MIDWIFERY IN THE REPUBLIC OF MACEDONIA

SITUATIONAL ANALYSIS

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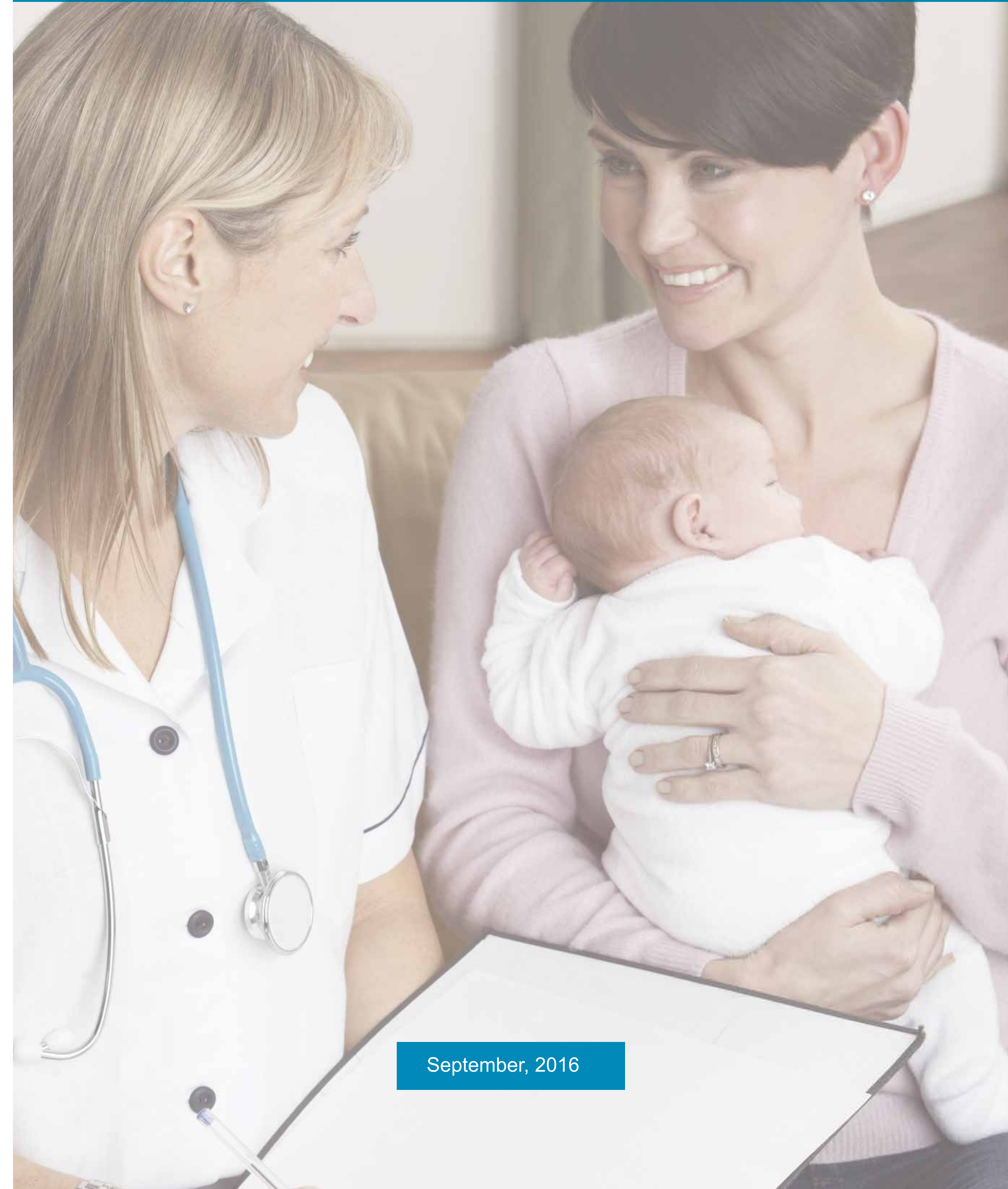

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FOREWORD:

The organization National Roma Centrum, within the framework of the “Promotion of access to healthcare protection for Roma women – Early prevention saves lives” project activities, in the period December 2015 – May 2016 performed a situational analysis of the midwifery profession in the Republic of Macedonia.

The midwives, as an important part of the health system’s workforce, could largely help women to ensure healthy pregnancy, safe delivery, but also care for the newborn, thus significantly promoting the sexual and reproductive health, maternal and newborn health.

The findings of the research show the state of the midwifery in the Republic of Macedonia through the frame of reference of the international standards, and aim to highlight the strengths and weaknesses, but also to propose recommendations for promotion of this profession. This would be an important contribution to the promotion of the women’s and children’s health in general, through provision of high-quality, culturally-sensitive and appropriate care of the women, newborns and families expecting a baby.

The research is part of the advocacy efforts of the National Roma Centrum for progressive realization of the right to health, with special emphasis on reproductive health of the Roma and other vulnerable groups of women, including improvement of the access to timely and quality health services.

1. INTRODUCTION

The promotion of women's and children's health represents an ongoing global challenge. Despite the major advances in medicine and technology, every year more than 300.000 women throughout the world die from maternal reasons while 8 millions suffer due to complications related to childbirth. 45% of all newborn deaths occur during childbirth, while millions of children suffer from consequences of birth trauma. Health indicators related to mother's and children's health show significant inequalities, not only among regions or countries, but also within. The reasons lie in the increasing social inequalities, which compromise the equity of access to health services, especially for the vulnerable groups of women. These health problems are more common in women with lower educational background, lower socio-economic status, certain ethnic groups, women from rural areas. They face different types of barriers in access to timely, appropriate and quality health care. It is estimated that these are the reasons many countries did not meet the Millennium Development Goals – MDG 4 (reduction of child mortality) and MDG 5 (reduction of maternal mortality).

Improving the accessibility to quality midwife care is gaining increased importance on the list of global priorities. The vision is that every woman has access to the best health care during pregnancy and childbirth. Many international documents highlight the need for increased efforts for promotion of the women's and children's health. The Global Strategy for Women's and Children's health1 calls all countries to ensure that women have access to comprehensive, integrated package of services, including the following: family-planning information and services, care during pregnancy, labour and postpartum period, emergency obstetric and newborn care, highlighting the need to deliver the interventions across a continuum of care. The strategy emphasizes the need to deliver the services not only in health institutions, but also in the living and working environment of the woman (in the home or community).

One of the recommendations given in the Global Strategy for Women's and Children's health emphasizes that strengthening of the midwifery, as part of the efforts to strengthen the human resources for health, could in great deal contribute to the promotion of women's and children's health.

Quality midwife's services, coordinated and integrated in the community and the health system, i.e. well educated midwives, at the right place and at the right time, equipped with appropriate technology, is one of the main recommendations given in this Strategy. The need to strengthen the midwifery is recognized through many resolutions of the Executive Board of the World Health Assembly of the World Health Organization: Resolution on strengthening nursing and midwifery (EB128.R11)2 and Resolution on health workforce strengthening (EB128.R9)3, adopted in 2011. There are around 20 resolutions adopted in the last 20 years, urging for strengthening of this profession, as part of the comprehensive strategies for strengthening of the human resources for health.

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[1] *Global Strategy for Women's and Children's Health.United Nations Secretary-General, The Partnership for Maternal, Newborn and Child Health, 2010*
[2] *Strengthening nursing and midwifery, Resolution to the WHA, EB128.R11, 21. January 2011.*
[3] *Health Workforce Strengthening, Resolution to the WHA, EB128.R9, 21. January 2011*

1.1 Short history of midwifery

The original meaning of the word midwife is “to be close to the woman”. The first school for midwives was opened in the Netherlands in 1600, while in the 19th century the midwifery was recognized as a sovereign profession in many European countries. After the First World War, in 1919, the International Midwives Union was established, which set for the first time the performance standards. During the 20th century midwifery was established as a profession in many countries throughout the world. Three models of education have been developed: the first one establishes the midwifery as an autonomous profession with focused education (French model); the second is the English model, where the nurse is upgraded with competencies for a midwife; the third model combines the two. During this time the legislation for nurses/midwives was created, professional associations were established, thus creating opportunity for separate licensing of midwives and recognition as a profession for itself. In the 1970-ies the separate licensing for midwives was gradually abandoned and the midwifery has faced decrease of its visibility.

1.2 Midwifery - definition, objectives and principles

According to the International Confederation of Midwives – ICM (International Definition of the Midwife), a midwife is a person:

- who has successfully completed a midwifery education programme that is recognized in the country where it is located and that is based on the Essential Competencies for Basic Midwifery Practice[4] and the framework of the Global Standards for Midwifery Education[5], defined by the International Confederation of the Midwives;
- 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[6].

