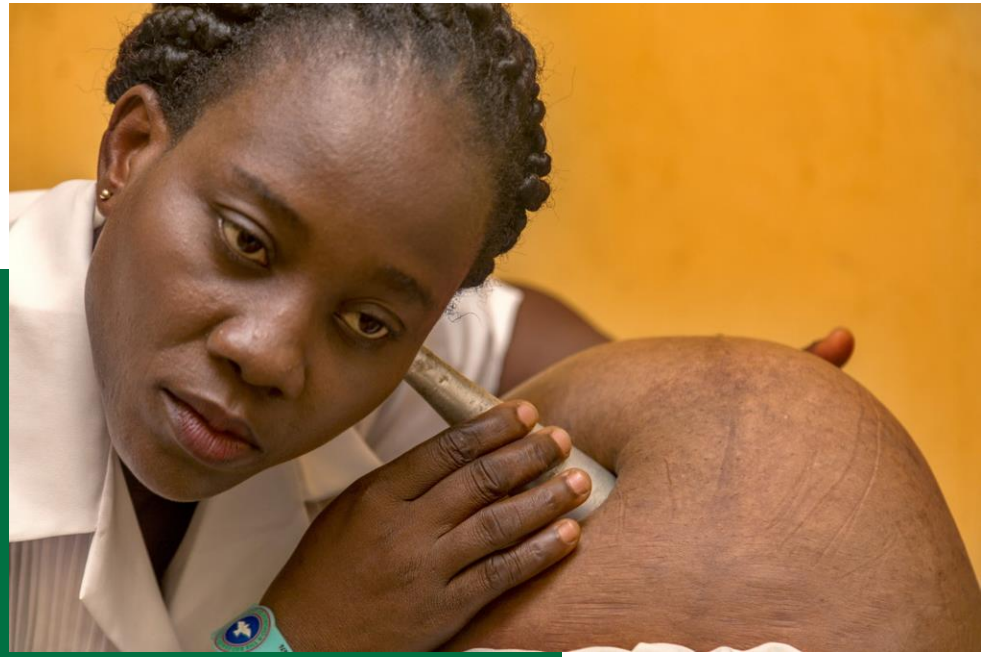
Topic: Involvement of nurses and midwives in clinical decisions regarding the eligibility criteria for caesarean section among pregnant women



Sub-topic: Nurse and midwives advocacy on policies and initiatives at improving maternal health outcomes and disparities in access to caesarean section

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SPEAKER

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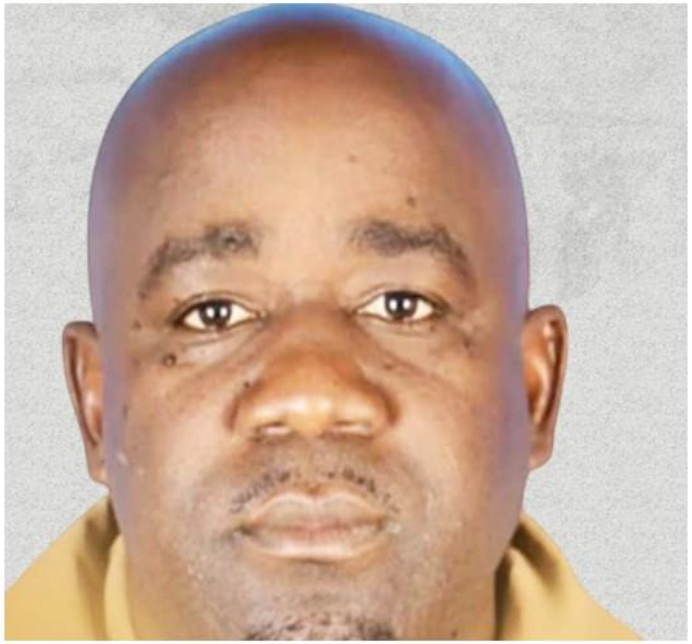
MSc NE, BSc NE, DipN

A holder of Master of Sciences in Nursing Education (MSc NE), Bachelor of Sciences in Nursing Education (BSc NE), Diploma in Nursing (DipN) registered by as Psychiatric Nurse. I had more than 17 years working experiences in Health System served in administration of health training institution and hospital departments, health care services, training and education affairs and I am expert in Project Planning and Management, Health Monitoring and Evaluation, Research and Training Development, Strategic Plan development and analysis Situational, root cause, force field, stakeholders and statistical); currently working as a Head of Research and Training Unit at Njombe Regional Referral Hospital



AREA OF FOCUS

Nurses and midwives advocacy on policies and initiatives aimed at improving maternal health outcomes and reducing disparities in access to cesarean section.

