Midwifery continuity of care: Potentiality of midwives adherence to the new model of care

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Abstract

Background: The midwifery continuity of care is gaining more attention, and the WHO recommends the use of its models to provide antenatal, intrapartum and postnatal care in a setting where effective midwifery programme exists. However, in many countries, implementation of continuity of care model has been challenging for midwives.
Purpose: The purpose of the study was to assess the potentiality of midwives adherence to midwifery continuity of care as a new model of care.
Method: The research is descriptive that adopted cross-sectional design. The population of the study was the midwives serving in antenatal clinic (ANC), maternity and labour units. The instrument for data collection was researcher made, self-administered questionnaire. Census sampling was used in taking the entire midwives of the units as the subjects of the study. The results of the study were presented in frequencies and percentages, with Chi-square as a statistical tool for inferential analysis.
Results: Generally, 46.3% of the respondents were having good potentiality, 44.8% were having poor potentiality, and only 9.0% were having very good potentiality. 56.7% of the respondents with 0-5 years of experience were having poor potentiality, in contrast with 27.3% in respondents with >15 years of experience. 34.6% and 53.7% of the respondents that were midwives and those that were nurse-midwives in specialty respectively were having good potentiality to MCC adherence. There is no significant association between respondents' years of experience and their potentiality to MCC adherence, $P > 0.05$. There is no significant association between respondents' specialty and their potentiality to MCC adherence, $P > 0.05$.
Conclusion: The respondents of this study had a moderate potentiality to MCC adherence. The possibility of midwives adherence to MCC can be improved if it is introduced into the system with some modifications and flexibilities; and when the midwives realise its positive impact on maternal and new-born health.

Keywords: Adherence; Continuity of care; Midwives; Model of care; Potentiality

INTRODUCTION

Philosophically, midwifery practice is about strengthening family relationships, empowerment and normal birth (Killingley, 2016). This is done more effectively through patient centered care, and continuity of care agrees with the call for making care to be patient centered (Burau & Overgaard, 2015). In midwifery, it has been proven that continuity of care is safe and developed trust between midwife and woman which bring about empowerment and informed choice (Boyle et al., 2016). Based on the human right approach, the concern about women is not only on avoiding death and morbidity, but also promoting health and wellbeing with respect, dignity and rights (World Health Organization [WHO], 2016a), an issue of great concern to developing countries. Thus, midwifery continuity of care (MCC) models are highly recommended for maternal and neonatal health (National Maternity Review, 2016; WHO, 2016b).

The World Health Organisation (2014) asserted that about 99% of maternal deaths occur in low-resource settings and most of it can be prevented; and approximately 2.6 million babies from low-resource settings were stillborn in 2015 (Blencowe et al., 2016). It is estimated that in the occurrence of each maternal death there is between 50-100

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severe maternal morbidity suffered by other women (Geller, et al., 2018; Miller, et al., 2016). However, a review by Sandall et al. (2015) revealed that continuity of care improve the health outcomes of women and their babies.

Midwifery is a health care profession that offers care to childbearing woman during the periods of pregnancy, labour and post-partum. It provides care to newborn, primary care to healthy pregnant women, family planning and menopausal care (Oyetunde, 2014). In Nigeria the midwifery service is largely through a traditional midwifery practice by which midwives run a shift duty in rotation (Morning, evening and night duties) with some days given as off duty between every shift. Thus, a pregnant woman would be having contact with many different midwives through her pregnancy, delivery and post-partum care. Also, traditional birth attendants (TBAs) provide midwifery services, most commonly in rural areas (Oyetunde, 2014). However, in 2009 the Nigerian government introduces a Midwifery Service Scheme (MSS) in which the newly qualified, unemployed, and retired midwives are recruited and deployed to public primary health facilities especially in rural areas (Okeke et al., 2017).

MCC are models of maternity care by a single midwife familiar to the woman, the primary midwife, back up by a partner midwives. The primary midwife sees the woman consistently during pregnancy, labour and post-natal period and is supported by teams of specialists through referral (Sandall et al., 2016). The two main continuity of care models are case load model, in which one midwife cares and facilitate relational care for up to 45 women; and team midwifery model in which group of four to six midwives provide care for up to 360 women throughout the period of pregnancy, labour and post-natal period (WHO, 2016b). These types of continuity of care are called "relational continuity" or "personal continuity". They enhance trust and familiarity between patient and midwife (Perdok et al., 2018).