The midwives and the other health workers having competencies for practicing midwifery are an important part of the workforce of every health system. They work with the women in their home and in the community, in the healthcare institutions providing antenatal and obstetric care. They are at the frontline of the services for maternal health, in constant collaboration with the health providers at the primary, secondary and tertiary health care.

1.3 Concepts and competencies

The midwife works in partnership with the women to give the necessary support, care and advice during pregnancy, labour and the postpartum period; she is able to manage normal vaginal deliveries, and to provide care for the newborn and infant. This care includes preventative measures, promotion of normal physiologic labour and birth, detection of complications in the mother or the baby and carrying out of emergency measures[4].

[4] International Confederation of Midwives: Essential competencies for basic midwifery practice 2010. Revised 2013.
[5] International Confederation of Midwives: Global Standards for Midwifery Education 2010. Amended 2013.
[6] International Confederation of Midwives (ICM). International Definition of the Midwife, available at: http://www.internationalmidwives.org/who-we-are/policy-and-practice/icm-international-definition-of-the-midwife/

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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.

The midwife may practise in the home, community, health units, including the primary level, hospital or the obstetrics unit.

Well trained midwives and other health workers, competent for performing midwifery practice, are able to manage the health needs of the women and babies during pregnancy, labour and in the postpartum period. They can conduct normal vaginal delivery and detect complications before they become life threatening. In the case of emergency or serious complication, they can and know how to make a judgement and refer the woman to a higher level of care, for a service which is beyond their competencies.

1.3.1 Key midwifery concepts

Key concepts of the midwifery are:

- partnership with the woman to promote the health of the mother, infant, and the familiy;
- respect for human dignity and respect for human rights;
- advocacy for woman so her voice is heard;
- 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 natural life event.

1.3.2 Key midwifery competencies

The key competencies of the midwifery are defined by the International Confederation of Midwives, and stated in the document - Essential competencies for basic midwifery practice[7]. They are classified in 7 groups:

[7] International Confederation of Midwives: Essential competencies for basic midwifery practice 2010. Revised 2013. Available at: http://www.internationalmidwives.org

Group 1. Competency in social, epidemiologic and cultural context of maternal and newborn care

- 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.

Group 2. Competency in pre-pregnancy care and family planning

- 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.

Group 3. Competency in provision of care during pregnancy:

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

Group 4. Competency in provision of care during labour and birth:

- 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.

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Group 5. Competency in provision of care for women during the postpartum period:

- Midwives provide comprehensive, high quality, culturally sensitive postpartum care for women.

Group 6. Competency in postnatal care for the newborn:

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

Group 7. Competency in facilitation of abortion-related care:

- 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.

1.4 The three pillars of quality midwifery

The organization of the health system in a country has an important role in creating supportive working environment for all health professionals, including the midwives. It encompasses adequate infrastructure, communication tools and referral system, adequate supervision, motivation, professional collaboration and adequate political framework. The elements, which are particularly important for creation of quality midwifery care, are:

1/ the process of education,

2/ existing regulatory framework and

3/ strong midwifery associations.

1.4.1 Midwifery education

There are different pathways for educating midwives (graduate, pre-service), as well as maintaining of quality in the trained health workers with competencies for midwifery practice (continuing medical education, in-service). The curricula vary in different countries and are created to prepare the midwives for direct entry into the health system as graduated midwives, or as graduated nurses upgraded with post-nursing advanced training in midwifery.

There is diversity in the entry requirements, length and content of education programme, capacity of the education institution, teacher/student ratio – the recommended ratio is two students to one tutor, time spent doing clinical practice, and the compliance of all elements with the guidelines set by the International Confederation of Midwives.

In 2009 WHO published the “Global standards for the initial education of professional nurses and midwives”[8], in collaboration with the International Confederation of Midwives and the International Council of Nurses. In 2010, the International Confederation of Midwives published its own global standards specific for the midwifery, which encompass:

1) Entry level of students is completed of secondary education

2) Minimum length of direct entry midwifery programme is three years

3) Minimum length of a post-nursing/health care provider programme is eighteen months

4) Midwifery curriculum should include both theory and practice elements to a minimum of 40% theory and a minimum of 50% practice.

5) The practice obtained in practical learning institutions, under adequate supervision is an important element for acquiring competencies.

These standards can be adapted to the specific context of each country.

[8] *WHO, Global standards for the initial education of professional nurses and midwives, 2009.*

Maintaining quality of the existing midwives workforce, through continuing medical education (in-service training) is a very important factor for the quality of the services and demands existence of regulatory mechanisms and certification. This type of training is important for the professional development, enabling midwives to achieve careers advancements and reaching levels of educators, supervisors or researchers.

1.4.2 Regulatory framework

The International Confederation of Midwives, on request of the midwives, their professional associations, the Governments, the UN agencies and other stakeholders, in 2011 developed standards for regulation of this profession - ICM Global Standards for Midwifery Regulation[9]. The purpose of these standards is to promote regulatory mechanisms, which in the first place protect the public (women, children, families), by ensuring that competent professionals provide high standards of midwifery care to every woman and baby. On the other hand, the aim of the regulation is to support midwives to work autonomously within their full scope of practice. Raising the status of midwives through regulation will also improve the standards of maternity care and the health of mothers and babies.

According to these global standards the legislation related to the midwifery should fulfill the following minimum functions/aims:

1. Define the scope of practice;

2. Define the requirements for registration and licensure;

3. Define the requirements for re-licensing of midwives and continuing quality in competence;

4. To deal with complaints to midwives and to maintain discipline;

5. To establish code of conduct and professional ethics.

The purpose of these standards is to describe the regulatory framework necessary for effective midwifery regulation. The framework defines the elements of regulation in order to:

- determine who may perform midwifery;
- describe the scope of practice of a midwife consistent with the definition of a midwife given by the International Confederation of Midwives;
- ensure that midwives enter the register following education consistent with the ICM Global Standards for Midwifery Education (2011);
- ensure that midwives enter the register able to demonstrate the ICM Essential Competencies for Basic Midwifery Practice (2011);
- ensure that midwives are able to practice autonomously within their prescribed scope of practice;
- ensure that midwives demonstrate continuing competence to practice, and
- ensure public safety through the provision of competent and autonomous midwifery workforce.

In many countries the midwifery is regulated by councils for midwives or councils for nurses and midwives. These councils function as regulatory bodies with all responsibilities for regulation of this profession (registration of midwives, quality assurance and training, setting standards in professional conduct). In addition, in countries like Great Britain there is another level of regulation, activated in the cases of misconduct or adverse events, which investigates such cases and implements sanctions.

In the countries where midwifery is not established as an independent profession, and other professionals perform these tasks, there is a great challenge for appropriate regulation of this profession and establishing the necessary performance standards.

1.4.3 Professional associations

Strong professional association, supported by its members and recognized by the Government, is the third pillar of the strategy for promotion of high-quality midwifery workforce. The professional associations can be independent, with midwives as their only members, but they can also be associations of nurses, including midwives in their membership and protecting their interests as well. The professional associations should have well documented policy guidelines and procedures, which regulate their activities and management. The function of such associations is to promote and improve midwifery, to contribute to the decision making process and the creation of policies for promotion of mother and child health at all levels of the health system.

The professional associations have multiple roles and responsibilities, among which:

- promotion of the quality in the profession, through setting standards for midwifery practice;
- participation in development of educational curricula;
- partnership with authorities in setting standards for continuing medical education;
- collaboration with other professional associations and governmental institutions on central and local level, as is the Ministry of Health, during the process of policy creation for promotion of the mother and child health;
- promotion of professional networking and interdisciplinary practice;
- negotiation with governmental institutions for appropriate reward system and supportive work environment;
- partnership with civil society and other advocates for promotion of the reproductive health of women and the health of newborns and children.

[9] *International Confederation of Midwives: Global Standards for Midwifery Regulation (2011)*

To perform these functions, the associations should have appropriate management capacities, technical expertise and adequate administrative and financial procedures, they should be recognized by the health authorities and participate in the consultation processes for policies creation, and they should also be equipped with adequate resources. The national authorities do not praise these associations enough, and do not give enough opportunities (or not at all) for their inclusion in the decision making process. This is mostly due to the perception that these associations' capacities and financial security are weak.

2. AIMS OF THE RESEARCH/ANALYSIS

2.1 Overall aim

The overall aim of the analysis was to examine the state of the midwifery in the Republic of Macedonia, including review of the basic national organizational context of the midwifery through the frame of reference of the international standards, in order to highlight the strengths and weaknesses, but also to give recommendations for promotion of this profession.

