

Operations Research Study 3:

Midwifery Scope of Practice and Opportunities for Task-Shifting in Northeast Syria (NES)

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A summary is provided in Arabic (Page 4 Short Summary, Pages 9-11 Summary)

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Short Summary

This study explores the current role of midwives in delivering Reproductive, Maternal, and Newborn Health (RMNH) services in NES and opportunities for task-shifting.

A survey among 174 midwives shows that the majority (80%) have more than 10 years' experience, and 75% of all midwives surveyed provide all or some of the components of the 6 main RMNH care packages including antenatal and postnatal care (ANC, PNC), skilled birth attendance (SBA), Emergency Obstetric and Newborn Care (EmONC), Family Planning and Reproductive Health Care. However, less than 60% of midwives are trained in all components of each care package which is lowest for Basic EmONC with only 22% of midwives trained in all 7 components of Basic EmONC. On the other hand, 1 in 4 midwives are not permitted to perform essential tasks despite being trained and confident to perform these.

Focus Group Discussions (FGD) with midwives, obstetrician-gynaecologists, and managers reveal the absence of a defined scope of practice or job description for midwives. The tasks a midwife is permitted to do vary according to geographic location, type of healthcare facility, and sector (public, private or NGO). While there is consensus on certain tasks such as supporting uncomplicated pregnancy and vaginal birth, there is no consensus regarding other essential components of care, with midwives often requiring permission from doctors to perform key tasks, particularly in emergency care.

In Key Informant Interviews (KII) stakeholders (including health authorities, NGOs, and professional associations) are agreed that task shifting is needed and there are opportunities to implement this in NES. Perceived barriers to task shifting include community acceptance, doctor reluctance due to concerns about midwife competency and potential loss of income, midwife workload concerns, and the absence of clear regulatory frameworks.

Based on dissemination of the findings of the study recommendations were developed by all stakeholders which advocate for collaborative efforts to define midwives' scope of practice, establish legal frameworks to support expanded responsibilities, disseminate clear job descriptions, provide ongoing training opportunities, develop standardized clinical guidelines, and conduct clinical audit. These efforts aim to elevate midwifery standards and enhance maternal and newborn health outcomes in NES

ملخص قصير

تستكشف هذه الدراسة الدور الحالي للقابلات في تقديم خدمات الصحة الإنجابية وصحة الأم والوليد في شمال شرق سوريا وفرص تحويل المهام.

يظهر الاستبيان الذي أجري على 174 قابلة أن الغالبية (80%) لديها أكثر من 10 سنوات من الخبرة، وأن 75% من جميع القابلات اللاتي شملهن الاستطلاع يقدمن كل أو بعض مكونات مجموعات الرعاية الصحية ال (الصحة الإنجابية وصحة الأم) الستة الرئيسية بما في ذلك رعاية ما قبل الولادة وما بعد الولادة، والقابلة الماهرة، ورعاية التوليد وحديثي الولادة في حالات الطوارئ، وتنظيم الأسرة ورعاية الصحة الإنجابية. ومع ذلك، يتم تدريب أقل من 60% من القابلات على جميع مكونات كل حزمة الرعاية، وهو أدنى مستوى بالنسبة لرعاية التوليد وحديثي الولادة في حالات الطوارئ الأساسية حيث تم تدريب 22% فقط من القابلات على جميع المكونات السبعة. من ناحية أخرى، لا يُسمح لواحدة من كل 4 قابلات بأداء المهام الأساسية على الرغم من تدريبها وثقتها في أداء هذه المهام.

تكشف مناقشات المجموعات المتخصصة (FGD) مع القابلات وأطباء أمراض النساء والتوليد والمديرين عن عدم وجود نطاق محدد للممارسة أو الوصف الوظيفي للقابلات. تختلف المهام التي يُسمح للقابلة بالقيام بها وفقًا للموقع الجغرافي ونوع منشأة الرعاية الصحية والقطاع (عام أو خاص أو منظمة غير حكومية). في حين أن هناك إجماع على مهام معينة مثل دعم الحمل غير المختلط والولادة المهبلية، لا يوجد إجماع بشأن المكونات الأساسية الأخرى للرعاية، حيث يجب على القابلات في كثير من الأحيان الحصول على إذن من الأطباء لأداء المهام الرئيسية، وحتى في بعض حالات الطوارئ.

في مقابلات مزودي المعلومات الرئيسيين، اتفق أصحاب العلاقة (بما في ذلك السلطات الصحية والمنظمات غير الحكومية والجمعيات المهنية) على أن هناك حاجة إلى تغيير المهام وهناك فرص لتنفيذ ذلك في شمال شرق سوريا. تشمل العوائق الملموسة التي تحول دون تحويل المهام قبول المجتمع، وإحجام الأطباء بسبب المخاوف بشأن كفاءة القابلة واحتمال فقدان الدخل، والمخاوف المتعلقة بعبء عمل القابلة، وغياب أطر تنظيمية واضحة.

بناءً على نشر نتائج الدراسة، تم تطوير توصيات من قبل جميع أصحاب المصلحة الذين يدعون إلى بذل جهود تعاونية لتحديد نطاق عمل القابلات، وإنشاء أطر قانونية لدعم المسؤوليات الموسعة، ونشر توصيف وظيفي واضح، وتوفير فرص التدريب المستمر، وتطوير مبادئ توجيهية سريرية موحدة. ، وإجراء التدقيق السريري. وتهدف هذه الجهود إلى رفع معايير القبالة وتعزيز النتائج الصحية للأمهات والأطفال حديثي الولادة في شمال شرق سوريا.

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Summary

Background

Midwives are the single largest group of healthcare providers for Reproductive Maternal and Newborn Health (RMNH) providing care at all levels of the health system in NES including at Primary Healthcare Centres (PHC), Comprehensive PHC and Hospital levels. The range of practice and variety of tasks that a midwife is required to carry out to meet the needs of women attending for care is wide-ranging and may include Antenatal Care (ANC), Postnatal Care (PNC), Skilled Birth Attendance, Basic-Emergency Obstetric Care (EmONC), Newborn Care, and Reproductive Health - including Family Planning, Gender Based Violence, Sexually Transmitted Infections, and basic Gynaecology. However, there is currently limited or no knowledge and understanding of legal frameworks and policies in place to guide scope of practice for midwives working in NES. In discussion with midwives, lack of central guidance is raised as being of concern generally to them as well as leading to delays in patients receiving the right care at the right time. At the same time, it is commonly agreed that there is an overall lack of human resources. Approaches to address this could include a) supporting an increase in the number of healthcare providers trained (pre-service training), b) improving the knowledge, skills, and competency of existing health care providers (in-service training), and c) facilitating healthcare providers to take up additional tasks through task-shifting.

Methods

A mixed methods approach was used including; A) a Midwifery Practice Survey to assess training, workplace setting, the range of services provided, ability to provide these, and whether permission (174 respondents), B) Focus Group Discussions (10 FGD) with Midwives and Obstetrician-gynaecologists to explore perceived need for, barriers and enablers to task shifting, and C) Key Informant Interviews (16 KII) with healthcare leaders regarding regulations for and scope of practice of Midwives and opportunities for task shifting. Quantitative data were analysed using simple descriptive statistics and qualitative data were analysed using a thematic framework approach with identification of illustrative quotes.

Findings

Midwifery Survey

The majority of midwives completed midwifery school (79.3%) and were accredited (through a variation of bodies) with almost 80% of the respondents having more than 10 years of working experience. 9.2% work unsupervised, 16.1% are supervised by a senior midwife and 27.1% are supervised by an obstetrician-gynaecologist or (non-specialist) general doctor. More than 75% of midwives reported providing all (or some of) the components of the 6 main care packages included in the continuum of care. However, a minority (<10%) provide all signal functions of Basic Emergency Obstetric and Newborn Care (BEmONC). For each care package the proportion of midwives trained in all components and therefore able to provide the complete care package

is less than 60% overall and ranges from 22.0% for BEmONC to a maximum of 57.7% for Skilled Birth Attendance. On average 89.5% of midwives providing care are confident they know how to do this. Training is associated with increased confidence. Between 9.1% (for Postnatal Care) and 22.0% (for BEmONC) of midwives are not able to provide components of a care package because of 'lack of permission' even though they are trained and confident to provide this.

Focus Group Discussions (FGD)

Midwives themselves as well as obstetrician-gynaecologists and managers, report there is no defined scope of practice for midwives and that this varies according to the geographic area (rural or urban), type of healthcare facility to which they are posted (PHC, CPHC or Hospital) and sector (public, private or NGO). Some organisations have written (clinical) guidelines or protocols but mostly midwives receive verbal instructions regarding their role at the start of their employment from the Manager of the organisation responsible for the healthcare facility. In FGD no consensus was reached on which tasks a midwife can and cannot do (allowed, not allowed) except for supporting '*normal vaginal birth*'. There is agreement and recognition that a midwife can and does carry out more tasks in practice. Midwives often require permission from doctors to be able to carry out key tasks including regarding providing emergency care. BEmONC signal functions such as providing magnesium sulphate, assisted vaginal delivery, manual vacuum aspiration or D&C for retained products of conception are considered 'not allowed' despite the realisation that this is much needed especially when there is no doctor (obstetrician-gynaecologist or relevant general doctor). Neonatal resuscitation is only recently added to midwives' tasks. Pain relief during labour using Pethidine cannot be provided by midwives. Similarly, midwives are not permitted to care for women with a previous CS or any other obstetric complication. Midwives are expected to provide antenatal and postnatal care (but there is no consensus) as well as family planning (but not all components).

Task shifting is a new concept for most but seen as 'useful' especially because of the shortage of healthcare providers. Although midwives are worried task shifting would be '*blocked*' by obstetrician-gynaecologists, the latter are in fact mostly in favour of task shifting. However, all are agreed that this would need to be developed after consultation with a wide group of stakeholders, would require central agreement, and a legal framework to provide midwives with the security to carry out an expanded range of tasks. The important of '*getting the community on-side*' was also noted.

Key Informant Interviews (KII)

There is general agreement among KI that there is no defined scope of practice for midwives working in the NES. In practice their tasks are decided by the organisation for which they work and is dependent on the level of healthcare facility they work in and/or the presence of a doctor or obstetrician-gynaecologist. All KI agree there is a need for task shifting (shortage of human

resources, lack of services especially in remote areas) and there are opportunities to introduce task shifting in NES. There is a general realisation that many midwives, the NGO sector, and the donors would favour this. In addition, Health Authorities are collaborative and would accept task shifting. There are however also barriers which are perceived to include: i) the community not accepting this, ii) doctors not agreeing to this because midwives may not be competent and/or doctors may lose income, iii) midwives not accepting this because of already high workloads and in the absence of clear regulatory frameworks, and iv) the need for increased salary for midwives if they take on more responsibilities. Consultation will be needed with all stakeholders to agree the frameworks within which task shifting can be implemented. Additional training and supervision are also seen as important if task shifting is to succeed.