However, there are other forms of continuity of care, these include "information continuity" whereby healthcare providers exchange information about the patients for appropriate care; and "management continuity" whereby healthcare providers coherently provide care by connecting to one another (Haggerty eta al. Cited in Perdok, et al. 2018). Research findings had it that personal continuity of care is associated with reduced preterm birth, or miscarriage (Sandall et al., 2016), and fewer interventions in pregnancy and delivery (Sandall et al., 2015). Geller et al. (2018) postulated that the mother's health and wellbeing is a crucial factor that is closely associated with new-born child's good health and survival. Thus, MCC can be a means of improving children health.

In a study by Rayment-Jones et al. (2015), women with complex social factors in caseload midwifery model had fewer caesareans, fewer antenatal admissions and shorter length of post-natal hospitalization. They are more likely to be referred to specialist services; and their babies had low neonatal admissions. Women in MCC have greater satisfaction with advices, explanation, information, delivery venue, labour and birth, behaviour of the midwife, choice for pain relief, and feel less anxious (Mclachlan et al., 2015). Based on these kind of research evidences, the WHO has recommended scaling up the midwifery care that facilitate continuity (Mortensen et al., 2018).

The midwifery continuity of care is gaining more attention (Burau & Overgaard, 2015), and the WHO recommends the use of midwifery continuity of care models to provide antenatal, intrapartum and postnatal care in a setting where effective midwifery programme exists (WHO, 2016b). However, implementation of continuity of care model has been challenging in many countries (Homer et al., 2017). According to Homer et al. (2017) and Dawson et al. (2018), for midwives, and in many countries implementing continuity of care is a challenge. Applying midwifery continuity of care therefore, requires midwives willingness to sustain the new model throughout the antenatal, intrapartum and postnatal periods (Taylor et al., 2019).

Most of the researches on midwife led continuity of care were conducted in developed countries (Graham et al., 2016; Sandall et al., 2016); and utilising this model of care is challenging in developing countries. Therefore, for the prospective thinking of implementing MCC there is need to assess the midwives' potentiality to

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adhering to MCC in developing countries. This will give an idea on whether the midwives are having positive thinking and potentiality to adhere to MCC or not. Thus, this research was aimed at assessing the potentiality of midwives adherence to midwifery continuity of care as a new model of care.

RESEARCH METHODS

The research was descriptive that adopted cross-sectional design to assess the potentiality of midwives adherence to midwifery continuity of care as a new model of care in Sir Yahaya Memorial Hospital Birnin-Kebbi, Kebbi State, Nigeria. The population of the study was the midwives serving in antenatal clinic (ANC), maternity and labour units of the hospital. The instrument for data collection was 27 items, researcher made, self-administered questionnaire. The questionnaire is made up of 2 sections, section A and section B. Section A consists of 2 questions that assess the demographic variables of the respondents; while section B consists of 25 questions that assess the respondents potentiality to MCC adherence using 5 point Likert scale of 1=strongly disagree, 2=disagree, 3=neutral, 4=agree and 5=strongly agree. It assess the agreement and disagreement of the positive impact of MCC on pregnancy in ante-natal, intra-natal and post-natal period as potentiality of midwives to adhere to MCC. Three experienced nurse-midwives vetted the questionnaire and they ascertained its face and content validity.

The reliability of the instrument was 0.966 using Cronbach's alpha. Census sampling was used in taking the entire midwives of the units as the subjects of the study. The ethical approval to conduct the research was obtained from Kebbi state health research ethical Committee, with assigned number 105:4/2020. Permission to conduct the research was also taken from the hospital management, and data were collected from 24th February 2020 to 20th March 2020, with the response rate of 100%. SPSS version 16 was used in data analysis; and the results were presented using frequencies and percentages, with Chi-square as a statistical tool for inferential analysis.

RESEARCH RESULTS

Table 1 shows the demographic variables of the respondents; in which 44.8% of the respondents were having 0-5 years of working experience, and 16.4% were having more than 15 years of experience. Majority (61.2%) of the respondents were nurse-midwives, while 38.8% were midwives.