2.2 Specific aims

Specific aims of the research were:

- To perform analysis of the regulatory framework of the midwifery in Macedonia, to identify any inconsistencies and to point out to the current efforts of the State to improve the legislation;
- To review the national policies related to the public health areas pertinent to midwifery (mother and child health, sexual and reproductive health, emergency obstetrics care etc.);
- To review the structure of the educational background of the current midwifery health force, as well as the graduate studies curricula, offered by the State universities;
- To assess the level of professional association of the midwives in Macedonia;
- To analyze the licensing-relicensing and the system of continuing education of the midwives;
- To review the international standards related to midwifery in terms of regulatory framework, educational programs, professional association and in-service training, licensing system;
- To compare the findings of the analysis of the state of the midwifery in Macedonia with the international standards;
- To identify the strengths of the midwifery in Macedonia, but also to pinpoint the key weaknesses and inconsistencies with the international standards;
- To propose directions for improvement of all aspects of this profession in the Republic of Macedonia.

2.3 Objectives

The situational analysis of the midwifery in Macedonia was performed in the following dimensions:

- context assessment – identification and review of the national policies, regulatory framework, educational curricula in Macedonia, as well as the international standards;
- empirical assessment - characterization and providing deeper understanding of the strengths and weaknesses of the midwives as health workers;
- analysis of the results – aiming to identify and assess the inconsistencies, to analyze the strengths and weaknesses, to compare the situation in Macedonia and the international standards.

3. RESEARCH METHODOLOGY

3.1 Study design and data collection techniques

This study follows a qualitative methodological approach, in a form of assessment of the current circumstances in the Republic of Macedonia, followed by comparative analysis with the international standards. The assessment is conducted using the following techniques for gathering both primary and secondary data:

1) In-depth interviews; 2) Focus groups; 3) Documents research.

The qualitative component of the research was included in order to gain an in-depth understanding of the topic and to obtain more complex information about the organizational context of the process being investigated. Although the findings obtained by the qualitative methodologies are usually not statistically representative of the population under study, they provide basic understanding of a given situation and possible directions to overcome the identified obstacles.

The in-depth interviews and the focus groups were realized using semi-structured questionnaire. The advantage of this type of questionnaire is that the questions are pre-coded, with a pre-determined set of open questions (questions that prompt discussion) with the opportunity for the interviewer to explore particular themes or responses further, even for topics not envisaged in advance. The pre-coding of the questions facilitates the further data processing. Having in mind the complexity of the qualitative methodology (especially the focus groups) during the realization, but also later – in the process of data analysis, it was decided that the interviewers are actually the members of the professional team that designed and implemented this research. A brief structured list of questions about the respondent's education, occupation and professional background was included. The participants in the focus groups were asked for a permission to tape-record the event, with the explanation that in this way the subsequent detailed analysis would be facilitated, and the "memory bias" would be avoided. All focus groups were tape-recorded, transcribed and entered to computer later on. Notes were taken as well, which were transcribed immediately after the interview took place, as an attempt to minimise the impact of the "memory bias".

The **in-depth interviews** were conducted among key informants pertinent to the field of gynecology and obstetrics in Macedonia. The participants of the focus groups were midwives, engaged in all three levels of health care - at primary level represented by the community nurses, while at secondary and tertiary level, despite midwives, gynecologists were invited as well.

For the field research the method of purposive **sampling** was used, which aims to sample a group of people with particular characteristics, selected because they have knowledge and diverse experiences that are valuable to the research process.

The questionnaires used for the interviews/focus groups encompassed the following topics: education, in-service training, competencies/work tasks, organization of work/support,

professional motivation, involvement in policy creation, professional association.

The semi-structured interview guide, used during the focus groups, is annexed to this document.

The **documents research** entailed analysis of public official documents: government policies, strategies and programs, legislation, national and international recommendations and guidelines, statistical sources, curricula of the universities. The findings from the documents research were triangulated with the ones from the in-depth interviews and the focus groups.

3.2 Research locations

The research was conducted in the towns of Kumanovo, Kochani and Skopje. The involvement of three towns in the study was not done in order to obtain territorial representativeness of the study, but to provide more information on the process which was investigated.

Three focus groups, with 26 participants were organized. The following tables show the structure of the participants in the focus groups according to their educational background, as well as the service they are engaged in.

Table 1: Structure of the focus groups participants, according to the educational background

Location:	Total no. of participants	Midwives with secondary education	Midwives with high education	Nurses	Gynecologists
Skopje	3		1	1	1
Kumanovo	14	10	2	1	1
Kochani	9	5	1	2	1
Total:	26	15	4	4	3

Table 2: Structure of the focus groups participants, according to the service they are engaged in

Location:	Total no. of participants	Midwives / nurses in community nursing service	Midwives / nurses in hospital care	Gynecologists in hospital care
Skopje	3		2	1
Kumanovo	14	3	10	1
Kochani	9	5	3	1
Total:	26	8	15	3

3.3 Data processing and analysis

The processing of the data was computer-assisted, using the qualitative computer software “Atlas. ti”. The textual data was initially transcribed and explored using method of content analysis to identify the main analytical categories (thematic groups), under which to organize and compare data. The concepts and issues included in these thematic groups were pre-defined, but also others were inductively generated and developed alongside data collection.

The following measures for assuring internal and external **validity of results** were employed:

- Triangulation of the results from the different methods used;
- Performing checks for internal consistency of the gathered data, by comparing their plausibility for interrelated items and by using probes during the interviews;
- Avoiding leading questions and placing personal judgements and opinions during the field-data collection process, as a mean to diminish the potential for “interviewer bias”;
- Obtaining consent for tape-recording of the interviews/focus groups, and transcribing the notes in a short time period after the event took place, so that the “memory bias” could be avoided.

However, as an identified threat to the validity of the results is the “social desirability bias”, occurring during the interviews/focus groups, reflected in the respondent’s desire to provide “true” answers and over-report “good” behaviour.

4. ETHICAL ISSUES

This study was not intended to have a clinical component and no biological specimens were taken from study participants.

While Macedonia does not have its own codes for research ethics, the study complied with the ethical guidelines of international organizations such as the American Sociological Association (1999), the Statement of Ethical Practice of the British Sociological Association (2002), the Good Research Guidelines of the Medical Research Council (2000). The field research followed the principles of confidentiality and privacy. The study participants were given written information and explanation about the aims and objectives of the study, the principles of confidentiality and anonymity, the instruments used, the dissemination of the results. They were informed that they are free to withdraw at any time. Subsequently they were asked to give an informed consent prior to the interview. No remuneration / incentive was provided to the respondents.

5. RESULTS

5.1 Human resources practicing midwifery services

5.1.1 Number of professionally active midwives

According to the WHO Health for All Database[10], which obtains the Macedonian data from the national Institute of Public Health, the number of professionally active midwives in the Republic of Macedonia in 2013 was 1141, while the rate was 55.05 midwives per 100.000 population. This indicator shows a downward trend and decreases gradually compared to the 2000 values, when the total number of midwives was 1433, i.e. 70.72 per 100.000 population.

Table 3: Number of midwives in the Republic of Macedonia (2000 – 2013)

Year	Midwives per 100.000	No. of midwives
2000	70.72	1433
2001	71.55	1456
2002	74.35	1502
2003	69.08	1400
2004	68.68	1396
2005	64.56	1315
2006	63.13	1288
2007	57.69	1179
2008	61.07	1250
2009	59.44	1219
2010	59.27	1218
2011	58.1	1199
2012	57.49	1188
2013	55.05	1141

According to the same data source, in Macedonia the coverage with midwives is relatively good in relation to the other European countries.

[10] *WHO, European Health for All Database. Available at: http://www.euro.who.int/en/data-and-evidence/databases/european-health-for-all-database-hfa-db*

Table 4: The number of midwives in some European countries in 2013

Year	Midwives per 100.000	No. of midwives
Austria	16.27	1379
Bosnia and Herzegovina	29.93	1149
Bulgaria	45.09	3276
Croatia	37.83	1610
Czech Republic	41.67	4380
Estonia	31.26	412
France	32.87	20970
Germany	23.56	19000
Hungary	16.89	1671
Iceland	81.54	264
Italy	20.4	12290
Montenegro	40.08	249
Norway	54.37	2762
Poland	59.3	22833
Portugal	23.82	2491
Republic of Moldova	20.94	745
Romania	16.26	3458
Slovakia	32.79	1775
Slovenia	6.02	124
Spain	17.81	8297
Switzerland	30.9	2500
Macedonia*	55.05	1141
Great Britain	49.77	31907
European Region	40.14	
EU	32.1	

The existing data should be interpreted with caution, since in Macedonia the data on the rate of practising midwives (that provide services directly to patients) is still not available. There is no publicly available midwives registry.