Discussion and Recommendations

This study for the first time examines the scope of practice of midwives and opportunities for task shifting. The findings of this study were shared and discussed with a wide group of stakeholders including representatives (clinical and non-clinical) from all participating Partners during a dissemination workshop in NES. There is general enthusiasm for the introduction of task-shifting for midwives and recommendations for implementation were developed including to:

- Agree the scope of practice of Midwives through collaborative meetings and workshops with all health actors with a view to expanding midwives' responsibilities.
- Establish a legal framework with protection clauses to support and expanded scope of practice for midwives.
- Develop clear Job Descriptions outlining the tasks and duties of midwives. Disseminate this widely including to managers, midwives, and supervisors working in all three sectors (public, NGO and private).
- Provide ongoing training opportunities for midwives to improve skills and ensure competency-based practice.
- Develop standardized protocols and guidelines for midwives' tasks, including administering medications and handling emergency cases.
- Set standards for service delivery, conduct clinical audits, and prioritize areas for task shifting or role clarification.

Despite anticipated challenges the overall aim is to support task shifting and integrate midwives more effectively into the healthcare system. The recommendations collectively aim to elevate midwifery standards, ultimately improving maternal and newborn health outcomes in the region.

الدراسة الثالثة

نطاق عمل القابلات وفرص تحويل المهام في شمال شرق سوريا

ملخص

خلفية

القابلات هن أكبر مجموعة من مقدمي الرعاية الصحية للإنجابية للأمهات والأطفال حديثي الولادة (RMNH) حيث يقدمون الرعاية على جميع مستويات النظام الصحي في شمال شرق سوريا بما في ذلك مراكز الرعاية الصحية الأولية ومستويات الرعاية الصحية الأولية الشاملة والمستشفيات. إن نطاق الممارسات والمهام المتنوعة التي يتعين على القابلة القيام بها لتلبية احتياجات النساء اللاتي يحضرن للرعاية واسع النطاق وقد يشمل الرعاية السابقة للولادة، ورعاية ما بعد الولادة، والقابلات الماهرات، والرعاية الأساسية - رعاية التوليد في حالات الطوارئ، ورعاية الأطفال حديثي الولادة، والصحة الإنجابية - بما في ذلك تنظيم الأسرة، والعنف القائم على نوع الجنس، والأمراض المنقولة جنسياً، وأمراض النساء الأساسية. ومع ذلك، هناك حالياً معرفة وفهم محدودان أو معدومان للأطر والسياسات القانونية المعمول بها لتوجيه نطاق الممارسة للقابلات العاملات في شمال شرق سوريا. في المناقشة مع القابلات، أثير الافتقار إلى التوجيه المركزي باعتباره مصدر قلق لهن بشكل عام، فضلاً عن أنه يؤدي إلى تأخير حصول المرضى على الرعاية المناسبة في الوقت المناسب. وفي الوقت نفسه، من المتفق عليه عموماً أن هناك نقصاً عاماً في الموارد البشرية. يمكن أن تشمل أساليب معالجة ذلك (أ) دعم زيادة عدد مقدمي الرعاية الصحية المدربين (التدريب قبل الخدمة)، (ب) تحسين المعرفة والمهارات والكفاءة لمقدمي الرعاية الصحية الحاليين (التدريب أثناء الخدمة)، (ج) تسهيل مقدمي الرعاية الصحية لتولي مهام إضافية من خلال تحويل المهام.

المنهجية

تم استخدام نهج الأساليب المختلطة بما في ذلك؛ (أ) إستبيان ممارسات القبالة لتقييم التدريبات، وتنظيم مكان العمل، ومجموعة الخدمات المقدمة، والقدرة على تقديمها، وما إذا كان هناك الإذن بذلك (174 مشاركاً)، (ب) مناقشات المجموعات المتخصصة (10 مجموعات متخصصة) مع القابلات وأطباء النساء والتوليد لاستكشاف الحاجات و العوائق والعوامل المساعدة في تحويل المهام، و (ج) مقابلات مع مزودي المعلومات (16 مزود معلومات رئيسي) مع مدراء الرعاية الصحية فيما يتعلق باللوائح ونطاق ممارسة القابلات وفرص تحويل المهام. تم تحليل البيانات الكمية باستخدام إحصائيات وصفية بسيطة وتم تحليل البيانات النوعية باستخدام منهج الإطار الموضوعي مع تحديد الاقتباسات التوضيحية.

النتائج

استبيان القابلات

أكملت غالبية القابلات مدرسة القبالة (79.3%) وتم اعتمادهن (من خلال مجموعة متنوعة من الهيئات) مع ما يقرب من 80% من المشاركات لديهن أكثر من 10 سنوات من الخبرة العملية. 9.2% يعملون دون إشراف، و16.1% تحت إشراف قابلة قديمى، و27.1% تحت إشراف طبيب عام متخصص في أمراض النساء والتوليد. أبلغت أكثر من 75% من القابلات عن تقديم جميع (أو بعض) مكونات حزم الرعاية الرئيسية الست المدرجة في سلسلة الرعاية المستمرة. ومع ذلك، هناك أقلية (أقل من

10%) تقدم جميع الوظائف الخاصة بالرعاية الأساسية للتوليد وحديثي الولادة في حالات الطوارئ. بالنسبة لكل حزمة رعاية، تقل نسبة القابلات المدربات في جميع المكونات وبالتالي القادرات على تقديم حزمة الرعاية الكاملة عن 60% بشكل عام وتتراوح من 22.0% للرعاية الأساسية للتوليد وحديثي الولادة في حالات الطوارئ إلى حد أقصى قدره 57.7% للقابلات الماهرات. في المتوسط، 89.5% من القابلات اللاتي يقدمن الرعاية واثقات من أنهن يعرفن كيفية القيام بذلك. يرتبط التدريب بزيادة الثقة. ما بين 9.1% (لرعاية ما بعد الولادة) و22.0% (للرعاية الأساسية للتوليد وحديثي الولادة في حالات الطوارئ) من القابلات غير قادرات على توفير مكونات حزمة الرعاية بسبب "عدم الحصول على الإذن" على الرغم من أنهن مدربات وواثقات من توفير الخدمات.

مناقشات المجموعات المتخصصة (FGD)

تشير القابلات أنفسهن وكذلك أطباء أمراض النساء والتوليد والمديرون إلى أنه لا يوجد نطاق محدد لممارسة القابلات وأن هذا يختلف وفقًا للمنطقة الجغرافية (ريفية أو حضرية)، ونوع مرفق الرعاية الصحية الذي يتم إرسالهن إليه (الرعاية الصحية الأولية، أو الرعاية الصحية الشاملة أو المستشفى) والقطاع (عام أو خاص أو منظمة غير حكومية). قامت بعض المنظمات بكتابة إرشادات أو بروتوكولات (سريرية) ولكن معظم القابلات يتلقين تعليمات شفوية بخصوص دورهن في بداية عملهن من مدير المنظمة المسؤولة عن مرفق الرعاية الصحية. في مجموعة التركيز، لم يتم التوصل إلى توافق في الآراء بشأن المهام التي يمكن للقابلة القيام بها والتي لا يمكنها القيام بها (المسموح بها وغير المسموح بها) باستثناء دعم "الولادة المهبلية الطبيعية". هناك اتفاق واعتراف بأن القابلة يمكنها القيام بمزيد من المهام في الممارسة العملية، وهي تقوم بذلك بالفعل. غالبًا ما تحتاج القابلات إلى إذن من الأطباء حتى تتمكن من القيام بالمهام الرئيسية بما في ذلك توفير الرعاية في حالات الطوارئ. تعتبر وظائف الرعاية الأساسية للتوليد وحديثي الولادة في حالات الطوارئ مثل توفير كبريتات المغنيسيوم، أو الولادة المهبلية المساعدة، أو الشفط اليدوي أو التوسيع والكشط لمنتجات الحمل المحتجزة "غير مسموح بها" على الرغم من أن هناك إدراك الحاجة الماسة إلى ذلك خاصة في حالة عدم وجود طبيب (طبيب أمراض النساء والتوليد أو طبيب عام ذو خبرة). لم تتم إضافة إنعاش الأطفال حديثي الولادة إلى مهام القابلات إلا مؤخرًا. لا يمكن للقابلات توفير تخفيف الألم أثناء المخاض باستخدام البيثيدين. وبالمثل، لا يُسمح للقابلات برعاية النساء اللاتي يعانين من قيصرية سابقة أو أي مضاعفات توليدية أخرى. من المتوقع أن توفر القابلات الرعاية السابقة للولادة وبعدها (ولكن لا يوجد إجماع) بالإضافة إلى تنظيم الأسرة (ولكن ليس جميع المكونات).

يعد تحويل المهام مفهومًا جديدًا بالنسبة لمعظم الأشخاص، ولكنه يُنظر إليه على أنه "مفيد" خاصة بسبب النقص في مقدمي الرعاية الصحية. على الرغم من أن القابلات يشعرن بالقلق من أن تحويل المهام قد يتم "حظره" من قبل أطباء النسائية والتوليد، إلا أن أطباء أمراض النسائية والتوليد يؤيدون في الواقع تحويل المهام. ومع ذلك، فقد اتفق الجميع على أن هذا الأمر سيحتاج إلى تطوير بعد التشاور مع مجموعة واسعة من أصحاب المصلحة، وسيطلب اتفاقًا مركزيًا وإطارًا قانونيًا لتوفير الأمن للقابلات للقيام بمجموعة واسعة من المهام. كما تمت الإشارة إلى أهمية "جعل المجتمع يقف إلى جانبنا".

مزودي المعلومات الرئيسيين (KII)

هناك اتفاق عام بين مزودي المعلومات على أنه لا يوجد نطاق محدد لممارسة القابلات العاملات في شمال شرق سوريا. ومن الناحية العملية، يتم تحديد مهامهم من قبل المنظمة التي يعملون بها وتعتمد على مستوى منشأة الرعاية الصحية التي يعملون فيها و/أو وجود طبيب أو طبيب النسائية والتوليد. يتفق جميع مزودي المعلومات على أن هناك حاجة إلى تحويل المهام (نقص الموارد البشرية، ونقص الخدمات خاصة في المناطق النائية) وهناك فرص حقيقية لإدخال تحويل المهام في شمال شرق سوريا. هناك إدراك عام بأن العديد من القابلات وقطاع المنظمات غير الحكومية والجهات المانحة سيفضلون ذلك. بالإضافة إلى ذلك، فإن السلطات الصحية متعاونة وتقبل تغيير المهام. ومع ذلك، هناك أيضًا عوائق يُنظر إليها على أنها تشمل:

1) عدم قبول المجتمع لذلك، 2) عدم موافقة الأطباء على ذلك لأن القابلات قد لا يتمتعن بالكفاءة و/أو قد يؤثر على الدخل، 3) عدم قبول القابلات لذلك بسبب أعباء العمل المرتفعة بالفعل وفي غياب أطر تنظيمية واضحة، و4) الحاجة إلى زيادة رواتب القابلات إذا تحملن المزيد من المسؤوليات. وستكون هناك حاجة إلى التشاور مع جميع أصحاب المصلحة للاتفاق على الأطر التي يمكن من خلالها تنفيذ تحويل المهام. كما يُنظر إلى التدريب والإشراف الإضافيين على أنهما مهمان إذا أردنا نجاح عملية نقل المهام.