Table 1 Percentage Distribution of Respondents' Demographic Variables N=68

Variables	Frequency	Percetage
Years of Experience		
0-5 30 44.8	30	44.8
6-10	17	25.4
11-15	9	13.4
>15	11	16.4
Specialization		
Midwife	26	38.8
Nurse-midwife	41	61.2

Table 2 indicates that majority of the respondents either agree or strongly agree with most of the items of the instrument. However, some of the items have majority of the respondents disagree or strongly disagree; and most of these items are those postulating negative effect if the midwife is not familiar with pregnant woman. This is found in items 13-16. These items are also shown to have the lowest means.

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Table 2: Respondents' Level of Potentiality to MCC Adherence by Questionnaire Items

No.	Questionnaire	SD F/P	D F/P	N F/P	A F/P	SA F/P	M/SD F/P
1.	Pregnant woman should have easy access to a midwife as first point of professional contact when pregnant	12/17.9	0/0.0	3/4.5	14/20.9	38/56.7	3.99/1.50
2.	Pregnant women should receive majority of their midwifery care by single and same experienced midwife, including prenatal, intra-natal and postnatal care	12/17.9	15/22.4	8/11.9	16/23.9	16/23.9	3.13/1.47
3.	Pregnant woman should have 24-hour access to advices and supports from single and same experienced midwife, including prenatal, intra-natal and postnatal care	10/14.9	13/19.4	7/10.4	19/28.4	18/26.9	3.33/1.44
4.	Providing care by a single and same experienced midwife is more affordable and sustainable model of maternity care	12/17.9	13/19.4	11/16.4	21/31.3	10/14.9	3.06/1.36
5.	To effectively care for a woman, midwives should be able to directly refer to other professionals/agencies (when need arise) and receive referrals back	6/9.0	8/11.9	2/3.0	15/22.4	36/53.7	4.00/1.37
6.	Providing care by a single and same experienced midwife can best ensure the right care by the right health professionals in the right setting and at right time	12/17.9	13/19.4	9/13.4	18/26.9	15/22.4	3.16/1.44
7.	Providing care by a single and same experienced midwife can provide best means for achieving woman's needs.	10/14.9	12/17.9	7/10.4	18/26.9	19/28.4	3.36/1.45

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8.	Providing care by a single and same experienced midwife can provide safer services with quality maternal and neonatal outcomes based on best practice	13/19.4	11/16.4	9/13.4	17/25.4	17/25.4	3.21/1.48
9.	Providing care by a single and same experienced midwife provides woman with informed choice and greater control of her birthing experience	10/14.9	16/23.9	8/11.9	18/26.9	15/22.4	3.18/1.41
10.	Providing care by a single and same experienced midwife can provide best means for evidence-based midwifery care	9/13.4	7/10.4	7/10.4	27/40.3	17/25.4	3.54/1.34
11.	Assigning each experienced midwife a specific number of women to care for through pregnancy, labour and post natal period makes midwifery more effective	10/14.9	10/14.9	9/13.4	16/23.9	22/32.8	3.45/1.46
12.	Assigning each experienced midwife a specific number of women to care for through pregnancy, labour and post natal period develops a trusting relationship	11/16.4	7/10.4	8/11.9	23/34.3	18/26.9	3.45/1.42
13.	Seen different midwives by pregnant woman at different visits can negatively affect pregnancy outcome	22/32.8	18/26.9	6/9.0	12/17.9	9/13.4	2.52/1.45
14.	Pregnant woman should have one-to-one care by a midwife she is familiar to when in established labour	15/22.4	22/32.8	6/9.0	13/19.4	11/16.4	2.75/1.43
15.	Seen a midwife that is not familiar to a woman during labour can negatively affects labour outcome	16/23.9	19/28.4	11/16.4	12/17.9	9/13.4	2.69/1.37
16.	Seen a midwife that is not familiar to a woman during postpartum period can negatively affects postpartum outcome	18/26.9	24/35.8	11/16.4	2/3.0	12/17.9	2.49/1.39