Evaristus P. Makota

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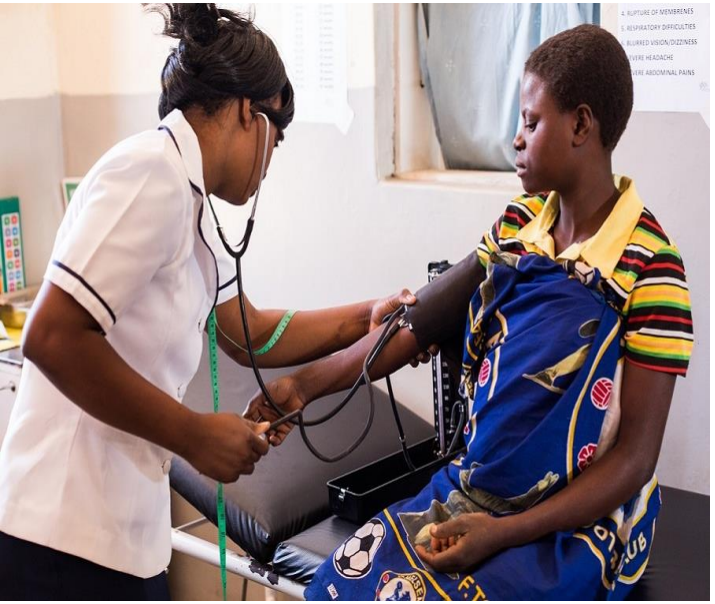

Presentation Outline

1. Evidence based practices on CS
2. Clinical decision making on CS
3. Conclusion and way forwards
4. Welcome note for Q & A sessions

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1.0.Evidence based practices (EBP) on Caesarean Section

1.1. Prevalence of C-Section

According to the research report of June 16, 2021 of the WHO, CS use is continues to rise globally, accounting to more than 1 in 5 (21%) of all childbirth. This is set to continue increasing over the coming decades, with nearly a third (29%) of all births likely to take place by CS by 20230 (WHO, 2021); rising rates suggest increasing number of medically unnecessary potentially harmful procedure. This also noted in the report; 'While CS can be essential and lifesaving surgery, it can put mothers and babies at unnecessary risk of short-term and long-term problems if performed when there is not medical need'

Trending and updates on C-Section prevalence in Tanzania (TDHS-MIS, 2022)

Background Characteristics	% delivered via C-section	Number of Births
Residence		
Urban	**19.1**	1,251
Rural	7.6	3,255
Zone		
Southern Highland	**25.2**	242
Eastern	18.9	597
Southern	15.9	180
Region		
Njombe	**33.2**	47
Dar es Salaam	26.3	265
Simiyu	1.5	160

1.2. Economic consequences of CS:

The evidence from household survey done by Binyaruka with his friends on economic consequences of caesarean section revealed that; C-section increased the likelihood of paying for health care by 16% compared to normal delivery. Women with C-section delivery spent an extra 2 days at the health facility compared to normal delivery, but this was reduced slightly to 1.9 days in public facilities. The distribution of C-section coverage was significantly in favour of wealthier than poorest women (Binyaruka, P., & Mori, A. T, 2021).

2.0. Clinical decision making on caesarean section: Policy, legal and initiatives perspectives

2.1. Legal and guideline compliance: Nurses and Midwives Act, 2010 and its amendment; Nurses Scope of Practices, 2000: Nurses and midwives are NOT the final Decision makers on CS. According to International Federation of Gynaecology and Obstetrics (FIGO), professionally responsible decision making with patients is based primarily on the ethical principles of beneficence and respect of autonomy.