المناقشة والتوصيات

تبحث هذه الدراسة لأول مرة في نطاق ممارسة القابلات وفرص تغيير المهام. تمت مشاركة نتائج هذه الدراسة ومناقشتها مع مجموعة واسعة من أصحاب العلاقة بما في ذلك ممثلين (سريريين وغير سريريين) من جميع الشركاء المشاركين خلال ورشة عمل في شمال شرق سوريا. هناك حماس عام لإدخال نظام تحويل المهام للقابلات وتم وضع توصيات للتنفيذ بما في ذلك ما يلي:

- الاتفاق على نطاق ممارسة القابلات من خلال الاجتماعات وورش العمل التعاونية مع جميع الجهات الفاعلة الصحية بهدف توسيع مسؤوليات القابلات.
- إنشاء إطار قانوني يتضمن بنود الحماية لدعم وتوسيع نطاق عمل القابلات.
- وضع وصف وظيفي واضح يحدد مهام وواجبات القابلات. نشر هذا على نطاق واسع بما في ذلك المديرين والقابلات والمشرفين العاملين في القطاعات الثلاثة (العام والمنظمات غير الحكومية والخاصة).
- توفير فرص التدريب المستمر للقابلات لتحسين المهارات وضمان الممارسة القائمة على الكفاءة.
- وضع بروتوكولات موحدة ومبادئ توجيهية لمهام القابلات، بما في ذلك إدارة الأدوية والتعامل مع حالات الطوارئ.
- وضع معايير لتقديم الخدمات، وإجراء عمليات التدقيق السريرية، وتحديد أولويات مجالات تحويل المهام أو توضيح الدور.

على الرغم من التحديات المتوقعة، فإن الهدف العام هو دعم تحويل المهام ودمج القابلات بشكل أكثر فعالية في نظام الرعاية الصحية. وتهدف التوصيات مجتمعة إلى رفع معايير القبالة، مما يؤدي في نهاية المطاف إلى تحسين النتائج الصحية للأمهات والأطفال حديثي الولادة في المنطقة.

Background

In Northeast Syria (NES), midwives are the single largest group of healthcare providers for Reproductive Maternal and Newborn healthcare for all levels of the health system. In practice this includes all components of the Continuum of Care for women including 1) Antenatal Care (ANC), 2) Postnatal Care (PNC), 3) Skilled Birth Attendance, 4) Basic- Emergency Obstetric Care (EmONC), 5) Newborn Care, and 6) Reproductive Health - including Family Planning, Gender Based Violence, Sexually Transmitted Infections and Gynaecology.¹

The health system in NES has 3 main levels – Primary Health Care Centres (PHC) at which outpatient care is provided including Family Planning, Antenatal and Postnatal Care; Comprehensive PHC (CPHC) at which Skilled Birth Attendance and Basic Emergency Obstetric and Newborn Care (BEmONC) is also expected to be provided; and Hospitals which are expected to provide the full range of Reproductive Maternal and Newborn Services including specialist care.^{2,3,4} The majority of women living in NES access care for vaginal birth at a healthcare facility. Midwives are also the main providers of contraception and are consulted for a range of reproductive health problems including for miscarriage, vaginal discharge, and lower abdominal pain.

In practice the range of practice and variety of tasks that a midwife is required to carry out to meet the needs of women attending for care is wide-ranging. A midwife's scope of practice may vary with place of work. In a rural area with poor referral pathways, midwives may be the only cadre able to provide emergency care and/or stabilise a woman or baby for referral. In some cases, the scope of practice of a midwife is determined and supported by her direct employer. Different NGO partners implementing healthcare and employing staff have different staff policies and job descriptions including for midwives in their employment.

There is currently no Midwifery Association operational and there is limited or no knowledge and understanding of legal frameworks and policies in place to guide practice for midwives working in NES. In discussion with midwives, lack of central guidance is raised as being of concern generally. In addition, there are multiple case stories where absence of instructions or guidance to be able to provide certain tasks has resulted in delays in patients receiving the right care at the right time and/or in adverse outcome for the mother and/or baby. Examples provided by midwives include tasks such as assisted vaginal delivery, giving IM or IV magnesium sulphate in

¹ The Partnership for Maternal, Newborn and Child Health. Essential Interventions, Commodities and Guidelines for Reproductive, Maternal, Newborn and Child Health. 2011, Geneva, Switzerland

² EF Essential Health Services Package (EHSP) for Northeast Syria (NES) focused on Reproductive Maternal Newborn and Child Health (RMNCH) – July 2022 – Prepared by N van den Broek

³ PCI An Essential Primary Health Services Package for North East Syria November 2022

case of pre-eclampsia, IM or IV antibiotics in case of severe infection or sepsis and/or screening and referral for Gender-Based Violence (GBV).⁴

The ability of a country to meet its health goals depends largely on the knowledge, skills, motivation, and deployment of the people responsible for organizing and delivering health services.⁵ Across the NES it is commonly agreed that there is an overall lack of human resources and a need to build capacity of existing staff. Factors that contribute to this shortage of staff and lack of capacity include an inadequate number of people being trained (e.g., insufficient pre-service training opportunities for midwifery in NES), maldistribution of deployment (maternity services are concentrated in urban areas, the private sector is growing and provides high financial benefits for staff), migration of health workers within and out of NES ('brain drain' of medical staff, relocation of midwives to areas that are secure) and limited opportunity for updating skills or career progression.

Approaches used to address the shortage of healthcare providers globally include:

- i) increase the number of healthcare providers (pre-service training, accreditation, and appointment),
- ii) provide training and support to facilitate healthcare workers to take up additional tasks through task-shifting ⁶ (e.g., midwives trained to carry out tasks otherwise reserved for obstetrician-gynaecologists), and,
- iii) improve the knowledge, skills, and competency of existing health care providers through in-service training.

Ensuring an adequate number of health workers is not sufficient. Healthcare providers must be competent and motivated to deliver high quality effective care that is appropriate and acceptable to the socio-cultural expectations of the population and adequately supported by the health system.

Actions for assessing and strengthening the recruitment, distribution, retention, and productivity of the health workforce are important and may include adopting new approaches to pre-service and in-service training; strengthening workforce management; establishing or improving incentives for addressing distribution and retention challenges; or task-shifting (delegating tasks, where appropriate, to less specialized health workers). For RMNCH specifically several large reviews have highlighted the need to support healthcare providers to provide sufficient effective

⁴ EF Reports of Evaluation of TOT and Cascade Training 2022-2023

⁵ WHO 2006 The World Health Report – Working together for Health. World Health Organization, Geneva Available at: <http://www.who.int/whr/2006/en/index.html>

⁶ World Health Organisation. WHO recommendations: optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting. Geneva: World Health Organisation; 2012.

and quality care including through training and certification, supportive supervision, and task-shifting.^{6,7,8}

The **Objective** of this study is to explore factors that determine the current scope of practice of midwives and identify opportunities and mechanisms to support task-shifting to improve the availability and quality of Reproductive, Maternal and Newborn Care in NES.

Research Questions Developed

Main Research Questions

- What is the current scope of practice of midwives working in NES?
- Which areas of care expected to be provided by midwives working in NES are included in their pre-service training?
- Are there specific areas of care midwives are required to provide for which capacity needs to be developed?
- What are the areas of care for which task-shifting would be beneficial?
- What are the mechanisms for, and opportunities to, support task-shifting for midwives working in NES?

Methods

A mixed methods approach was used including A) a Midwifery Practice Survey, B) Focus Group Discussions (FGD) with Midwives and Obstetrician-gynaecologists and C) Key Informant Interviews (KII) with healthcare leaders.

Midwifery Practice Survey

A survey was conducted among midwives working in the NES. A preliminary list of contact details for up to 100 midwives who had attended in-service training was available. Snowballing technique was used to reach as many midwives as possible. Around 80% of healthcare provided in NES is supported by international and national NGOs and Partners⁹ with up to 200 midwives employed.¹⁰ Additionally midwives working in the public and private sector were contacted. The questionnaire included sections on work environment, training received, years of experience and

⁷ Negero MG, Sibbritt, Dawson A. How can Human resources for health interventions contribute to sexual, reproductive, maternal and newborn healthcare quality across the continuum in low- and lower-middle-income countries. A systematic Review. *Human Resources for Health* 2021; 19:54

⁸ Bolan N et al Human Resources for Health-related Challenges to Ensuring Quality Newborn Care in low- and middle-income countries – a Scoping Review *Global Health: Science and Practice* 2021; 9:1 160-176

⁹ Health Working Group NES – by January 2023

¹⁰ Preliminary survey of Partners conducted by EF staff February 2023

care practices. The questionnaire was piloted with 10-15 midwives to see if amendments were needed with minor adjustments to language required. The questionnaire was then administered using Kobo Toolbox.¹¹

Focus Group Discussions (FGD)

FGD were conducted with Midwives and Obstetrician-gynaecologists at healthcare facilities from across the NES including at PHC, CPHC, Hospital level; in rural and urban settings and working in private practice and/or having their own clinic. FGDs were conducted at a time that suited participants and were outside of their working hours.

A Topic Guide (*available on request*) including questions on knowledge and experiences regarding the scope of practice of midwives, whether this was defined and by whom, how supervision of midwifery work is organised in NES and whether they were aware of any regulatory framework, policies, or guidelines. This was followed by an exploration and discussion of tasks that doctors could perform but midwives might not be able or allowed to perform, and possible reasons for this. Probing questions included for tasks such as provision of magnesium sulphate, antibiotics, conducting an assisted vaginal delivery and starting a blood transfusion. Participants were asked if they knew about task shifting, including if they had experience of this, their perceptions on the need and/or opportunities for this, what would be needed to support task shifting and what might hinder implementation.

Key Informant Interviews (KII)

KII were conducted with a range of stakeholders including Health Coordinators, RMNCH Focal Points, staff involved in pre-service and in-service training of Midwives and Obstetrician Gynaecologists, Members and Faculty of Professional Associations in NES and Health Managers and Leaders. Where possible Regional and International Stakeholders with experience and knowledge of scope of practice of Midwives working in the region were approached. A snowballing technique was used to identify further Key Informants.

A topic guide was used (*available on request*) with separate sections to discuss was developed to guide the discussions including regarding whether there was an agreed scope of practice for midwives and how this was decided and by whom, which tasks midwives could or could not do and whether there were policies or guidelines in place for this, whether KI knew about task shifting, if this might be applicable in the NES, perceived barriers or enablers to support this, and what would be needed to support the introduction and implementation of task shifting. Additional questions pertained to availability and functioning of professional bodies or regulatory

¹¹ KoboToolbox - <https://www.kobotoolbox.org>

services for midwives, oversight of pre- and in-service training and related to management and organisation of staff including midwives at healthcare facility level including oversight of responsibilities and performance.

Data collection

For quantitative data (Practice Survey) data were checked and cleaned by a dedicated Research Officer. Each FGD was supported by two people including a Facilitator and a Note taker. With participants' consent FGD were recorded. KII were conducted by Zoom and were recorded with notes taken during interview.

Sample size

We expected between 75-100 midwives to complete the Practice Survey. An estimated 10 FGD with Midwives and Obstetricians and 10 KII with healthcare Leaders and Managers were expected to be required to reach saturation.