In relation to the level of education, the midwives that have the secondary education as their highest level dominate both in the obstetrics units, as well as in the community nursing service. However, the number of midwives with university degree, or midwives that currently attend university programs increases. The discrepancy in the educational level carries certain risks, but also advantages. The risks are associated with higher possibility for inconsistent practices/ while the advantage lies in the possibility to improve the quality of training, higher motivation and professional satisfaction. During the focus groups it was noted that the number of midwives / nurses in the maternity hospitals, as well as the community services is insufficient. This has become particularly apparent after the range of duties of the community nursing service was broadened (visits to older people, activities in rural areas etc.), which limited the service capacities for work in their primary task area, that is “safe motherhood”.

5.1.2 Competencies / scope of practice

The findings of indicate that in relation to the scope of practise, there are differences in the working areas of the midwives in the obstetrics units and in the community service. In the obstetrics units the focus is placed on competencies related to management of normal vaginal delivery and initiation of breastfeeding. The vaginal deliveries are performed by a team of a gynaecologist and a midwife, and there is a perception in the country that the midwives are well trained for management of normal vaginal delivery, under supervision of gynecologist.

In relation to the primary care, the findings show that there is an attitude among the nurses, but also among the gynaecologists, that the family planning is not in the scope of practice of the nurses, but of the gynaecologists. The primary gynaecologists engage mainly nurses in their teams, but not midwives. The midwives from the obstetrics units recognise that their role infamily planning is only related to the counselling process prior an elective abortion, and also during the postnatal period.

The community nurses are more active in the areas of antenatal care, care for the woman during the postnatal period, care for the newborn and breastfeeding, family planning in the postnatal period, and also care for the vulnerable woman. More specifically, they provide information on the benefit of family planning and occasionally perform counselling on contraception; however, they consider that they need more training, because this topic is not sufficiently represented in their education. In relation to antenatal care, the community nurses give advice on nutrition, use offolic acid, promote the necessary check-ups during pregnancy and inform the women on activities implemented as part of the preventive programs of the Ministry of Health. However, the community nurses devote most of the time to working with women in the postnatal period and care of newborns and infants, including breastfeeding and complementary feeding. Due to their field work activities, the community nurses have greater opportunities to develop competencies related to the social and cultural context of the work with vulnerable groups of women.

The main problem of the community nurses in terms of the prenatal visits to the pregnant women, especially in the bigger cities, is the fact that the women are rarely accessible in their homes. In the smaller towns the communication between the maternity hospitals and the community nursing service

is better. The inadequate communication with the gynecologists from the primary health care regarding the exchange of contacts for the pregnant women has been pointed out as well. However, there is a perceived need for better cooperation in terms of sharing of health information between these health profiles, which would be in the interest of maintaining good health of the women during their pregnancies or the period after giving birth.

The majority of the community nurses expressed a need to repair the existing and get additional equipment and work materials, to be able to perform their duties professionally (adequate vehicles for easier access to rural and remote areas where public transport is limited, field scales for measuring infants, devices for monitoring blood pressure, etc.). Regarding the mechanisms for professional motivation, the focus groups revealed that certain motivation strategies do exist (professional satisfaction, trainings, internships, provisions in the collective contract of nurses/ midwives that distinct the university degree midwives). Other types of motivation mechanisms were suggested - more regular training, greater involvement in the processes for creation of policies and promotional materials, mechanisms for additional financial reward, especially for community nurses. The need for greater efforts to improve the visibility of this profession, its status, greater participation in the creation of strategic documents and educational curricula, was emphasized as well.

5.2 Policies for promotion of sexual and reproductive health

Several national strategic documents of relevance to mother and child health were analyzed: Safe Motherhood Strategy in the Republic of Macedonia 2010 – 2015 with action plan, National Strategy for Sexual and Reproductive Health of Republic of Macedonia 2010 – 2020 and Action Plan for Reducing Maternal, Peri-natal and Infant Mortality 2012 – 2013. The objectives of the analysis were to assess:

- if these documents promote the importance of midwives and if they address the midwifery profession as part of the health workforce that independently participates in provision of care in this area;
- if the specific objectives and activities of the midwifery service are defined;
- if indicators are defined, measuring the impact of the activities envisaged with the action plans, related to the midwifery.

Findings:

Safe Motherhood Strategy in the Republic of Macedonia 2010 – 2015.

The goals and activities envisaged with this strategy are structured into 4 segments: pre-conception period, antenatal care period, delivery period and postnatal care period. Having reviewed the services for the mother and newborn, elaborated in this strategy, one can conclude that they correlate with the midwifery competencies, defined by the International Confederation of Midwives as essential competencies for basic midwifery practice. However, the midwife's role as an actor/stakeholder is emphasized in the hospital health care during the delivery. This is partly due to the fact that the services provided during the other periods (pre-conception period, antenatal period and the period after delivery) are considered as prior duty of the gynecologist-obstetrician, the neonatologist, the pediatrician in primary care, the community nurse and partly of the family doctor. In practise, the community nurses are more involved in service provision during the antenatal and postnatal period, while the midwives are more engaged during the intrapartum period, which is directed by the type of institution they are employed in. It should be emphasized that many of the community nurses, i.e. the nurses employed in the patronage (community) services are actually midwives, so there is an "overlap" in the work tasks of the community nurses and the midwives. These are the reasons that the role of the midwives employed in the maternity hospitals in the family planning, antenatal care, postnatal period, as well as in the health promotion and education is insufficiently recognized. It is expected that these services are responsibility of other health workforce profiles (community nurses, gynaecologist, neonatologist, primary care paediatrician, family doctor). The midwife from the obstetric units is not mentioned in the action plan of this strategy as service provider for the above mentioned areas. The strategy envisages many activities aimed at enhancing the quality of services by introducing continuous education for all health professionals and review of the existing curricula and their compliance with the required standards, but it does not explicitly treat the midwifery as separate profession.

None of the indicators defined in the Strategy is directly linked to the service of the midwives. The current practise in Republic of Macedonia that most of the deliveries are performed in the obstetrics clinics (99,8% in 2013 and 2014), under supervision of appropriate health care personnel – gynaecologist, gives an answer to the question why the "skilled attendants at birth", the indicator widely used worldwide, is not included in this strategy. This indicator points to the deliveries attended by skilled healthcare personnel – doctor, midwife or a nurse. In Republic of Macedonia almost all deliveries are managed by a gynaecologist and a midwife, i.e. nurse, with an exception of a very small number of deliveries which happen outside the delivery room, using this indicator would be inappropriate having in mind the local context.

National Strategy for Sexual and Reproductive Health of Republic of Macedonia 2010 – 2020.

This strategy encompasses 6 strategic areas: protection of sexual and reproductive rights, family planning and contraception, sexual and reproductive health of certain population categories (adolescents, vulnerable groups and marginalized groups as men, migrants, refugees, people with special needs, drug users etc.), safe motherhood, priority health problems and conditions (sexually transmitted infections and HIV, abortion, infertility, malignant breast neoplasm). The strategic action areas are health promotion, standards and norms – subjects and services, partnership and research. Many of the activities

envisaged in this strategy are related to health promotion and prevention and refer to the public health system, but also to all levels of health care, preventive and primary health care in the first place. Many of the topics, which are subject of this strategy, are complementary to the competencies of the midwives. The strategy defines a number of specific activities, but the midwife is not mentioned as provider of the activities, neither independently, nor in a team with other health workers. Obstetricians-gynecologists, family doctors and community nurses are the only health care workers listed as providers of defined activities. The defined indicators are also not related to the activities of the midwives. Again, this is partly due to the fact that the term midwife is used for those

working in the delivery hospitals, and the fact that part of the community nurses are actually midwives is not taken into consideration. This is a risk for the "visibility" of the profession of the nurses – midwives.

Action Plan for reducing of maternal, perinatal and infant mortality 2012 – 2013.