2.2. Informed decision making: Study of Sultana with his colleagues looking on an uninformed decision making process for CS in Dhaka City, Bangladesh they came up with: physicians were the primary decision makers for CS; all pregnant women attended ANC visit they neither received detailed information regarding CS nor attended any counselling session regarding decision.

2.3. Current situation-Where to Go: Quote obtained from the WHO Research report on CS, 2021:

"It's important for all women to be able to talk to healthcare providers and be part of the decision making on their birth, receiving adequate information including the risks and benefits. Emotional support is a critical aspect of quality care throughout pregnancy and childbirth," said Dr Ana Pilar Betran, Medical Officer at WHO and HRP.

- ✓ **WHO recommends some non-medical actions that can reduce medically unnecessary use of CS (WHO, 2021)**
- ✓ Educational interventions that engage women actively in planning for their birth such as childbirth preparation workshop, relaxation program
- ✓ Use of evidence-based clinical guidelines, performing regular audits of CS practices in health facilities
- ✓ Requirement for a second medical opinion for CS decision in **setting where is possible**
- ✓ For the sole purpose of reducing CS, some interventions have been piloted by some countries but require more rigorous research;
- ✓ **A Collaborative Midwifery-Obstetrician Model of Care;** for which care is provided primarily by MIDWIVES, with 24-hours back-up from a dedicated Obstetrician.
- ✓ **Financial strategies** that equalizes the fees charged for vaginal births and CS

3.0. Conclusion and way forward

Base on the presented concepts and EBP it is concluded that, collaboration between midwives and obstetrician is not satisfactory in most of the setting on involvement of nurses and midwives in clinical decision in the aspects of policy and initiatives for the purpose of improving maternal outcomes and reducing disparities in access to caesarean section; here are the evidence based recommendations:

- The health facilities through Quality Improvement Unit should use Midwives-Obstetrics Collaboration (MOC) Scale to assess the degree of collaboration between midwives and obstetrics on labor and births (Odeyamo et al, 2022)
- How to fosters collaboration between midwives and obstetrician on labor and birth units (Onibokun et al,2021)
  - ✓ **Develop trust and respect**
  - ✓ **Promoting effective communication**
  - ✓ **Individual variability and need for clear guidelines**
  - ✓ **Balancing autonomy**
- The Ministry of Health in collaboration with its agencies and other stakeholders should seek the need of incorporate collaborative clinical decision on CS in the reviewing national health policy and developing guideline for Midwifery-Obstetrician Collaborative Care for improved maternal health outcomes; this should be initially started with interventional research.

4.0. Welcome note for Q & A Session

- The position of nurse and midwives in clinical decision on CS;
- Are they involved and participate?
- Is there any implementation research conducted at your working place?
- ✓ **Challenges and way forward on involvement and participation of Nurses and midwives on clinical decision regarding eligibility criteria for CS.**
- Midwives-Obstetrician Collaboration on clinical decision on CS is stated in your developed hospital policy?
- Is there any initiatives in your working place to address the reported challenges?

Referencing List

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- International Federation of Gynaecology and Obstetrics (2020). Ethical and professionalism guideline: Decision making about vaginal and caesarean section delivery
- Mbunga et al, (2019), Prevalence of primary caesarean section deliveries among primiparous and multiparous women at Iringa Regional Referral Hospital, Tanzania; South Sudan Medical Journal, 12 (3), August 2019

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- Odeyamo O, Morelli EM, Kennedy H (2022). Reliability and validity of midwifery-obstetrics Collaboration (MOC) Scale: A tool to improve collaboration practice.Midwifery.2021 May; 96:102941.https//doi.org/10.1016/j.midw.2021.102941
- Onibokun O, Morelli EM, Illuzzi JL, White MA (2021). How to fosters Midwife-Obstetrician on labor and births units: Qualitative analysis experiences of clinicians in the United States.Midwifery.2021 May; 96:102941.https//doi.org/10.1111/j.mwh.2021.13382
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- TNMC (2014). Scope of practices for nurses and midwives in Tanzania
- WHO (2021). Caesarean section to rise, amid growing inequalities in access;

Thank You!

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