Data Analysis

Descriptive data analysis was used to summarise the findings for the Practice Survey. For qualitative data (FGD and KII) simple summaries were obtained and transcripts were developed (manually in Arabic and then translated to English). These were reviewed to identify key themes and representative quotes. Information obtained was further analysed and summarised using simplified thematic framework analysis.

Ethical considerations

For quantitative data, data entry and storage were done using a dedicated password protected computer. For the Practice Survey no information was collected that could be used to identify or locate the respondents. An explanation of the study was included in the invitation which was sent out by WhatsApp. A consent box was included in the questionnaire form. All participants of FGD and KII were explained the purpose and nature of the study and asked to provide consent. General characteristics of FGD and KII participants were recorded at the start of each session and are presented in aggregated format with no person identification or location data recorded for any of the participants.

All data collection forms and recorded FGD and KII were destroyed after the data was cleaned, and the data analyses completed.

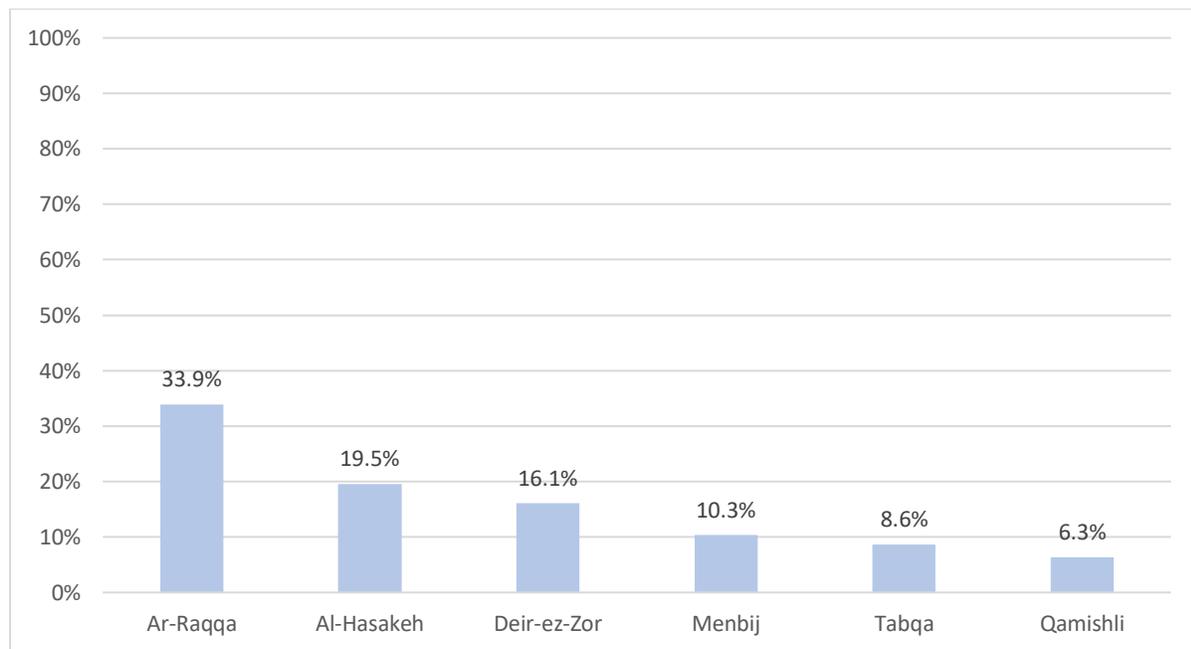
The funding agency was not involved in the design and conduct of the study. The Practice survey and KII were completed voluntarily. Participants of FGD were offered light refreshments and transport costs where needed.

Results

A) Midwives' Survey

A total of 174 questionnaires were completed out of 210 invitations sent giving a response rate of 82.9% and with good representation across the various geographical areas in NES. (Figure 1)

Figure 1: Geographical Area of Work



Midwives who completed the survey work in a variety of settings with most having one main place of work (73.6%, 128/174) but up to 1 in 4 midwives work at multiple sites (26.4%, 46/174). The majority of respondents are attached to a healthcare facility with roughly equal number working at Hospital level (35.1%), CPHC level (30.5%) or PHC level (29.9%).

13 out of 174 (7.5%) midwives also conduct home deliveries and 3 (1.7%) reported providing other maternity care (ANC, PNC) at home. About 1 in 5 (20.7%) work in private practice and/or have their own clinic and 10.3% of survey respondents work primarily in a camp setting.

Training and Years of Experience

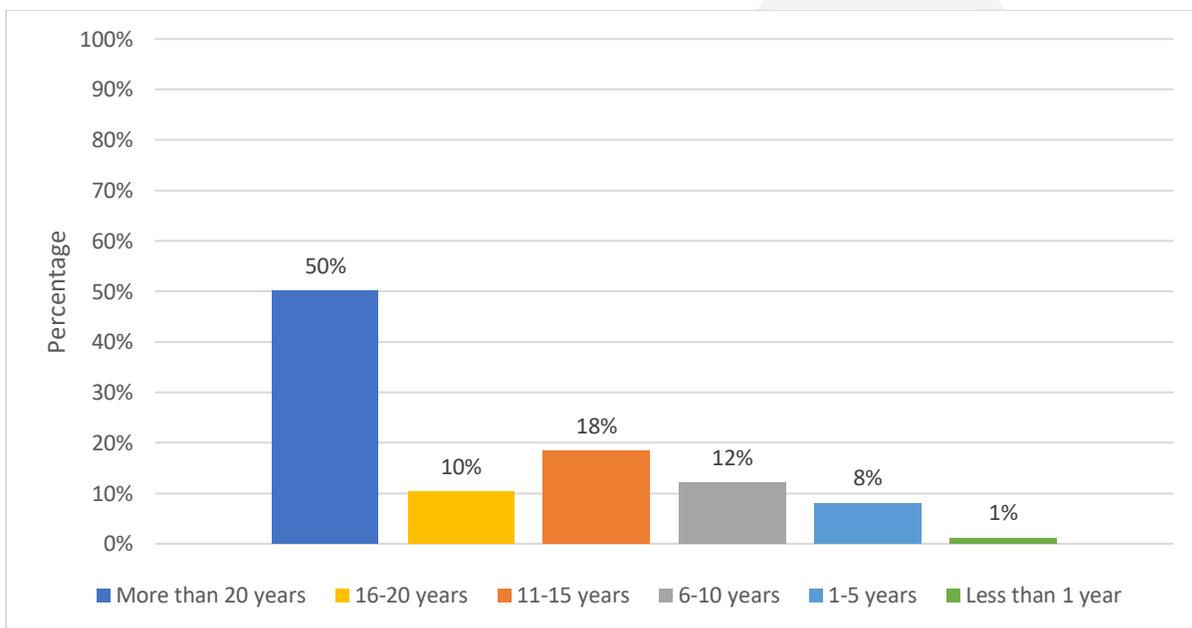
The question on 'highest level of training' was difficult to answer and yielded a wide variety of answers. The majority of midwives (79.3%) reported they had completed a Midwifery School

although with a variety of qualifications (Midwifery School, ‘Master’ of Midwifery¹², Nursing qualification working as a Midwife) and with different Registrations.¹³ One midwife reported working but had not completed her training, and 3 had trained under an obstetrician-gynaecologist and were considered ‘Daya’ (3/174, 1.7%). The median (interquartile range) for number of years of training was 3.5 (2,5) years.

The median (interquartile range) age of midwives who completed the questionnaire was 42 (37,46) years and most of the midwives who responded to the questionnaire were experienced with 78% having worked for more than 10 years. (**Figure 2**)

89.1% of the respondents had attended a training workshop (update training) of which 87.1% (135/155) in the last 12 months. The highest proportion of those who had not received update training were working in Menbij (10/19).

Figure 2: Number of years working in clinical practice



¹² A ‘Masters’ in Midwifery in this setting does not imply an MSc but generally means a study in Nursing was completed after which 1 year of Midwifery (specialisation) training is completed.

¹³ Information obtained at the time indicates that the Ministry of Health (WoS -Damascus) directs the Midwifery Schools, the Ministry of Higher Education (WoS - Damascus) directs the Nursing Schools and all curriculums used are in line with the central WoS curriculum. However, some training is registered only in NES. All staff are expected to register with the relevant authorities in Damascus.

Supervision of Midwives

Midwives are supervised by a variety of other staff; 27.6% (48/174) by a Program or Health Authority Manager, 16.1% (28/174) by a Senior Midwife, 21.8% (38/174) by a Doctor-in-Charge and 25.3% (44/174) are supervised by an obstetrician-gynaecologist. Almost 1 in 10 (16/174;9.2%) do not receive any supervision.

Supervision depends on geographical location – with 21/59 midwives working in the Raqqa area supervised by a senior Midwife; in Hassakeh (20/34) or Kobani (5/90) this was most frequently the Doctor/Obstetrician Gynaecologist and in Tabqa (5/15) and Quamishli (5/11) this was the Health Authority Manager.

Table 1: Supervision of Midwives

Who is the main person who supervises your practice?	Count	Proportion
Other	9	5.2%
Administrative Manager	3	
University	5	
General Supervisor	1	
No-one in particular	16	9.2%
Senior Midwife	28	16.1%
The Doctor in charge	38	21.8%
Health Authority Manager	39	22.4%
The Obstetrician-Gynaecologist in charge	44	25.3%
Grand Total	174	100%

Scope of Work

The majority of midwives report providing all the care packages of the continuum of care. For each of the 6 main care packages, the proportion of respondents who reported providing this in practice was; 93.7% for Antenatal Care (ANC; 163/174), 90.2% for Postnatal Care (PNC; 157/174), 85.1% for Skilled Birth Attendance (SBA; 148/174), 82.2% for Family Planning (FP; 143/174) and 75.3% for basic Gynaecological Services/Reproductive Health (RH; 131/174). This was much lower for Basic Emergency Obstetric Care (BEmONC) with less than 10% of Midwives provide all 7 designated signal functions of BEmONC. (Table 2).

Only 6.8% (12/174) of midwives reported providing only one area of the continuum of care which is most frequently Skilled Birth Attendance (6/12) followed by provision of Antenatal care (3/12).

For each individual care package, the proportion of midwives providing all components is generally lower. This was assessed in more detail in other sections of the questionnaire. (See Figure 4 and subsequent below).

Midwives were asked which essential drugs they could prescribe themselves. The proportion of midwives who can prescribe is lower than the proportion ‘providing’ as provision means midwives can give a drug after it is prescribed by a doctor.

