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Midwifery training to improve ante- and perinatal health in low- and middle-income countries of the former Soviet Union

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Summary Whether in the community or in the hospital, high-quality midwifery care is the preferable model of care for mothers and babies at the first level of care. Countries with professional midwifery care within a supportive system have the best outcomes for mother and babies. The low- and middle-income countries of the former Soviet Union report some of the highest maternal mortality and neonatal mortality in the European region, yet childbirth occurs in institutions with 'skilled attendants' (96–100%). Specific characteristics of maternal and neonatal care in countries of the former Soviet Union include over-medicalization, inappropriate use of technology, unnecessary hospitalizations, and ineffective and/or harmful interventions. This article highlights two midwifery trainings developed specifically to change the maternal and newborn care practices in countries of the former Soviet Union: the Family Centred Maternity Care Training of Trainers and the World Health Organization Essential Antenatal, Perinatal and Postpartum Care Training.

Introduction

Whether in the community or in the hospital, high-quality midwifery care is the most effective model for the majority of mothers and babies in the world. The World Health Organization (WHO) Health Report 2005 states

> '... first-level maternal and newborn care should preferably be organized in midwife-led birthing centres, combining cultural proximity in a non-medicalized setting, with professional skilled care, the necessary equipment and the potential for emergency evacuation.'

When care is provided in hospitals,

> ' ... first-level care should maintain the demedicalized and close-to-client characteristics of midwifery-led birth homes'[1]

Exemplary models of midwifery care are available in the European Union.[2–4] The health outcomes for these mothers and babies are consistently among the best in the world.[1] Yet there remains a sharp contrast in the health outcomes for mothers and babies between countries within the European region.[5] The wide range in maternal and neonatal mortality

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is unacceptable. Maternal mortality is reported from 4/100,000 live births (Ireland) to 210/100,000 live births (Kazakhstan); neonatal mortality from 2/1000 live births (Finland, Iceland, Norway) to 38/1000 live births (Tajikistan).[6] The low-income countries (Armenia, Azerbaijan, Georgia, Kyrgyzstan, Republic of Moldova, Tajikistan, Turkmenistan, Ukraine, and Uzbekistan) and some middle-income countries of the region (Belarus, Estonia, Kazakhstan, Latvia, Lithuania, and Russian Federation)[7] share a legacy as being part of the former Soviet Union (FSU). Much of the highest maternal and neonatal mortality in the European region (maternal mortality range is 24–210/100,000; neonatal mortality range 9–38/1000)[6] is reported from countries of the FSU. These same countries report 70–100% coverage for at least one antenatal visit.[6] The majority of childbirth occurs in institutions attended by 'skilled attendants' [range 96–100% with two low-income countries reporting 71% (Tajikistan) and 84% (Azerbijian), respectively].[6]

The paradox of moderate to high coverage for one antenatal visit, high rates for skilled attendants and institutional childbirth with unacceptably high maternal and neonatal mortalities signals problems with the quality of care.[8,9] Understanding general aspects of healthcare in the FSU and specifically for mothers and babies provides some answers and specific challenges.

Maternal and neonatal care in the FSU

The healthcare system in the FSU did provide access to care for everyone. However, isolation from advances in healthcare and medical knowledge in the world, specifically evidenced-based care and clinical epidemiology, created a system locked in time.[10] The care for mothers and newborns has minimally changed from post-war times.[11] Academics centralized in Moscow determined the standards and recommended treatments (prikaze) for all aspects of healthcare and diagnoses. Practice standards were not based on rigorous scientific investigation, e.g., randomized controlled trials, but on limited science and personal clinical experience; both share inherent biases.[10] These prikazes were disseminated throughout the healthcare system within the FSU. Adherence was mandatory with punitive consequences for deviations no matter the clinical or local circumstances. Open discussion and debate were discouraged. Concern for the user's active participation in decision-making and satisfaction with care was not included.[10] Another government ministry, sanitary-epidemiology (san-epi), controlled standards for cleanliness. This included strict standards for equipment and facilities in many industries, including healthcare. Many san-epi regulations were thought to prevent infection, but lack modern scientific support. Most of the regulations are in direct conflict with evidenced-based care for mothers and newborns.[10,12]

Specific characteristics of maternal and neonatal care in the FSU include over-medicalization, inappropriate use of technology, unnecessary hospitalizations, and ineffective and/or harmful interventions for healthy pregnant women, mothers and babies.[13,14] Maternity care is based on a medical/pathological model that is physician-led. Midwifery practice is severely restricted.[15]

More than 80% of pregnant women are categorized as high-risk for minor or common problems, e.g., vaginitis; oedema of pregnancy. Many women are unnecessarily hospitalized during pregnancy.[16] Effective screening and treatment during antenatal care for asymptomatic bacturia and Rhesus immunoprophylaxis are rarely performed.[17] Over diagnosis and ineffective treatment for pregnancy-induced hypertension is common.[18]

Routine interventions for labour and birth include routine pubic shaving, enemas, intravenous infusions, sedation and narcotic analgesia, artificial ruptures of membranes, and routine urinary catheterization; family members or a close companion are not allowed; birth occurs in the lithotomy position; routine episiotomies are done for primigravidas[14]

Newborns are tightly swaddled and separated from their mothers. Feedings are scheduled. Breastfeeding is not well supported. Routine supplementation with water or glucose water is common. Family visitation is rarely allowed. Women are discharged home 5–7 days after a vaginal birth; up to 10 days after a Caesarean section.[14]

Although many countries of the FSU are implementing healthcare reform,[19–21] the above characteristics are still the norm for many FSU countries and facilities.[14,22–24] Physicians, midwives and nurses from the FSU countries believe these practices benefit mothers and babies.[14] One must remember that many of the outdated maternal and neonatal care described was standard practice within hospitals in North America and some countries in Western Europe into the 1980s.[25,26] The process of changing maternal and neonatal clinical practices has taken decades and continues today.[27,28]

Given these characteristics, it was evident that rapid and sustained change in antenatal and perinatal care would require a multifaceted and unique approach. The midwifery training needed to address an entrenched and over-medicalized physician-led model of care, outdated and ineffective clinical practices, lack of understanding for modern scientific methodology, limited resources, and lack of concern for the user's perspective.

This article highlights two midwifery trainings that were developed specifically to address the maternal and newborn care practices in countries of the FSU: the Family Centred Maternity Care Training of Trainers (FCMC TOT) developed by the USAID funded John Snow, Inc./MotherCare Project and the American College of Nurse-Midwives; and the WHO Essential Obstetric Care: Essential Antenatal, Perinatal and Postpartum Care Training (EAPPC) developed by the WHO Regional Office for Europe.

FCMC TOT

The FCMC TOT was originally developed in 1996 for a pilot project in Ukraine[29] The FCMC TOT content and approach incorporates evidenced-based FCMC practices, adult learning methodology and communication skills; change theory; a criterion-based continuous quality improvement program with benchmarks; and an on-site 24-h clinical practice week with midwifery-led multidisciplinary teams. The FCMC table of contents is outlined in Fig. 1.

The original MotherCare/ACNM training teams included two certified nurse-midwives and one obstetrician from the United States or Europe. The intensive 2-week FCMC TOT