- There were very different midwifery practices across Abu Dhabi.
- Some hospitals were medically driven as opposed to evidence-based.
- The shared care model was dependent on a high level of support.
- Collaboration and cooperation between obstetricians and midwives was critical.

Economic factors

- The model must be cost-effective and efficient.
- There were different pay scales in each facility.
- Can we attract highly qualified and experienced midwives?
- Can we 'grow our own' midwives?
- There is a shortage of midwives in some areas.

Social factors

- Some areas are very remote and difficult to attract midwives to.
- There is a need to recruit Arab-speaking midwives.
- There were challenges over Emiratisation, which is the name of the nationwide programme to effectively assimilate the UAE national workforce in the labour market, and is a key priority of the UAE government (Abu Dhabi e-government 2016). There are very few UAE nationals working in health care settings

Technical factors

- Upskilling midwives has cost and woman-power implications.
- There are challenges in maintaining skills and competencies in smaller obstetric services.
- There is a need to strengthen the midwifery network through MNAG.
- It is imperative to work in partnership with obstetricians through the service line council.

Legal factors

- Reimbursement for midwifery services.
- Adoption of the latest UAE Nursing Midwifery Council Scope of Practice.

Environmental factors

- The infrastructure must be sustainable.
- The model must be supported by education and professional development.
- There is a need to continue the midwifery programme.

As a result of this analysis, our initial objectives were set as follows:

- Enlist the support of the Chief Medical Officers and Chief Nursing Officers in each facility.
- Continue to work with the MNAG to identify gaps and challenges in midwifery practice.
- Explore partnership with a local college to develop an education strategy.
- Develop a sustainable and economically viable model to grow our own midwives.
- Develop an evidenced-based competency framework driven by MNAG.

These findings were fed back to the Obstetric and Gynaecology service line, the group endorsed our Shared Care Model and we were off!

In order to establish the Shared Care Model across the system, three major challenges had to be addressed:

- Build our midwifery workforce to match demand.
- Establish a supportive environment for midwives to practise to their full scope.
- Develop clear pathways for low-risk women to gain access to midwifery services.

Tackling these challenges required a phased approach, starting with the 'low hanging fruit'. The first step was to identify licensed midwives within our organisation who had not been practising to their full scope, and upskill them.

Table 1. Midwifery upskilling programme content

<p>Completion of core competencies:</p> <p>Perineal repair for registered midwives</p> <p>Examination of the newborn</p> <p>Use of the neonatal resuscitator</p> <p>Conducting a normal birth.</p>
<p>Midwifery skills requirements:</p> <p>Twenty normal births</p> <p>Twenty antenatal examinations</p> <p>Twenty postnatal examinations</p> <p>Twenty examinations of the newborn</p> <p>Twenty cardiocotography interpretations</p> <p>Twenty vaginal examinations.</p>
<p>Individual professional development plan (IPDP):</p> <p>A tool to assist the midwife in identifying and documenting the encounters, and to develop short-term objectives to meet individual learning needs. One written IPDP is required per month.</p>
<p>Reflective practice:</p> <p>A reflective journal to record what has been learnt, professional development and reflection on practice. The journal can take the format of a notebook or traditional diary.</p>
<p>Research and evidence-based practice:</p> <p>How to critique research</p> <p>Conducting a literature search</p> <p>Understanding systematic reviews.</p>

Midwifery upskilling programme

We used the International Confederation of Midwives *International definition of a midwife* (ICM 2011) and the ICM *Basic competencies for midwifery practice* (ICM 2010) as the benchmarks for our theoretical and clinical competencies. In collaboration with the UAE Nursing and Midwifery Council scope of practice (UAE NMC 2012) we developed a comprehensive theoretical and clinical competency-based upskilling programme for which the aim was to provide a supportive practice environment for midwives who have been unable to practise their skills (Table 1). Underpinning the programme was developing the critical thinking and reasoning skills of the midwives, particularly around accessing the latest evidence, conflict resolution, and managing change, as many practices observed in the isolated areas were not based on evidence.

Since many of the midwives who needed upskilling were from the remote areas, a decision was made for one of the authors (GE) to travel to their region and offer an intensive theoretical programme. Following this, the midwives would return with her to the large tertiary hospital where they could complete their clinical competencies. To ensure safe staffing at their home facility, nurses from the tertiary hospital volunteered to backfill their posts whilst they completed their clinical competencies. Coordinating these logistics was not easy, but collaboration and support from all participating hospitals was admirable. The length of the programme was customised for each midwife, based on individual competency, proficiency and confidence. It was envisaged that most participants would complete the preceptorship in 1–3 months. Once the upskilling programme was successfully completed, each midwife would return to her home facility to practise.

Programme evaluation

Four cohorts of midwives participated in the upskilling programme. A total of 20 midwives in all successfully completed. The evaluations were all excellent and everybody enjoyed participating in the programme, including midwives from the tertiary centre. It was humbling how quickly the midwives regained their skills, some of whom had not delivered a baby for 15 years. What was extremely interesting was that the midwives who backfilled the midwives from remote areas came back with the utmost respect for their colleagues who worked in very isolated areas with very few births, but needed to maintain their skills. One midwife said *'I will never complain about being busy again!'*

Following completion of the upskilling programme, a final evaluation was completed, which indicated the programme was a complete success. All midwives in the SEHA government hospitals are now practising to their full scope and were enthused to implement their new found evidenced-based practice back in their own areas. The participants felt confident to challenge their medical colleagues over practices such as routine episiotomy and lithotomy position for vaginal birth. In addition, a strong network of clinical midwives has been developed so that colleagues can share evidence and support each other. The midwives will return to the tertiary hospital once a year to refresh their clinical skills so that they remain competent and confident.

The final measure of success came from a comment from one of the doctors who said:

'Why can't we do the course too?'

That is the next challenge!!

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Philidah Seda is standing next to Grace Edwards, fifth from the right