Table 2: Provision of the Care Packages of the Continuum of Care

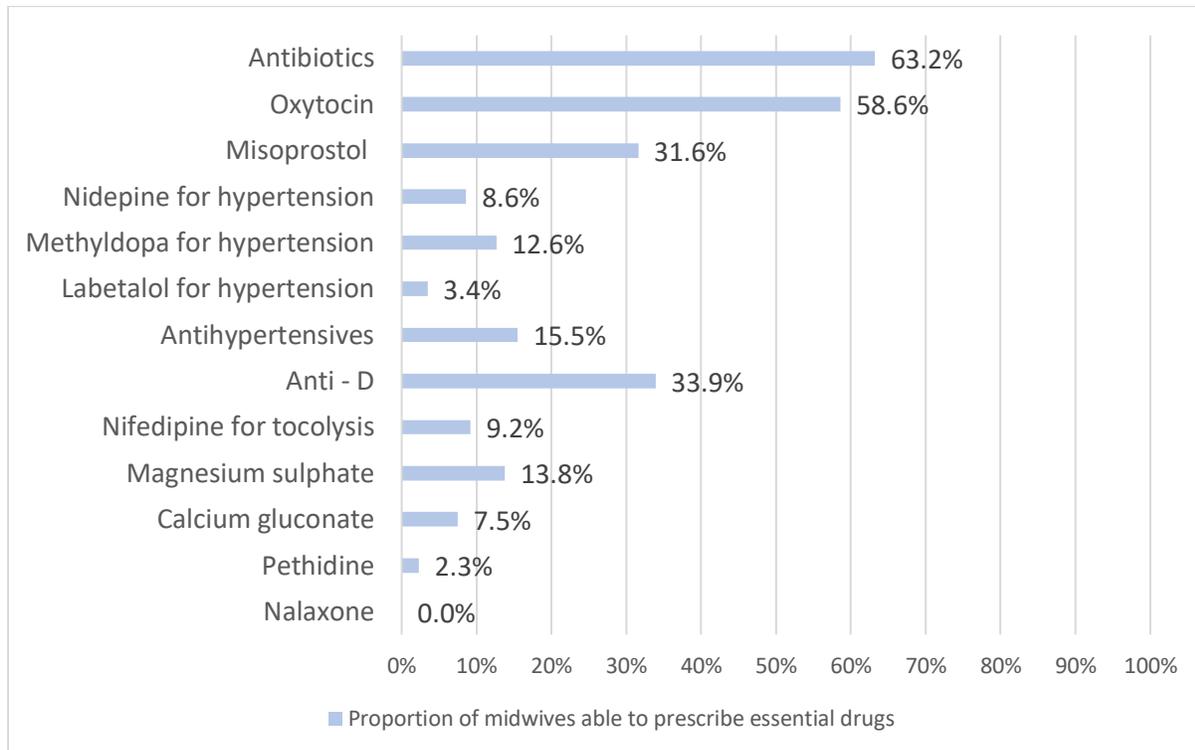
Continuum of Care Package	Number of Midwives who reported providing this care package	Proportion of Midwives
Antenatal Care (ANC)	163	93.7%
Skilled Birth Attendance	148	85.1%
BEmONC		
Iv/im oxytocics	139	79.9%
Iv/im antibiotics	110	63.2%
Iv/im magnesium sulphate	48	27.6%
Manual removal of retained placenta	140	80.5%
Assisted vaginal delivery (ventouse)	48	27.6%
Manual Vacuum Aspiration (MVA or D&C) of retained products of conception	12	6.9%
Newborn resuscitation (using bag and mask)	146	83.9%
Postnatal Care (PNC)	157	90.2%
Family Planning	143	82.2%
Reproductive Health – Basic Gynaecology	131	75.1%
Other		
Breast cancer Screening	77	44.3%
Assist at CS	29	16.7%

Figure 3 provides data for a midwife’s ability to both prescribe a drug herself and provide it to the patient. Noteworthy is that only 4 midwives could do so for Pethidine (2.3%) for pain relief during labour and none (0.0%) could prescribe and give Naloxone which is required for resuscitation of a baby if a baby is affected by Pethidine given to the mother.

In sharp contrast, 63.2% (110/174) of midwives can prescribe and give antibiotics but only 13.8% (24/174) can do this for magnesium sulphate which is a lifesaving drug in case of pre-eclampsia and eclampsia.

Just over half of all midwives (58.6%) can independently prescribe and give oxytocin which is the main component of active management of the third stage for all vaginal births.

Figure 3: Proportion of Midwives able to prescribe essential drugs during labour and birth



Components of care packages provided and for which midwives are trained

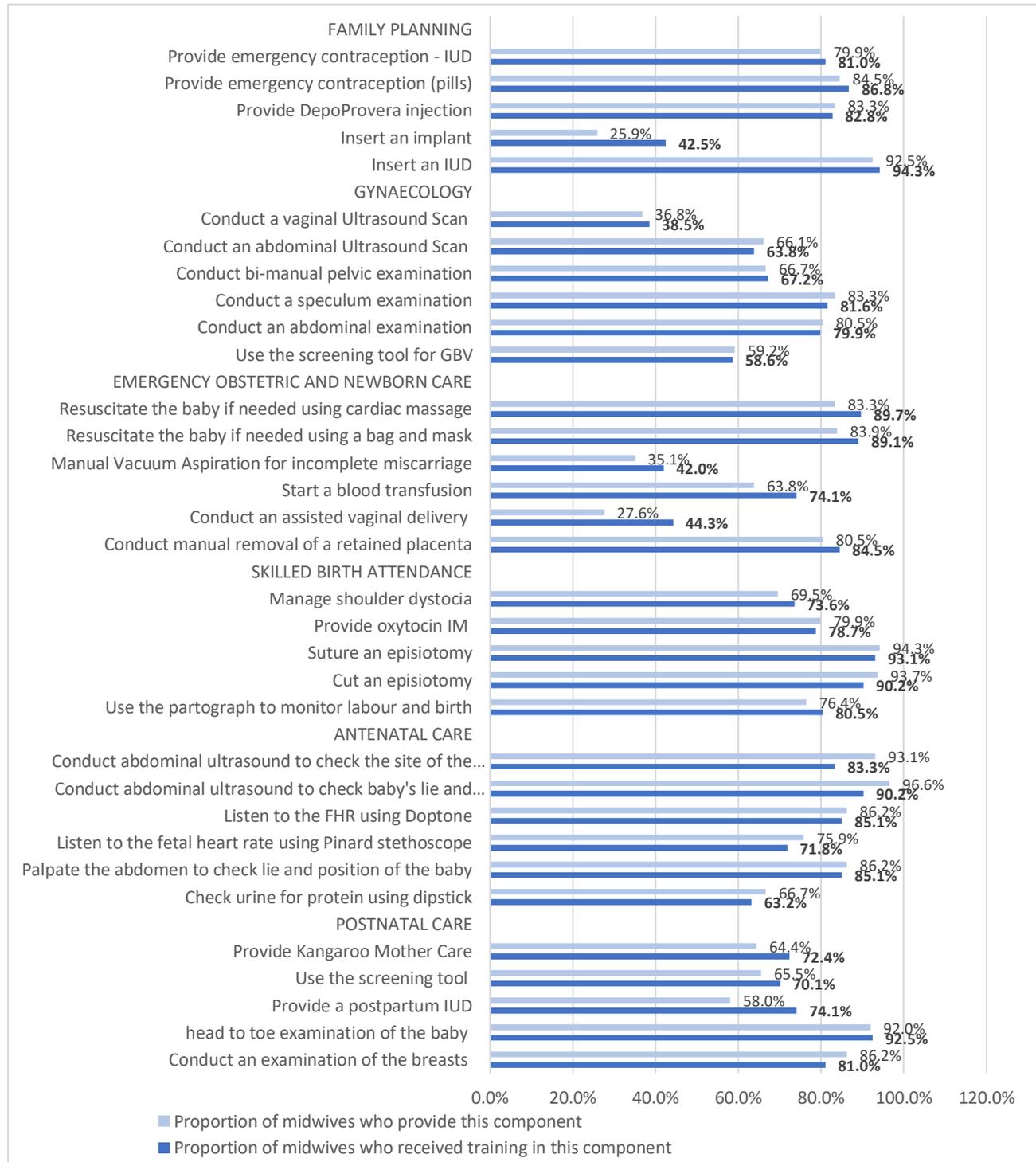
Key components of each of the main care packages under the continuum of care were identified and midwives were asked if they had been trained in and/or provided this component. The results are presented in **Figure 4**. Overall, there was good agreement regarding the proportion of midwives who had been trained and were providing any of the specific components of each care package.

Exceptions (more than 5% difference) were noted for Family Planning – for inserting an implant more midwives are trained (42.5%) than are providing this method of contraception (25.9%).

Similarly, for Basic EmONC, 42.0% of midwives reported being trained but only 35.1% reported providing manual vacuum aspiration (MVA) for retained products of conception. This proportion is noted to be higher than the response to a similar question asked earlier on in the questionnaire (**Table 2**). This discrepancy may be because of misunderstanding of the question and/or because it is considered illegal for midwives to carry out either a D&C or and MVA in NES.¹⁴

¹⁴ MVA was previously provided by 1 Partner in NES but since 2022-2024 is reported as ‘no longer available’.

Figure 4: Proportion of midwives trained in and providing key components of ANC, PNC, SBA, BEmONC and Basic Gynaecology services including Family Planning.



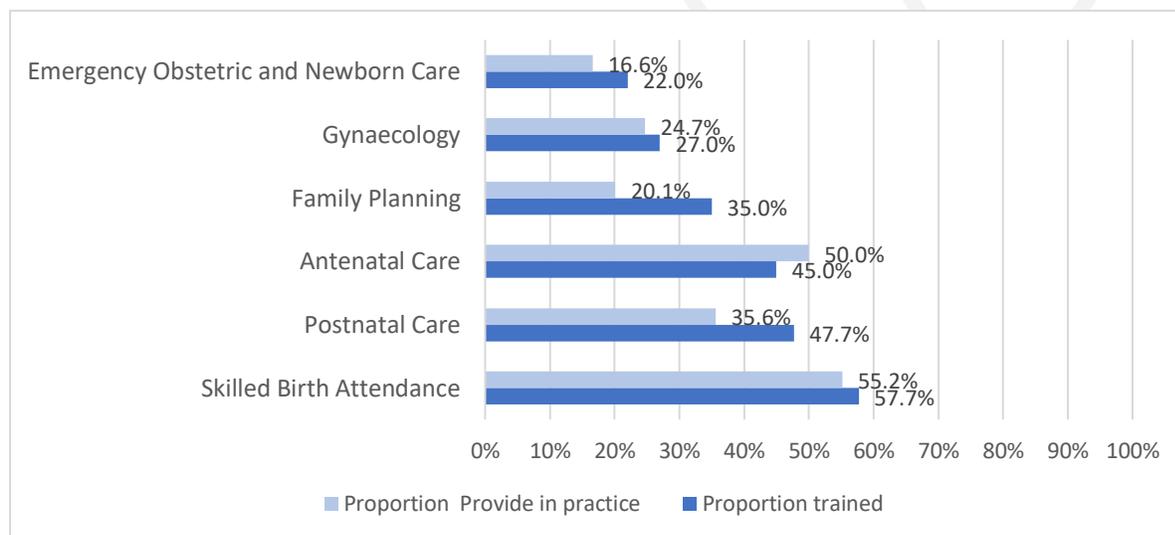
74.1% of midwives reported they had been trained on how to start a blood transfusion but only 63.8% provide this in practice. Just under half (44.3%) of midwives are trained to provide assisted vaginal delivery (ventouse delivery) but only 27.6% provide this in practice.