This plan is prepared by the Safe Motherhood Committee and aims to define activities focused at promotion of maternal health and decrease of perinatal and infant mortality in Republic of Macedonia in the period 2012 – 2013. The aims and envisaged activities are grouped into 4 categories, namely: pre-conception period, antenatal period, delivery and period after delivery. All areas covered by this Action plan are complementary with the competencies of the midwife. Number of different activities is defined; however as actors of the activities different institutions are mentioned, but not individual health profiles. Many activities related to the quality of the health professionals' performance are defined, but the recommendations given are general, not specifying the midwifery itself, for example "updating the curricula of the gynaecology and obstetrics" programs at the faculties for medical sciences, according to the national clinical guidelines for antenatal care and family planning". The gynaecologists and community nurses are mentioned as major actors ("Conducting of training for continuous medical education – CME – for antenatal care for the community nursing service and the gynaecologists from the primary health care"). The professional associations of gynaecologists are often mentioned as responsible for part of the activities, while the professional Association of nurses, midwives and medical technicians is not recognized as partner in activities' realization.

Regarding the involvement of the midwives themselves in creation of strategic documents, the focus groups revealed that they were partly involved in creation of the draft text of the Law on nurses and midwives, and the Strategy for Safe Motherhood. Still, they point out that this was not enough and their greater involvement is necessary.

5.3 Analysis of the regulatory framework in the R.Macedonia

" Midwifery care" is treatment for the women during pregnancy, delivery and post-delivery period, as well as for the newborn and the infant by midwives with the purpose of preserving or reaching their best health, as well as work in particular areas of gynecology and family planning.

This is the definition of midwifery care according to the Law on Health Protection of Republic of Macedonia. Despite the definition, the Law stipulates that the midwifery care is healthcare activity performed at primary, secondary and tertiary level, in outpatient and hospital health care. At the moment there is no other legislation regulating midwifery and nursing duties. There is no other regulation determining the scope, means and conditions necessary to perform nursing and midwife duties and determining misdemeanor sanctions for violation of such duties.

The midwife is not distinguished as a profession in the Law on Health Protection. Like the nurse, it is covered with the definition for "healthcare worker", as a "person who provides health services in the delivery of a particular healthcare activity **with two-year post-secondary school or higher vocational education or with 180 ECTS and healthcare workers who hold a secondary (high school) degree".** However, the term "two-year post-secondary school" is not defined in the current Law on Higher Education. Unlike nurses and midwives, the Law on Health Protection defines the doctor of medicine, doctor of dentistry and the pharmacist as "health worker with **university education or completed academic integrated studies with 300 or 360 ECTS** in medicine, dentistry and pharmacy". Before 1996 the training of midwives was at the level of secondary (high-school) education, and since then there is a three years higher education program that results with university degree.

As healthcare workers with secondary, two-year post-secondary school or higher vocational education, the midwives can independently perform health services after completion of probationary work and obtaining a license. The **probationary work** of healthcare workers with higher vocational education shall last ten months, for healthcare workers with two-year post secondary education is nine months, and six months for those with secondary school education. The probationary work shall be done in healthcare institutions under supervision of an authorized healthcare worker, or healthcare co-worker (educator for probationary work). The plan and the program for probationary work of healthcare workers with secondary education, two-year post secondary and higher vocational education, the composition of the examination commission, the means of taking the expert examination, as well as the criteria for educators shall be adopted by the Minister of Health. In contrast to this, these duties for the doctors of medicine, doctors of dentistry and pharmacists are given to the respective chambers.

Upon completion of the probationary work, the healthcare workers and the healthcare co-workers shall undertake an **expert examination** within a period of one year as of the day of completion of the probationary work program; in contrary they shall do the probationary work again. Unlike the doctors of medicine, doctors of dentistry and pharmacists, which undertake the examination in front of commissions established by the respective chambers, the expert examination of the healthcare workers with secondary, two-year post-secondary school or higher vocational education is performed in front of commissions formed by the Minister of Health.

After the expert examination is passed, the nurses, midwives and the other healthcare workers with secondary, two-year post-secondary school or higher vocational education are rewarded with a "**certificate** for passed expert examination", which is permanent and

is not to be renewed. This certificate is one of the conditions to independently perform healthcare services. For the doctors of medicine, doctors of dentistry and pharmacists, the license has the role as the certificate, but is to be renewed every 7 years.

The Law on Health Protection envisages that the healthcare workers with secondary, two-year post-secondary school or higher vocational education shall also join in chambers. This provision encompasses the nurses and midwives as well. Just like the chambers of doctors of medicine, doctors of dental medicine and graduated pharmacists, the chamber of healthcare workers with secondary, two-year post-secondary school or higher vocational education shall also adopt a statute, code of professional ethical duties and rights, shall form a court of honor and other assisting bodies. This chamber could, under certain circumstances, be granted by the Minister of Health equivalent authorizations in relation

to the procedures for licensing of health workers as those of the doctors', dental and pharmaceutical chamber. The Ministry of Health and the State Sanitary and Health Inspectorate shall supervise the lawfulness of the work of the chambers in the execution of the public authorization.

According to the Law, the healthcare workers with high school, two-year post secondary school or higher vocational education in the field of medicine, dental medicine, and pharmacy may join in **professional associations**. Through these associations they shall organize different forms of professional development of healthcare workers, shall draft professional instructions for work, and shall propose measures for promotion of the professional work of the healthcare workers.

The Law on Health Protection defines **other rights, duties and limitations** of the healthcare workers with high school, two-year post secondary school or higher vocational education, including midwives:

- to actively participate in the implementation of the annual program for monitoring and promotion of the quality of health protection,
- to undertake professional training and development in accordance with the needs of the healthcare institution in which he/she is employed,
- to be members of the Health Ethics Commission,
- they could not be holders of healthcare activity,
- they could not be directors of public healthcare institution etc.

The Law on Health Protection envisages **specialisations and subspecialisations** for healthcare workers with a university degree, namely doctors of medicine, doctors of dental medicine and graduated pharmacists, i.e. health workers with university education or completed academic integrated studies with 300 or 360 ECTS in medicine, dentistry and pharmacy. The healthcare workers with university education can specialize only if they have the probationary work finished, the expert examination passed and a license obtained. Specializations for professionals with two-year post secondary school or higher vocational education, including midwives, are not envisaged.

According to the Law on Health Protection, the Institute for Public Health, in direct collaboration with the corresponding chambers and the healthcare institutions, shall keep registry on health workers, recording data on educational level, specializations, additional training, licences and expert examination, as well as the employment of all health workers in Macedonia. The Law limits that this registry is to be used by the Ministry of Health, inspectorates in charge, and the corresponding chambers within the limits of their delegated authorizations.

The types of profiles of health personnel, the levels of education, the fields of work and degree of complexity of the work within the healthcare activity shall be prescribed by the Minister of Health.

The rights and duties of the employed midwives, in terms of **labour relations**, are regulated by the Labour Law and the Law on Health Protection.

The midwives, which are employed in public healthcare institutions, bear a status of public services providers in the health sector, therefore abiding by the provisions of the Law on Health Protection, Law on Public Administration, and the general regulations related to labour relations, but also more specifically – to the Collective agreement for health services in RM.

The public health institutions have the job positions systematized according to the groups and subgroups defined in the Law on Public Administration. The collective agreement also systematizes the job positions according to the complexity and depending on the level of education, and defines the salaries of the employees in the public health service. The work experience and the other special requirements for employment in a public health institution as health worker, or health co-worker, are defined in the regulative for systematization of job positions of the specific public health institution, according to the educational requirements, the competencies, the duties, type and complexity of the tasks, as well as the other criteria of interest for the specific job position.

The "midwives", according to the provisions of the Law on Health Protection that are in line with the Law on Public Administration, are mentioned as such only in the category of health workers with high school or two-year post secondary school. The category of health workers with higher vocational education encompasses "nurses" in general, and does not involve the midwives as a separate health personnel. However, these provisions are not yet fully enacted.

The midwives, as health workers, but also as public servants, have rights and duties to undertake professional training and development in accordance with the needs of the healthcare institution in which they are employed. These provisions are incorporated in

the Law on Health Protection, Law on Public Administration, as well as the Collective agreement. According to the Collective agreement for health services, the in-service training is financially supported by the employer. The employer has obligation to also support the training of employees, who themselves require so, if it is consistent with its needs.

The development of Law on nurses and midwives is in process, and this is supposed to regulate "numerous open questions related to the professions of the nurses and the midwives, having in mind the importance of their role in the health care system. Particular importance is given to the definition of the final educational model and the possibilities for continuous professional education, the scope, means and conditions to perform nursing and midwife care, the duties of the nurses and midwives, as well as the misdemeanor sanctions for violations of such duties" (draft Law on nurses and midwives, Skopje, December 2015, Government of the RM).

With regards to the participation in the creation of this Law, the Association of nurses, technicians' and midwives activated its sections in different towns, aiming to provide professional opinion and recommendations. Having in mind that this Law is not enacted, the Association does not have any feedback if their recommendations are taken into account. However, the study revealed that part of the midwives – members of the Association, which participated in the research, were not informed that such process was taking place.