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17.	Providing care by a single and same experienced midwife can best promote woman's satisfaction during pregnancy and childbirth	14/20.9	7/10.4	6/9.0	24/35.8	16/23.9	3.31/1.48
18.	Providing care by a single and same experienced midwife can best enable woman's participation in decision making relating to her care	10/14.9	9/13.4	11/16.4	25/37.3	12/17.9	3.30/1.33
19.	Providing care by a single and same experienced midwife can enhance a maternity team approach	11/16.4	17/25.4	17/25.4	12/17.9	10/14.9	2.90/1.30
20.	Providing care by a single and same experienced midwife is important in monitoring human resource use in midwifery	8/11.9	13/19.4	16/23.9	15/22.4	15/22.4	3.24/1.33
21.	Providing care by a single and same experienced midwife is valuable and safe for women with varying levels of risk in their pregnancy	15/22.4	15/22.4	13/19.4	13/19.4	11/16.4	2.85/1.41
22.	Providing care by a single and same experienced midwife is beneficial to woman with complex pregnancy	14/2.9	21/31.3	4/6.0	14/20.9	14/20.9	2.90/1.49
23.	Providing care by a single and same experienced midwife can contribute to safety, reduction in stillbirth, neonatal death and maternal death rates.	8/11.9	20/29.9	13/19.4	14/20.9	12/17.9	3.03/1.31
24.	Providing care by a single and same experienced midwife can contribute to woman centered care and personalised care plan	10/14.9	14/20.9	10/14.9	20/29.9	19/19.4	3.18/1.37
25.	Providing care by a single and same experience midwife can contributes to ensuring an increased focus on multi-disciplinary working	7/10.4	18/26.9	11/16.4	11/16.4	20/29.9	3.28/1.41

Key: SD = Strongly disagree, D = Disagree, N = Neutral, A = Agree, SA = Strongly agree, M = Mean, SD = Standard deviation

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Table 3 reveals the level of respondents' potentiality to MCC adherence. It shows that 46.3% of the respondents were having good potentiality, 44.8% were having poor potentiality, and only 9.0% were having very good potentiality. It also reveals 56.7% of the respondents with 0-5 years of experience were having poor potentiality to MCC adherence, in contrast with 27.3% in respondents with >15 years of experience. However, in good potentiality level, 26.7% of the respondents with 0-5 years of experience were having good potentiality, in contrast with 72.7% in respondents with >15 years of experience. Also, table 2 indicates that there is no significant association between respondents' years of experience and their level of potentiality to MCC adherence, *P > 0.05*.

Table 3. Respondents' Level of Potentiality to MCC Adherence by Respondents' Years of Experience

Level of Potentiality	Years of Experience					R^2	P
	0-5 F(P)	6-10 F(P)	11-15 F(P)	>15 F(P)	Total F(P)		
Poor Potentiality	17(56.7)	7(41.2)	3(33.3)	3(27.3)	30(44.8)	**9.55**	**0.09**
Good Potentiality	8(26.7)	9(52.9)	6(66.7)	8(72.7)	31(46.3)		
Very Good Potentiality	5(16.7)	1(5.9)	0(0.0)	0(0.0)	6(9.0)		

Table 4 indicates that 50% and 41.5% of the respondents that were midwives and those that were nurse-midwives in specialty respectively were having poor potentiality to MCC adherence. However, 34.6% and 53.7% of the respondents that were midwives and those that were nurse-midwives in specialty respectively were having good potentiality to MCC adherence. But 15.4% midwives in specialty were having very good potentiality in contrast with only 4.9% nurse-midwives. There is no significant association between respondents' specialty and their level of potentiality to MCC adherence, *P > 0.05* (Table 3).

Table 4. Respondents' Level of Potentiality to MCC Adherence by Respondents' Specialization

Level of Potentiality	Specialization			R^2	P
	Midwife F(P)	Nurse-midwife F(P)	Total F(P)		
Poor Potentiality	13(50)	7(41.5)	30(44.8)	**3.40**	**0.18**
Good Potentiality	9(34.6)	22(53.7)	31(46.3)		
Very good Potentiality	4(15.4)	2(4.9)	6(9.0)		

DISCUSSION

Though, the respondents with good potentiality to MCC adherence were having highest percentage, but the level of poor potentiality is also high; the difference between good potentiality and poor potentiality is very limited. This may be due to the fact that MCC is not existing in the hospital of the study; and the staff were used to traditional practice of midwifery. It can be evident in which very small percentage had very good potentiality to MCC adherence. This finding is in agreement with finding of a research by Taylor et al. (2018) to

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explore midwives' perspectives of different ways of working, it was revealed that the number of midwives needed to implement continuity of care was inadequate due to gap in midwives' acceptance of the model. This leads to the call for modifications on MCC, because it is asserted that midwives can change to MCC if it comes with flexible working patterns (Jepsen et al. 2016; Newton et al., 2016). This finding is also in line with a cross sectional survey by Taylor et al. (2019) to study the Midwives' perspectives of continuity based working in the UK, where it was found that some midwives suggested that current approaches to delivering care were working well, with good ante and postnatal continuity, and questioned the need for change (Taylor et al., 2019).