For postnatal care, overall, 72.4% of midwives reported they were trained to provide Kangaroo Mother Care (KMC) but only 64.4% provide this in practice. Although an IUD is provided as part of Family Planning by 92.5% of midwives only 58.0% do so in the postpartum period.

For some components under Antenatal Care this was the reverse with more midwives providing components without having been trained e.g., for checking the lie of the placenta or position of the baby using abdominal ultrasound (6-10% discrepancy), and for breast examination and screening for breast cancer 86.2% of midwives provide this but only 81.0% report being trained in how to do this.

For each care package the proportion of midwives trained in all components and therefore able to provide the complete care package is less than 60% overall and ranges from 22.0% for Basic EmONC to a maximum of 57.7% for Skilled Birth Attendance. (Figure 5)

Figure 5: Proportion of Midwives who are providing care package and proportion trained in all essential components of each care package under the Continuum of Care



Midwives who were trained reported increased confidence (assessed using a Likert scale) compared to those who had not received training, and this was noted for all care packages. This is illustrated for the components assessed for the EmONC care package in Figures 6 and Figure 7 below.

Data were analysed for each component of each care package ([Supplementary Figure 1](#)) and for each care package as a whole (**Figure 8**).

For areas requiring more skill such as assisted vaginal delivery it is likely additional training, practice in providing, and supportive supervision is needed.

Figure 6: Confidence in Provision of components of Basic EmONC for Midwives who have been trained in EmONC

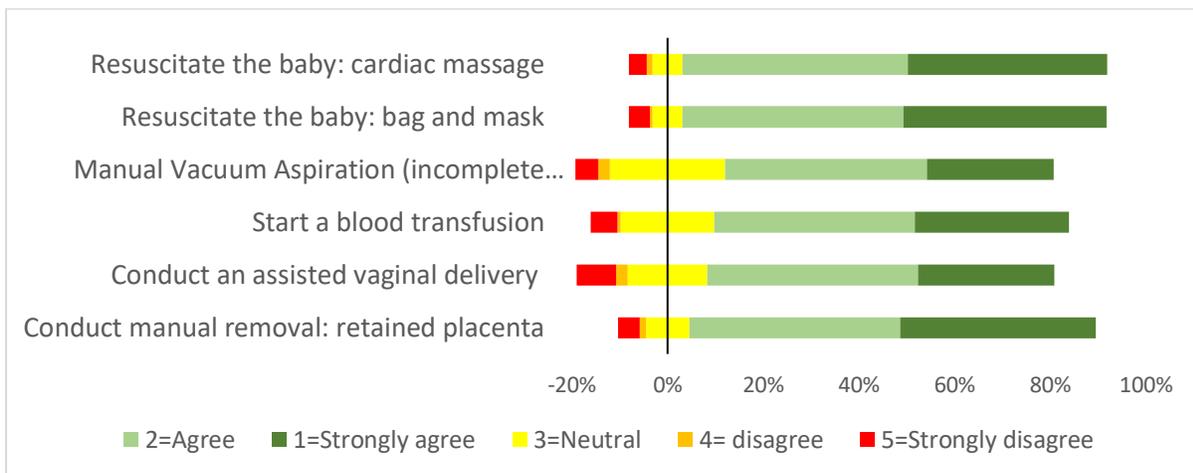
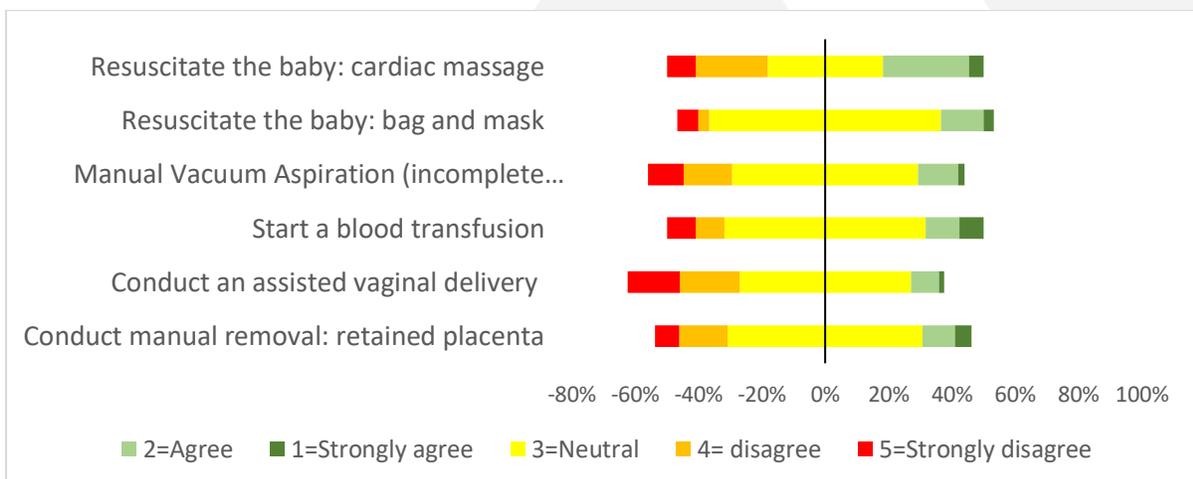
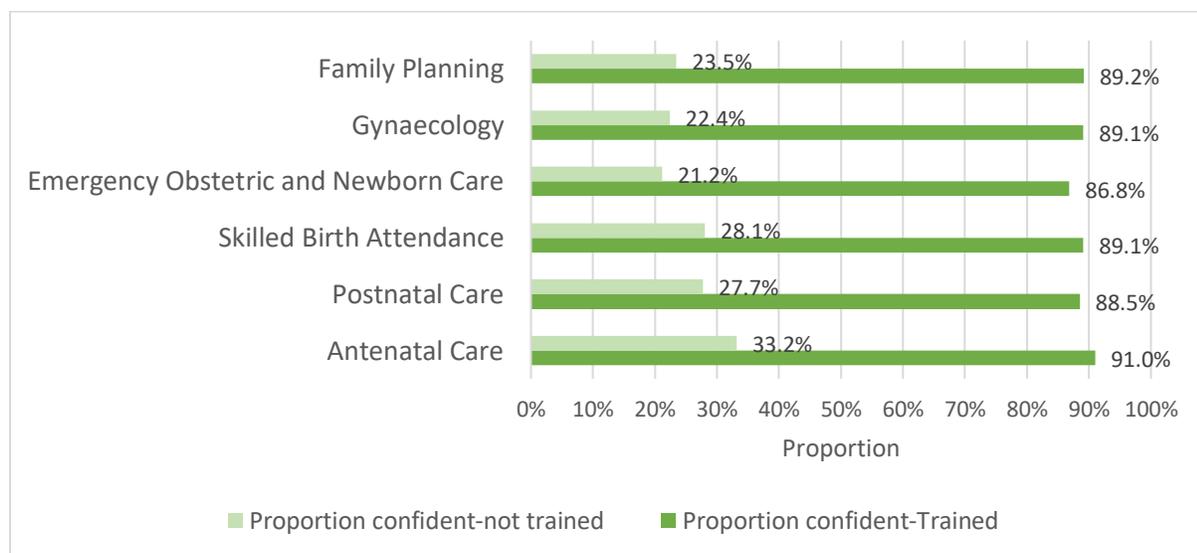


Figure 7: Confidence in Provision of components of Basic EmONC for Midwives who have not been trained in EmONC



For each care package the average was calculated (including all components of each care package) for the proportion of midwives reporting they felt confident. The proportion of midwives who reported being confident in their care provision was significantly higher for those who had been trained (in one or all components of the care package). This was most marked for EmONC with an average of 21.2% of midwives who had not been trained saying they were confident in providing components compared to 86.8% who had received training.

Figure 8: Proportion of midwives providing the care package who reported being confident comparing those who were trained with those who were not trained, for each Care Package. (Confident is taken as agreed or strongly agreed on Likert scale)



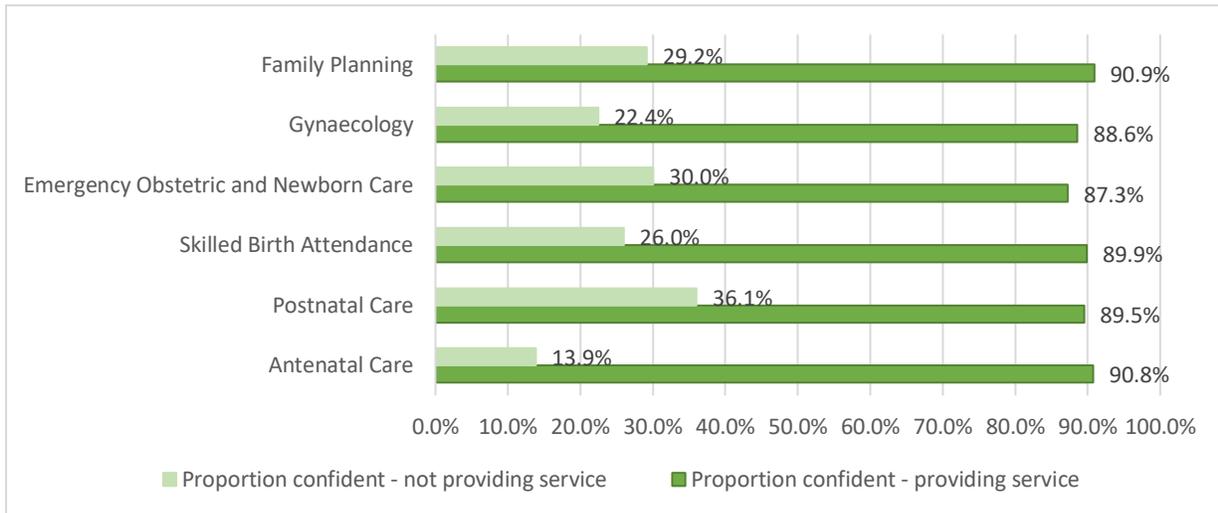
Midwives who provide care are generally confident in doing so (**Figure 9** average for all components in care packages) with overall 89.5% of those providing components confident compared to 26.3% non-providers.

Figure 10 shows the proportion confident in specific components.

Midwives are least confident in inserting an implant (77.8%), Manual Vacuum Aspiration for retained products (MVA, 72.1%) and performing assisted vaginal delivery (ventouse, 68.8%).

For all other components more than 80% of midwives who provide these components in practice are confident to do so. This is in sharp contrast to midwives who do not provide tasks – presumably because they are not allowed to and are also not confident to do these tasks. (Supplementary Figure 2).

Figure 9: Proportion of midwives who report being confident comparing those who are providing the care package with those who do not provide this in practice. (Confident is taken as agreed or strongly agreed on Likert scale)



For midwives providing care packages and the components of these, the area of least confidence was for EmONC components. The proportion of midwives reporting being confident was obtained for each component for each care package comparing those who are providing the care component with those who are not ([Supplementary Figure 2](#)).