Although the **work protocols** were not subject of this study, it is recommended that existence of such protocols, as well as their appropriateness and the correlation with the international standards and the recent scientific evidence, is a topic of some further research.

5.4 Education and training of midwives

5.4.1 Educational curricula

In Macedonia the education of midwives is organized at the level of higher vocational education, although midwifery is practiced also by midwives with secondary (high school) and two-years post secondary education, according to the older system of education, practiced until 1996.

Study programs covering education for midwives are offered by 4 state universities. Three of these universities offer specialized educational programs for midwives (University St. Kliment Ohridski - Bitola, University Goce Delchev - Stip and State University - Tetovo), while the University of St. Cyril and Methodius offers a program where the acquisition of midwifery skills is incorporated in the educational programs for nurses.

Entry level of students at these programs is completed secondary (high school) education; however it is not mandatory that the high school is of medical background.

The studies are classified in "Medical Sciences and Health – Healthcare (Nursery)" scientific area. The duration of the study programs of the first cycle of all universities are 6 semesters (3 years), and their completion yields 180 ECTS points.

The curricula of university study programs for nurses/midwives in Macedonia comprise both theoretical (lectures), as well as practice elements. The practical training (exercises, seminars and practical work) constitutes the majority of the classes, and involves cabinet exercises as well as clinical exercises and clinical practice at the out-patient and in-patient departments.

The study programs include vocational, basic and social subjects. These study programs encompass acquisition of knowledge and skills not only for perinatal and postnatal care, but also for antenatal care of women. The elements of antenatal care are represented in higher proportion in the curricula of the studies specialized for midwives.

However, there is no legal instrument which would regulate the basic criteria for midwifery education curricula. The Law on nurses and midwives, which is in process of adoption, is provided to regulate issues like these. Some faculties offer second cycle of specialized education in the field of midwifery services. Goce Delchev University offers specialization for family and community nurses, St. Kliment Ohridski University offers specialization in perinatal care and specialization in primary health care.

The duration of post-nursing/health care provider programme after graduation (probationary work) is 10 months and is performed in healthcare institution, under supervision of healthcare worker – educator.

The basic characteristics of the university curricula encompassing education for midwives in Macedonia generally follow the basic global standards, set by the International Confederation of Midwives (2010): entry level of students is completed secondary education; minimum length of direct entry midwifery programme is three years; the ratio of theory and practice elements is a minimum of 40% theory and a minimum of 50% practice. The only discrepancy is in the length of practice after graduation – according to the criteria given by the Federation it should be 18 months, and the Macedonian regulation provides 10 months.

Some midwives from the obstetric units, which participated in the field research (the focus groups), expressed that to some extent they are not satisfied with the scope of practical training during their education, nor the quality, as they usually were left on their own, or they were not allowed to work but only to observe. Similar viewpoint was expressed for the current studies for nurses / midwives. Some of the participants expressed that the practice in the past, when the education for midwives was at the level of secondary vocational education, was better implemented and provided a solid foundation for further involvement in health care. As an example, they pointed that at some point in the past, to be able to pass the graduation exam the midwife was required to prove that she performed 30 births. However, over the years the criteria were getting looser. According to the participants in the research, the practice period spent in appropriate facilities under

adequate supervision is more important element compared to the theoretical knowledge, as it offers opportunity for learning and self-development, but also practical application of the theoretical knowledge. Gynecologists who participated in the survey also shared the opinion that it would be better that the new curricula for education include greater extent and quality practice, which would be a prerequisite for introducing a system of licensing-relicensing. One should especially bear in mind that even high school graduates without any medical background can enroll the higher vocational university programs for nurses / midwives, so in any case they would need additional practice hours.

Many of the research participants indicated that although, according to the global standards, university programs for midwives must exist, it would anyhow be beneficial to take into account reinstatement of the special program for midwives at the medical high school. This way "more prepared personnel" would be entering the further educational system and the health care practice. But still some of the participants believe that it would be a retrograde process, given that there is a global trend of increasing the educational level of nurses.

The field research also suggested a lack of midwives – educators, who'd taught the practical lessons.

It was pointed out at the problem of the so-called "apprenticeship", a period that the midwives in the past had to pass after their employment, which was of paramount importance to their training. During this period they worked under supervision, had limited responsibilities and received lower wages than others. At the time being there is no "apprenticeship" for midwives.

5.5 Professional association and international cooperation

In Macedonia there is no association of midwives only, but their interests are represented by the "Association of nurses, technicians and midwives of the Republic of Macedonia". The perception is that this kind of joint approach provides better contribution in protecting the interests of midwives and other profiles represented in the association, as it ensures bigger membership. Also, the additional procedures for establishment and operation of separate associations are avoided. Also the joint association brings higher financial strength, which is an important factor for the operation of any professional association.

All nurses that were involved in the focus groups (both engaged in hospital care and in the community service) confirmed that they were members of the Association. The membership of the Association is organized into sections, often according to the territory they cover. Some of the nurses – midwives, which participated in the focus groups, expressed that establishment of a separate association of midwives would be more efficient approach.

The association has a Statute which governs its operation and activities, but also the management of the organization.

The position of the Association is that it would be beneficial if a chamber of midwifes, nurses and technicians is established in future, however some prerequisites - both in terms of human and financial resources, would be necessary.

The Association supports and promotes the midwifery profession. It has adopted a Code of conduct and professional ethics, which aims to define the professional code of conduct of midwives and is one form of documented policy, which provides guidelines for functioning of the profession.

According to information given by representatives of the leadership of the Association, congresses and other professional events for nurses, technicians and midwives are regularly organized by the Association, in order to strengthen the quality of the profession, to promote the professional networking and interdisciplinary practice, to promote and strengthen the collaboration with relevant professionals and the international cooperation. These events cover topics that promote the quality of the profession. However, some of the midwives, participating in the focus groups, expressed a need for better information sharing. They gave an example - the employees in one of the hospitals surveyed, were not informed about the cessation of the secondary education (high school) for midwives, only until they realized, few years after, that no more high-school trainees were arriving in the hospital for realization of the mandatory midwifery practice.

The Association builds partnership with the authorities to regulate the operation standards of the nurses, midwives and medical technicians. It gives its contribution to the decision-making process and whenever asked it gets involved in the creation of policies for promotion of the mother and child health. Some association members expressed specifically that they had participated in creation of important strategic documents, such as National Strategy for Safe Motherhood 2010-2015, participated actively in the process of preparation of the draft Law on nurses and midwives, in harmonization with the EU Directive 2006, in preparation of records forms etc. The Association has its representatives in the expert bodies of the Ministry of Health such as the National committee for the promotion, protection and support of breastfeeding.

The Association expects that the new law shall regulate all the necessary aspects such as work duties, necessary conditions for registration and licensing, necessary preconditions for re-licensing and the continuous medical education, all in direction of maintaining the continuity in the quality of midwifes' and nurses' competencies, etc.

The Association develops partnerships and collaborates regularly with civil society and other advocates for promotion of the reproductive health of women and the health of infants and children.

The involvement in the development of competencies of the midwives is in direction of promotion of the quality of the profession by promoting professional standards and quality of work.

The Association maintains good cooperation with international professional associations;

it is an active member of the International Confederation of Midwives and the European Association of Midwives. The cooperation and membership in international associations resulted in more projects aimed at improving the quality of work of midwives - development of curriculum for undergraduate studies in midwifery, participation in a number of projects such as the "Baby Friendly Hospitals Initiative" project, implemented in cooperation with UNICEF and aimed at promotion of breastfeeding, participation in large number of activities aimed at capacity building for promotion of the quality of work of the community service in different areas of mother and child health, preparation of educational materials for community nurses as well as parents etc.

6. CONCLUSION

Human resources practicing midwifery services

The number of professionally active midwives in the Republic of Macedonia in 2013 was 1141, while the rate was 55.05 midwives per 100.000 population. This indicator shows a downward trend and decreases gradually compared to the 2000 values, when the total number of midwives was 1433, i.e. 70.72 per 100.000 population. According to the same data source, in Macedonia the coverage with midwives is relatively good in relation to the other European countries.

The existing data should be interpreted with caution, since in Macedonia the data on the rate of practising midwives (that provide services directly to patients) is still not available.

In relation to the level of education, the midwives that have the secondary education as their highest level, dominate both in the obstetrics units, as well as in the community nursing service. However, the number of midwives with university degree, or midwives that currently attend university programs increases. The discrepancy in the educational level carries certain risks, but also advantages. During the focus groups it was noted that the number of midwives / nurses in the maternity hospitals, as well as the community services is insufficient.