Since the good potentiality was having highest percentage and when combined with very good potentiality, it can be said that majority of the respondents were having positive potentiality toward MCC adherence. This finding is in agreement with a research by Sidebotham et al. (2015) to study perception of midwives on their role within the context of maternity service reform. It was found that midwives accepted the concept of continuity of midwifery care as important and required maternity care system that is woman centered. It is however, contrary to a research by Taylor et al. (2018) to explore midwives' perspectives of different ways of working, where it was found that many midwives report barriers to being able to change the way they work to make continuity happen.

From the result of this study, it is revealed that majority of the respondents showed an agreement with most of the items of the instrument, except in items 13-16 in which majority of the respondents showed there disagreement. This is probably because the items with high disagreement are those postulating negative effect of unfamiliarity between pregnant woman and midwife; and the existing system of midwifery practice in the country is highly associated with unfamiliarity between pregnant woman and midwife. Thus, to increase the potentiality of midwives' adherence to MCC, there is need for passing awareness about MCC among midwives. This is because the MCC is solely dependent on relationship between pregnant woman and midwife; and familiarity between them influence the relationship, thereby impacting the pregnancy and its outcomes positively.

The result of this study revealed that, the level of poor potentiality is decreasing with the increase in years of experience. Respondents with the 0-5 years of experience had majority with poor potentiality, while the respondents with >15 years of experience were having few poor potentiality. In contrast, the good potentiality is increasing with the increase in years of experience. However, in very good potentiality, the presentation becomes odd, in which no respondents had very good potentiality among respondents with 11-15 and >15 years of experience respectively. It might be possible, years of experience influence the potentiality to MCC adherence, and thus working experience might have an impact on respondents' potentiality. This is in accordance with the assertion by some researchers that continuous exposure of midwives and students to MCC could cause an increased in awareness and interest (Carter et al., 2015; Dawson et al., 2018), even though in this case the exposure was not on MCC.

The only midwives in specialty respondents were having higher poor potentiality to MCC adherence than their counterpart that were nurse-midwives. Also the nurse-midwives were having higher good potentiality compared to those that were midwives only. However, respondents that were midwives only in specialty were having higher very good potentiality. Thus, the trend of the potentiality level is in favour of nurse-midwives except in very good potentiality where nurse-midwives were having lower potentiality. Nevertheless, when good potentiality and very good potentiality are added together, the nurse-midwives were having higher percentage than the midwives only specialty respondents.

Owing to differences in culture and traditions between developed and developing countries, certain modifications might be necessary when implementing MCC in developing countries. The modifications and MCC flexibility of MCC to suit the local environment would help the midwives in developing countries to adhere to MCC more quickly. Therefore, there is need for passing awareness and imparting more knowledge about

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MCC to midwives in order to increase their understanding on this model of midwifery care. Thus, conferences, seminars and professional development programmes could be used as a ground for updating knowledge, sensitizing colleagues and educating self about MCC; and thereby increasing the level of acceptance of this model of care.

CONCLUSION

It is mostly accepted that MCC supports client's centered care and bring about trust, respect, dignity and empowerment to both women and midwives. The respondents of this study had a moderately positive potentiality to MCC adherence. This could be attributed to non-existence of any of its model in the hospital of the study or virtually absent in Nigerian midwifery care system. There is need for policy makers and professional organisations in developing countries to consider MCC implementation; sensitise the midwives by passing awareness and updating knowledge about this model of midwifery care. The acceptance and potentiality to MCC adherence can be improved if it is introduced into the system with some modifications and flexibilities; and when the midwives realise its positive impact on maternal and new-born health.

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Midwifery continuity of care: Potentiality of midwives adherence to the new model of care

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