Reasons for non-provision of Components of Care Packages

For midwives who reported not providing a component of care we assessed whether this was a) because they did not feel ready or competent to provide this component of care b) because they had no patients requiring this type of care or c) they were not permitted to provide this care. This ranges from between 1.7% (abdominal ultrasound to check for foetal lie and position) to 51.1% (for assisted vaginal delivery) of midwives. (**Figure 11**) On average for Family Planning 12.6% of midwives do not provide components because they are not permitted to. This was 17.5% for Reproductive Health/ basic Gynaecology, 22.0% for Basic EmONC, 13.8% for Skilled Birth Attendance, 9.1% for Postnatal Care and 17.6% for Antenatal Care.

We additionally assessed what proportion of midwives were trained but did not provide this component of care. There is a significant proportion of midwives who were trained but are not providing essential components of a care package because they report not being permitted to provide this component. This is most marked (>5%) for provision of an implant, a postpartum IUD, for conduct of a manual vacuum aspiration for retained products, assisted vaginal delivery using a ventouse and starting a blood transfusion ([Supplementary Figure 3](#))

Figure 10: Proportion of midwives providing care and being confident to do for each component of the care packages. (Confident is taken as agreed or strongly agreed on Likert scale)

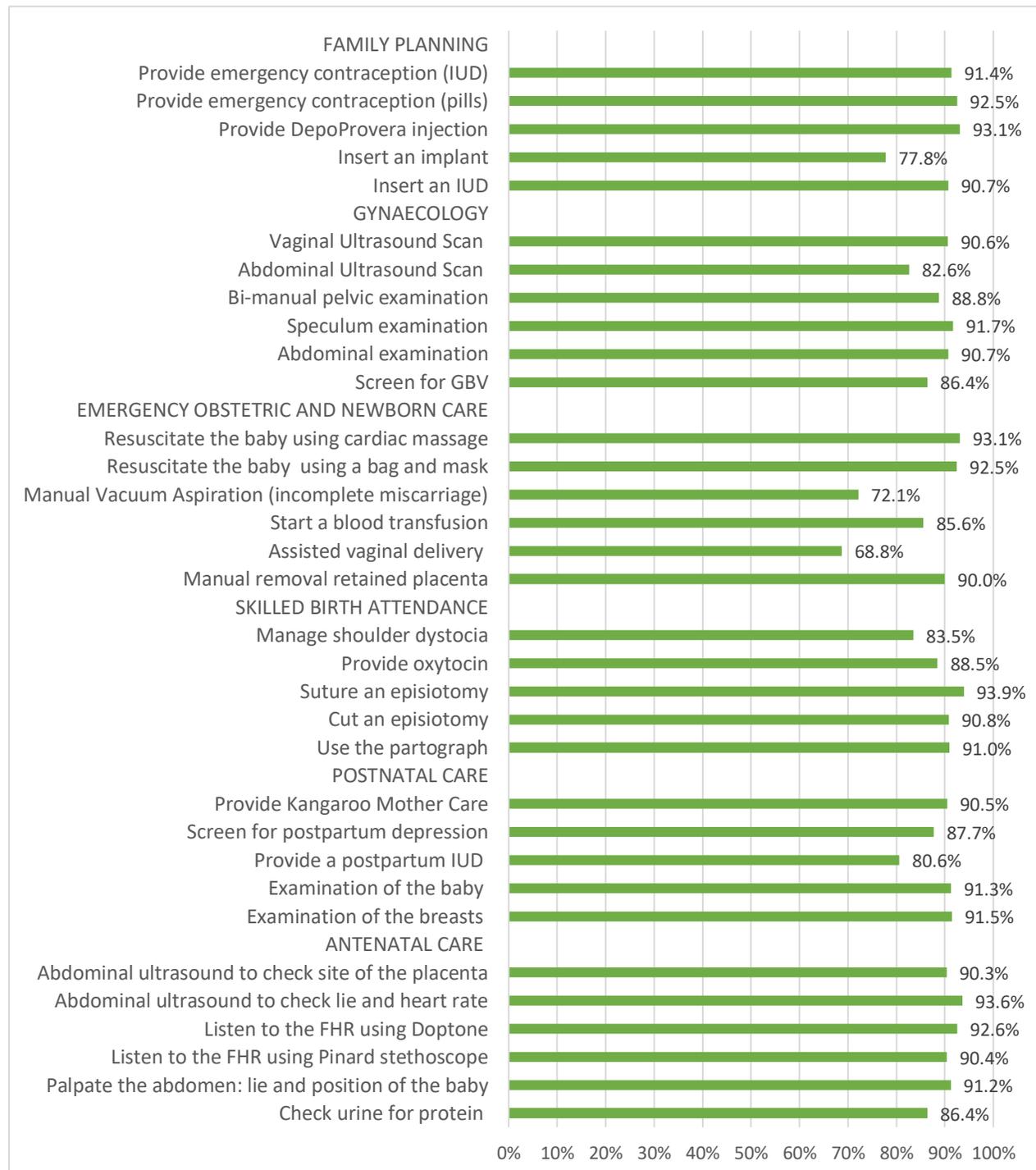
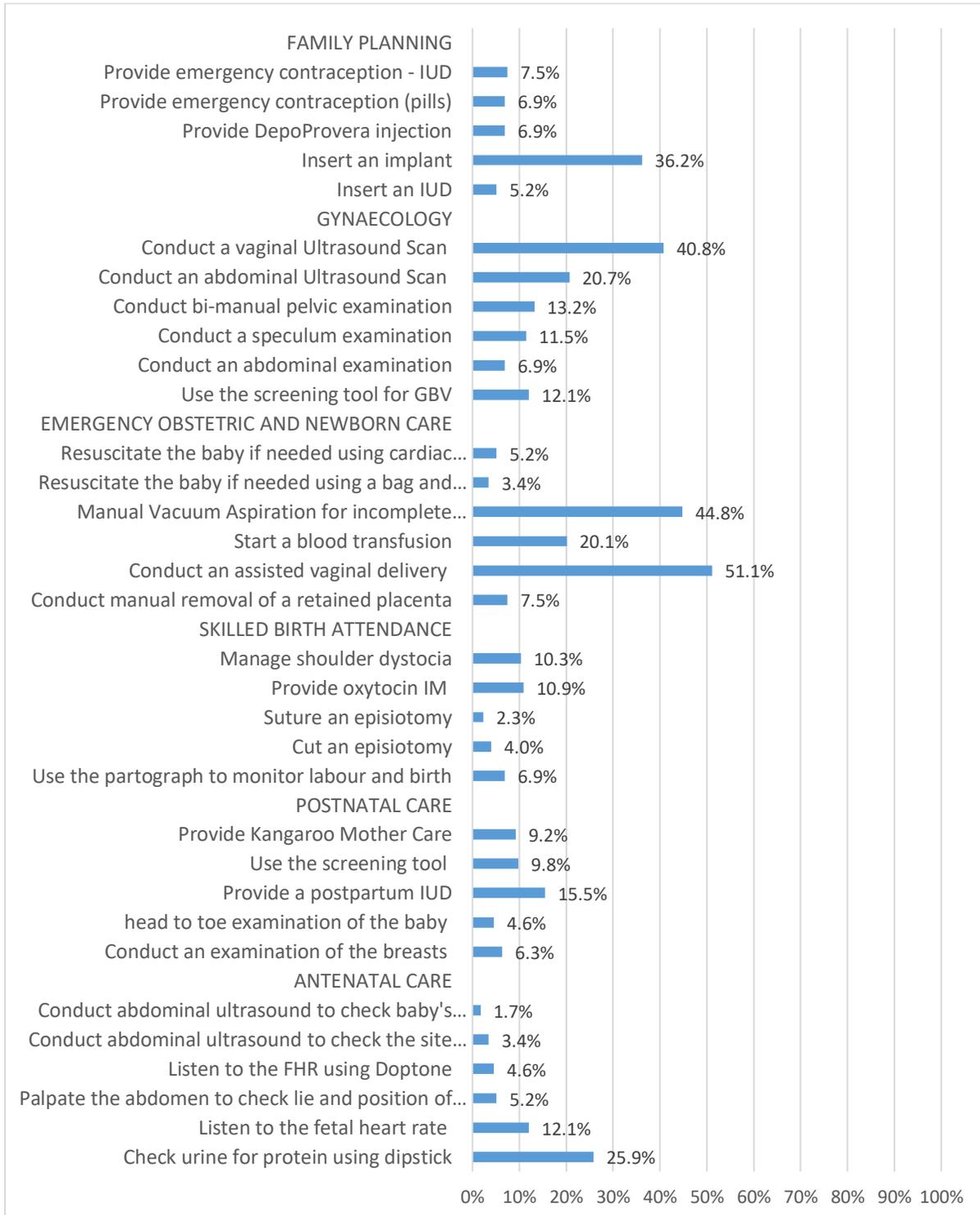


Figure 11: Proportion of midwives who are not providing components of care packages because they are not permitted to do so. (Out of 174 respondents)



B) Focus Group Discussions

A total of 10 FGD were conducted (7 with Midwives, 2 with Obstetrician-Gynaecologists and 1 with Managers and RH Focal Points) with 25 participants. In most cases FGD were small as it was difficult to get people together for a discussion given their heavy workloads and busy surroundings. (Table 3)

Table 3: Characteristics of Participants of Focus Group Discussions (FGD)

FGD number	Number of Participants	Characteristics	Place of Work
Midwives			
FGD 1	2	Midwives	Al-Hassakeh
FGD 2	2	Midwives	Manbij
FGD 3	2	Midwives	Qamishli
FGD 4	2	Midwives	Kobani
FGD 5	3	Midwives	Raqqa
FGD 8	2	Midwives	Raqqa
FGD 10	3	Midwives	Raqqa
Total			
Obstetrician-Gynaecologists			
FGD 7	3	Obstetrician-gynaecologists	Raqqa
FGD 9	3	Obstetrician-gynaecologists	Raqqa
Managers			
FGD 6	3	Managers, Focal Points for Reproductive Health.	Raqqa
Total	25		

A narrative summary of findings of the FGD is provided by theme and with selected quotes. Additional illustrative quotes are provided in [Supplementary Table 1](#).

Scope of Practice, Policies and Guidelines.

In FGD with midwives the consensus was that their scope of practice is not clearly defined centrally nor are they aware of any documents defining this and/or a legal framework. There is a widespread perception that there is '*no centralised body*' in the NES responsible for this which some midwives report was however in place before the conflict (from Damascus Whole of Syria Government and allied organisations)

Decisions regarding scope of practice and tasks to be done predominantly depend on where a Midwife is *'posted to'* or *'works'*, and decisions surrounding this rest with the manager/supervisor or organisation they work for. Midwives generally report that there are no written guidelines or policies they are aware of. Some mentioned *'guidance'* such as protocols for *'when to call an obstetrician-gynaecologist'* agreed within an organisation. A minority mentioned the Health Authorities or Committees having for example *'a list of what is allowed and not allowed'* and some mentioned textbooks of midwifery or clinical guidelines and protocols which would set out their scope of practice. A Midwifery Association (or *'Syndicate'*) was mentioned by a minority of midwives and referred to negatively rather than seen as a supportive organisation.

Midwives commonly reported that the focus of their work is widely understood to be *'normal deliveries'*, although many explained that they provide a lot more care in practice and/or would be able to do more but were not permitted to do this.