National policies

The national policies that address maternal and child health do not recognize enough the importance and the role of the midwives as separate and specific profession. The role of the midwives is not sufficiently recognized in the most important strategic documents for promotion of the sexual and reproductive health. Even those documents who are focused on safe motherhood, an area which correlates mostly with the competences of midwives, do not define activities for promotion of midwives' competencies, nor do they include midwives as perpetrators of defined activities. This implies that the significance of this profession becomes less visible. It may not be a result of their role and insufficient representation, but of the under-representation and participation in preparation of such documents, and also because large part of their traditional activities are taken over by other health profiles, primarily by community nurses. This situation of under-representation and visibility could lead to even greater weakening of this profession in future. The analysis of international documents shows that this trend is not unique for Macedonia.

All activities aimed at promotion of this profession, but also at maximal utilization of each type of investment in its development, should be included in the comprehensive health policies and plans, focused on improving the maternal and child health. While drafting of these documents in the future the specific context of the country should be taken into consideration, but it is also necessary to follow the recommendations of the international public health institutions, such as the UN agencies, that promote the importance of the midwifery profession.

Regulatory framework and educational system

The existing legislation provides only the basic regulation for performing midwifery care, not addressing the specific characteristics of the midwifery as a health care activity. The obligations and rights and the Code of ethical conduct of the midwives are regulated at the level of health workers. There is no regulation which specifically and in more detail deals with the scope, means and conditions to perform midwifery care, the duties of the midwifes, their distinction depending on the educational level (high school v.s. university education), the misdemeanor sanctions etc.

The educational profile of midwives as health workers is regulated only in its core, and many inconsistencies among different legal instruments are observed.

The training of midwives after completion of their education – the professional practice, continuous professional education, the expert examination (licensing and relicensing), is also regulated just basically and it does not comply fully with the Global standards for midwifery regulation, developed by the International Federation of Midwives. The existing laws do not provide a system of licensing-relicensing and mandatory continuous education. The specialization of midwives is not regulated, although specialization programs are already offered by certain universities. The specific competencies of the educators, who may be involved in post-nursing training of midwives, are not defined.

The legislation regulates the right of association of midwives in chamber and associations. However, in practice there is no chamber of midwives, as currently the main competences that the chamber should maintain (registry keeping, licensing, organizing expert examination, etc.) are taken over by other state institutions (the Ministry of Health, Institute of Public Health).

The registering of midwives as health workers is also regulated only basically, the authorization being given to the Institute for Public Health. Given that the Institute keeps the records of healthcare workers in direct cooperation with the chambers (referring to the Chamber of doctors of medicine, doctors of dental medicine and graduated pharmacists), and no chamber of midwives and nurses exists, one could question the validity and the comprehensiveness of the midwives' registry. No legal mechanisms to check its validity exist.

The provisions that are regulated in detail at different levels of the legislation (laws, collective agreements, systematization, etc.) are those that regulate the rights and obligations of midwives related to labor relations. The legislation provides good basis for supportive working environment of midwives as health professionals, and the basis for accountability of midwives as workers, and more specifically as health workers. However, the legislation that regulates labor rights of health care workers is also considered to bear inconsistencies concerning the educational profile of midwives.

A process of adoption of Law on nurses and midwives has begun, and it is supposed to regulate all open issues related to midwifery care and midwifery profession. The adoption of this law should also harmonize certain provisions throughout related laws and regulations.

Reviewing the basic features of the curricula of the study programs encompassing education for midwives in Macedonia, it can be concluded that they generally follow the basic global standards set by the International Federation of Midwives (International Confederation of Midwives, Global Standards for Midwifery Education 2010). The only discrepancy is in the length of practice after graduation – according to the criteria given by the Federation it should be 18 months, and the Macedonian regulation provides 10 months. However, the legislation that needs to be adopted / harmonized, should provide mechanisms for more detailed monitoring of the structure and quality of the education for midwives, as well as its compliance with international standards.

The field research indicated that the attitude of the midwives, nurses and gynaecologists is that the practice during the midwifery education is insufficient, and over time the situation in this regards is not getting any better. The new university curricula for education of midwives should include greater extent and quality of practice, especially bearing in mind that even high school graduates without any medical background can enroll the higher vocational university programs for nurses / midwives. Reinstatement of the special program for midwives at the medical high school could be one way to raise the expertise of the professionals, who will later on enrol the university studies or the healthcare practise.

Continuing medical education (in-service training) is important for maintaining the service quality. The community nurses have had more opportunities to attend different types of training in the areas of safe motherhood, in contrary to the midwives from the obstetrics units. However, the training taking place in the hospitals themselves - projects aimed at improving maternal and child care, training on new equipment usage etc. – were highlighted as good practice.

Professional association and international cooperation

Despite the many constraints, the Association performs a number of functions and activities, aimed at improving the quality of the profession by promoting professional standards and competencies and the Code of ethical conduct, capacity building, developing international cooperation. The Association is prepared to contribute to the development of national educational programs, it builds partnership with authorities and takes part in the development of strategic documents and regulatory mechanisms, participates in the creation of standards for continuous medical education, cooperates with governmental public health institutions, such as the Ministry of Health, and cooperates with international institutions in the process of policy-making and implementation of activities to improve the health of women and children, builds partnerships with civil society and other advocates for improving the reproductive health of women and the health of infants and children.

7. RECOMMENDATIONS

Policy level

- Creating more space for cooperation with the health authorities and greater involvement of midwives in the process of health policy-making and strategic documents creation in the area of safe motherhood (family planning, antenatal care, midwifery care, post-natal care, safe abortion, prevention of sexually transmitted infections) and the health of infants and children;
- Greater recognition of the profession as a basis / key to providing services for promotion of the maternal and child health in all areas of safe motherhood and the health of newborns and children, thus somehow compensating the lack of health workers due to the current trend of brain drain of health workers;
- Paying more attention to this profession while creating the human resources strategy.

Health system level

- Strengthening the role of midwives in all domains of safe motherhood, especially in antenatal care and in prevention and management of emergencies in obstetrics, as one of the most important aspects of maternal health;
- Greater involvement of midwives in the drafting process of clinical guidelines, related to improving all components of clinical practice in the area of safe motherhood;
- Establishing a continuous system of cooperation between the obstetrics units and the other levels of the health system in the country, in order to exchange knowledge and experiences, harmonize the approaches in treatment and care and regularly update the work protocols;

Legislation

- Establishing a sound legislative framework for midwifery care and midwifery profession and its harmonization with the existing regulation in the country and with the international standards;
- Harmonization of the regulations dealing with human resources in health, with the regulations from the area of education;
- Continuous follow up of the consistency of the regulatory framework and the educational system for midwives with the international standards.

Education

- Greater collaboration with universities in creating educational curricula and participation in the development of national education programs;
- Emphasizing the practical elements of the educational and training programs, and greater involvement of well-trained midwife educators in appropriate institutions, aiming to better transfer competencies for quality care;
- Giving opportunities for continuing the education process by regulating and developing postgraduate studies and specializations at the existing university programs for nurses and midwives;
- Stimulation of the in-service training as a legal obligation for the midwives, especially in the obstetrics units, and support of this process by the hospital as an employer;

Professional association

- Establishing Chamber of nurses, technicians and midwives;
- Establishing system for licensing-relicensing and continuous medical education for the midwives;
- Improving the records keeping of the personnel who perform midwifery activities, tracking of the staff practicing direct work with patients and providing public access to the registry of midwives;

Partnership with international organizations and civil society

- Further cooperation with related international associations, aiming to exchange knowledge, good practise and innovations;
- Further cooperation with non-governmental organizations, civil associations and patient associations, aiming to achieve synergy in the activities.

8. REFERENCES

1. Global Strategy for Women's and Children's Health. United Nations Secretary-General Ban Ki-Moon, The Partnership for Maternal, Newborn and Child Health, 2010.
2. Strengthening Nursing and Midwifery, Resolution to the WHA, EB128.R11, 21. January 2011.
3. Health Workforce Strengthening, Resolution to the WHA, EB128.R9, 21. January 2011.
4. International Confederation of Midwives: Global Standards for Midwifery Education (2010). Amended 2013.
5. International Confederation of Midwives: Essential competencies for basic midwifery practice 2010. Revised 2013.
6. International Confederation of Midwives: Global Standards for Midwifery Regulation (2011).
7. WHO, Global standards for the initial education of professional nurses and midwives, 2009.
8. Medical Research Council. 2000. Good Research Practice. Available from http://www.mrc.ac.uk
9. ASA (American Sociological Association). 1999. Code of Ethics and Policies and Procedures of the ASA Committee on Professional Ethics. ASA. Washington.
10. British Sociological Association. 2002. Statement of Ethical Practice of the British Sociological Association's. Available from: http://www.britsoc.co.uk/user_doc/ Statement of Ethical Practice.pdf
11. WHO, European Health for All Database. Available from: http://www.euro.who.int/en/data-and-evidence/databases/european-health-for-all-database-hfa-db
12. The State of World's Midwifery 2014: A Universal Pathway – A woman's right to health. UNFPA, WHO, International Confederation of Midwives.
13. Every Women, Every Child, 2015. The Global Strategy for Women's, Children's and Adolescent Health (2016-2030). Sustainable Development Goals.
14. International Confederation of Midwives: Comprehensive Midwifery Programme Guidance.
15. Ministry of Health of the Republic of Macedonia. National Strategy for Sexual and Reproductive Health of Republic of Macedonia 2010 – 2020.
16. Ministry of Health of the Republic of Macedonia. Safe Motherhood Strategy in the Republic of Macedonia 2010 – 2015 with action plan.
17. Action Plan for Reducing Maternal, Peri-natal and Infant Mortality 2012 – 2013.
18. Law on Health Protection. Official Gazette of RM, No. 43/2012 from 29.03.2012. Final change Official Gazette of RM, No. 37/2016 from 26.02.2016.
19. Draft Law on Nurses and Midwives. December 2015.
20. Law on Higher Education. Official Gazette of RM, No. 35/2008 from 14.03.2008. Final change Official Gazette of RM, No. 30/2016 from 19.02.2016.
21. Labour Law. Official Gazette of RM, No. 62/2005 from 28.07.2005. Final change Official Gazette of RM, No. 27/2016 from 15.02.2016.
22. Law on Public Administration. Official Gazette of RM, No. 27/2014 from 05.02.2014. Final change Official Gazette of RM, No. 27/2016 from 15.02.2016.
23. Collective agreement for health services of RM. Independent labor union on health, pharmacy and social protection of RM. May 2006.

Annex 1: Check-list for discussion in focus group

Category 1: Education / training		
Sub-category	**Main question**	**Additional question**
	1. Where do you work? What is your job position, what do you work? Are there midwives in your institution, which are not engaged in midwifery – obstetrics, community service etc.?	1.1. Give the number of: - midwifes in obstetrics unit ___ - community nurses (midwife or nurse) ____ - nurses in obstetrics unit in maternity ward ___ - midwifes working with primary health care gynecologist ___ - midwives in obstetrics unit, but not in maternity ward ___
Education before employment (pre-service training)	2. Which educational degree do you have (medical high school, higher vocational university education, etc.)?	2.1. Is your education with midwifery background (regardless of whether it is high school or university)? 2.2. If you have university education, which track/ specialization did you follow?
	3. Do you consider that the educational program (curricula) was well balanced in terms of acquiring both theoretical and practical knowledge and skills for further midwifery care?	3.1. Can you give an estimation of the ratio of theoretical and practical elements (for ex. 60% theory – 40% practice)? 3.2. Are you informed whether your educational program complied with the international standards (for example the ones given by the International Confederation of Midwives)?
	4. Did you, during your study, gain enough knowledge and practical training / skills for the following areas: - family planning, - ante-natal care, - normal vaginal delivery, - detection and treatment of emergencies in midwifery (ex. post-partum hemorrhage, hypertension) before they become life-threatening, - post-partum care of the woman, - care of the healthy newborn and infant, - breastfeeding, - post-abortion care of the woman, - competencies related to the socio-cultural and epidemiological context of the maternal and child health, cultural competencies for work with vulnerable groups of women in the first place?	
	5. Have you, after the employment, participated at any training (in- service training) on the topics related to midwifery practice / safe motherhood: - family planning, - ante-natal care, - normal vaginal delivery, - detection and treatment of emergencies in midwifery (ex. post-partum hemorrhage, hypertension) before they become life-threatening, - post-partum care of the woman, - care of the healthy newborn and infant, - breastfeeding, - post-abortion care of the woman, - competencies related to the socio-cultural and epidemiological context of the maternal and child health, cultural competencies for	

	work with vulnerable groups of women in the first place?	
Category 2: Competencies / work relations / clinical practice		
Sub-category	**Main question**	**Additional question**
	6. In your day-to-day activities do you work in the following areas: - family planning, - ante-natal care, - normal vaginal delivery, - detection of emergencies in midwifery (ex. post-partum hemorrhage), - post-partum care of the woman, - care of the healthy newborn and infant, - breastfeeding, - post-abortion care of the woman, - social determinants of health and cultural competencies for work with vulnerable groups of women?	6. 1. What are the particulars of your engagement related to family planning (providing information on the benefit of family planning, counseling of the women on modern contraceptive methods, on birth spacing, …. else)? 6. 2. What are the particulars of your engagement related to pregnancy follow-up (counseling on nutrition, blood pressure monitoring, providing information to the pregnant women on the necessary gynecological check-ups, recognition of risk signs, handling of usual symptoms in pregnancy…)? 6.3. Do you manage independently normal vaginal delivery? (question for midwives of obstetrics units)

		6.4. What are the particulars of your engagement in the post-natal period with the woman (what type of advices and services you provide) and the newborn (what type of advices and services you provide) - …family planning, breastfeeding, care of newborn…)?
	7. Do you feel trained/competent enough to perform your work duties, i.e. do you need any additional training?	7.1. What topic do you need training for mostly? 7.2. Do you need more theoretical or practical training?
Category 3: Organization of work / support		
Organization of work	8. Do you consider that the current work organization at the health institution you are employed in is supportive enough for the type of work you are engaged in? - are there enough human resources? - do you have enough time? - work protocols? - precisely defined work tasks? - referral systems? - support by the management? - else....name it	8.1. What elements of the work organization should be improved in the first place?
Professional motivation	9. Is there any type of motivation at your workplace - (financial, verbal praise, education, study visits abroad, participation in development of professional documents – guidelines, curricula, distinctions in the collective agreement or any other type of motivation – name it)?	9.1. What do you consider as the most important type of motivation?

Category 4: Policies / legislation		
Strategies, programs, regulations	10. Are you informed on existing strategic documents which support the midwifery profession (strategies, programs, regulations etc.)?	10.1. Have you been involved in the drafting process of any such document?
	11. Do you think that the midwifery profession is recognized enough in the political documents (strategies, programs, regulations etc.)?	11.1. Specify few such documents
Regulatory framework	12. Are you informed on the existing legislation related to midwifery – which laws regulate the nursing profession (ex. Law on health protection, Law on nursing, regulations, standards and norms, collective agreement etc.)?	
	13. Does the existing legislation regulate the following: a) define the work tasks, b) define the pre-conditions for registration and licensing, c) define the pre-conditions for re-licensing and continuity in the quality of their competencies, d) handle the complaints and maintain discipline, e) establish Code of ethical conduct?	

Category 5: Professional association		
	14. Is there a separate association on midwives? 15. Do you consider necessary and beneficial if there would be a separate association of midwives? (ex. – greater visibility of the profession, better status, greater involvement in policies creation, easier promotion of the necessary standards for work, educational curricula, better and easier cooperation with international institutions and related associations, else … ?	14.1. Do you think that the current position of the professional association protects enough the interests of the midwives?
Category 6: Strengths, limitations, barriers		
Strengths of the midwifery in Macedonia	16. What are the strengths of the midwifery in Macedonia?	
	17. What could be improved?	
Limitation factors for the quality and the development of the midwifery in Macedonia	18. What do you consider as limitation factors for the quality and the development of the midwifery in Macedonia? (ex. – the education process is not good enough; in-service training and study visits are not being offered; description of work tasks does not exist; the motivation is insufficient – which of these is most important?)	

	18. What do you consider as limitation factors for the quality and the development of the midwifery in Macedonia? (ex. – the education process is not good enough; in-service training and study visits are not being offered; description of work tasks does not exist; the motivation is insufficient – which of these is most important?)	
	19. What is the significance of the midwifery profession and why should it be strengthened? (ex. – promotion of the sexual and reproductive health, decrease of the maternal and infant mortality, promotion of the accessibility to health services for the vulnerable groups of women, gender equality, improved integration of health services)	
Category 7: Recommendations for promotion of the profession and improvement of its visibility		
	20. Suggest few recommendations for activities to be undertaken to improve the situation with the midwifery profession in Republic of Macedonia (quality, visibility, recognition) namely: - at the level of policies and legislation - at the level of education - at the level of work organization within the health system - motivation - cooperation with international organizations	
Is there something you'd like to add?		