Many midwives felt that policies and guidelines are predominantly *'controlled'* by obstetrician-gynaecologists, some of whom would oppose expanding midwives' scope of practice. Typically, midwives report being supervised (technically) by senior midwives or obstetrician-gynaecologists with Facility Managers (in NGO sector) and Regional Health Committees (in the public sector) as *'administrative'* supervisors. Instructions for tasks and scope of practice are usually given verbally by *'Managers'* at the start of employment or a new position.

The consensus among obstetrician-gynaecologists is that the policies, guidelines, and regulations governing midwifery are inadequately defined and/or absent in the sense that these, if in place, are certainly *'not formalised'*. The majority of participants expect the (current) Ministry of Health, its Health Committees and Professional Associations to be actively involved in developing implementing and overseeing such policies which *'were largely in place before'* (the conflict). However, there is general recognition that there is no robust central authority to standardize policies and guidelines across the sector and are aware of the limitations of health committees in effectively overseeing the public, non-governmental, as well as private healthcare sectors.

Most of the obstetrician-gynaecologists do not see any significant input from the Midwives' or Nursing Association in policy formulation and these are largely seen as *'inactive'*. There was agreement among them that obstetrician-gynaecologists should have a substantial role in developing policies and guidelines for midwives and they therefore tend instead to see this as a role for the Medical Association. Obstetrician-gynaecologists unanimously agree that the direct supervision of midwives should fall either to themselves or to senior midwives rather than to (non-clinical) managers. This would depend also on the type of healthcare facility - larger healthcare facilities have obstetrician-gynaecologists on staff whereas smaller ones may have only midwives.

Table 4: Illustrative Quotes by Theme - Scope of Practice, Policies and Guidelines

Illustrative Quotes - Scope of Practice, Policies and Guidelines
Midwives
We almost specialize in natural births only. (FGD 5)
In the area I am in, I am only allowed to do normal vaginal deliveries, even though I can do other things. (FGD 2)
They said (in the NGO), according to the midwife’s protocols, it is not allowed. But I did not see anything written. (FGD 4)
The Health Committees have a list of things that are allowed and prohibited for midwives. (FGD 2)
At the beginning of our job, supervisors told us our tasks, but nothing written. (FGD-8)
There is no legal framework. So, we will have different instructions from every health committee; in Hassakeh, Raqqa and Menbij etc. (FGD 2)
We are members of the Nursing and Midwifery Association. However, they are collecting fees only. (FGD8)
Obstetrician-gynaecologists, Managers
In general, we have three sectors: the public sector, the private sector, and the work sector of humanitarian organizations. They are not united by reference and authority. (FGD 6)
The leading organisation is the Government sector, such as the Health Committee. (FGD 6)
Nursing and midwifery practice should be in coordination with doctors. There must be a council of doctors to determine the work. (FGD 7)
It is by the Donor or the Health Administration. Our work system is arranged according to the organization’s protocol previously established. There is a doctor and an administrator. If I make an error, the administrator is the one who supervises. (FGD 9)
The distribution of midwives and tasks are given by the Director of the medical facility. (FGD9)
It is by the donor or the administration. Our work system is arranged according to the organization’s protocol previously established by it. There is a doctor and an administrator. If I make an error, the administrator is the one who supervises. (FGD9)
The Director of the medical facility is the one who gives you tasks. (FGD9)

Discussion on Tasks that are Allowed or Not Allowed

Midwives emphasise that what they are or are not allowed to do depends very much on where they work and on which organisation they work for. Most midwives work under the supervision of an obstetrician-gynaecologist *'to support the doctor'*. Among midwives the consensus regarding tasks that are allowed is that these include *'first aid management'*, *'prepare patients to be treated by doctors'*, prescribe *vitamins and tonics*, antenatal care and (limited) family planning services (not including IUD insertion or implants). They can assist at a CS and change wound dressings. No specific postnatal care tasks were mentioned.

Midwives agree amongst themselves that the tasks they are currently not allowed to perform include any *'surgical intervention'* including episiotomy (perhaps with the doctor's permission), D&C, Manual Vacuum Aspiration (MVA), prescribing or using *'restricted drugs'* including Pethidine, misoprostol, and magnesium sulphate to provide pain relief, manage serious cases of bleeding or eclampsia (even if this is an emergency). Antibiotics are not considered *'restricted'* drugs, and the consensus seems to be that midwives can provide these (and even prescribe them)

In general midwives working in NGO-supported health care facilities report they learn more and new tasks and are allowed to do more than when working in the public sector. In the private sector the situation is very variable - *'in the same city there are two private hospitals each allowing different tasks'*

Obstetrician-gynaecologists and Managers generally agreed that the following tasks are in any case *'allowed'*: natural birth, ante- and post-natal care, family planning, *'first aid'* in case of emergencies including giving oxytocin in case of bleeding, giving vitamins, treating *'morning sickness'*. All obstetrician-gynaecologists agreed that *'with proper training and experience'*, midwives *'can do a lot of things'*. Some noted that midwives are already capable of doing and expanded number of tasks but that this was *'not allowed'*.

There was no clear consensus and a lot of variation in what obstetrician-gynaecologists and/or managers perceived to be allowed or not allowed tasks.

Examples of what are considered *'expanded tasks'* by obstetrician-gynaecologists included basic ultrasound, management of sexually transmitted diseases, management of severe obstetric bleeding, giving magnesium sulphate and treating hypertension in case of pre-eclampsia, as well as insert contraceptive implants.

Tasks that obstetrician-gynaecologists considered to be *'not allowed'* include difficult delivery, breech presentation, trial of labour in case of a previous CS, any procedure related to the operating theatre, managing extended perineal tears and management of bleeding in the first trimester. Cutting an episiotomy was permitted only after permission is sought from a doctor.

Table 5: Illustrative Quotes by Theme – Discussion on Tasks

Illustrative Quotes by Theme
Midwives
We alone know what we are not allowed to do. We tell the patient because there is nothing to protect us. (FGD 1)
Through studying at the nursing or midwifery school, they determine what is permitted and prohibited. (FGD 1)
In our NGO, we have written documents for allowed tasks and not allowed tasks. (FGD-8)
Some organizations allow the midwife to prescribe antibiotics, while others do not. (FGD4)
Sometimes pregnancy monitoring (antenatal care) is prohibited. (FGD 2)
In general, midwives are capable of monitoring pregnancy (antenatal care). (FGD 3)
Ultrasound, as example, can be done by midwives but not allowed. (FGD 3)
Giving misoprostol and labour induction are not allowed, even if the midwives are able to do it. (FGD-8)
At least we should have permission to give the initial procedures until you reach the hospital. (FGD5)
Obstetrician-gynaecologists, Managers
Allowed are labour management, natural childbirth. (FGD 6)
A primiparous patient needs an episiotomy and the midwife may not be able to make this decision without consulting the doctor. (FGD 6)
Her mission is to listen to the foetus and communicate with the doctor. (FGD 6)
A midwife is allowed to give antibiotics, but a midwife is not allowed give magnesium sulphate intramuscularly. (FGD 7)
She is allowed to give blood when needed. But with the organization's system, you cannot open two intravenous lines, no matter how critical, and then inform the doctor. (FGD 7)
A midwife is not allowed to support natural birth after one CS (trial of labour after one CS), support twin pregnancy, malpresentation or induction of labour. (FGD7)
As for those who have a history of CS, it is forbidden to insert an IUD except under the supervision of a doctor. (FGD9)

Opinions on Task Shifting

Most midwives had not heard of task shifting. A minority of midwives had worked for an NGO that practices and supported task shifting. However, all midwives were in favour of task shifting – at least for some key tasks and for midwives who were experienced.

Tasks that midwives specifically mentioned and discussed included being able to conduct assisted vaginal delivery (ventouse), D&C, management of more complicated vaginal births, management of obstetric emergencies especially (pre-)eclampsia and severe bleeding and the ability to prescribe more (needed) drugs.

All midwives were confident that they could safely give antibiotics IV or IM but noted that for assisted vaginal birth (ventouse) and giving magnesium sulphate IM or IV training and experience are required. Midwives were clear that they are competent giving a blood transfusion and that not being allowed to do this was a real problem especially in an emergency (*'completely not allowed even in an emergency'*).

Approximately half of the obstetrician-gynaecologists are aware of the concept of task shifting for midwives, primarily through information from NGOs. A number of these specialists perceive NGOs as being more flexible and adaptable in implementing task shifting. The idea of task shifting was unanimously supported if midwives are *'experienced'* and/or midwives receive *'additional training and supervision'*.

There is a belief among some obstetrician-gynaecologists and managers that midwives operating in private clinics may lack adequate supervision.

Obstetrician-gynaecologists and managers propose and discussed (no consensus) several specific tasks that could be done by midwives if task shifting was supported including:

- Initial management of life-threatening conditions such as eclampsia, hypertension, haemorrhage, and diabetes.
- Conducting vaginal deliveries for patients who have had (one) previous CS.
- Performing neonatal resuscitation (this was changed a few years ago and is in fact allowed already)
- Preparing patients by inserting IV lines (sometimes this is only allowed to be done by nurses) and arranging for basic medical investigations (sometime a midwife needs a doctor's permission to begin any medical check or arrange tests).

There was consensus that there is a lack of experience in assisted vaginal delivery (ventouse delivery) and that this is *'not allowed legally'*. Some obstetricians thought that with training some midwives might be able to conduct assisted vaginal delivery.

The majority of obstetrician-gynaecologists are against midwives giving IV magnesium sulphate, but they were more flexible regarding giving this IM (after training).

Giving antibiotics was generally perceived as probably permissible but obstetrician-gynaecologists were worried regarding 'abuse'.

Most obstetrician-gynaecologists are against midwives being able to give a blood transfusion and are of the opinion that midwives should '*ask a doctor's permission, but she can open 2 IV lines and prepare for the procedure*'.

Implementing Task Shifting

Both Midwives and obstetrician-gynaecologists are aware of and report the public sector to be a hierarchical healthcare system, placing the Ministry of Health at the apex with various regional Health Committees present in each Governorate, as the next level and below these the Facility Managers.

Midwives recommend that discussion is needed with all levels and especially with the 'Technical Committees' of the Ministry of Health (in NES and Damascus) so that '*official documents and plans*' can be agreed to enable task shifting.

Obstetrician-gynaecologists suggest that the composition of Technical Committees should include gynaecologists and administrative personnel, and possibly senior midwives as well.

While participants of the FGD (midwives, obstetrician-gynaecologists, and managers) were generally supportive of task shifting, they suspect that many other obstetrician-gynaecologists might oppose it. Similarly, midwives are worried obstetrician-gynaecologists will oppose '*expansion of midwives' tasks*'. Midwives are clear that they will need the support of obstetrician-gynaecologists if task shifting is to be implemented. They have limited expectations from the '*weak*' Professional Association(s).

Midwives see the opportunities that will support task shifting including that international regulations and guidelines support this, there is a shortage of human resources in NES and some NGOs are already in favour and have tried it (successfully) in the past.

Key barriers to implementation mentioned by most midwives are that there is no law and/or legal framework, some health committees are known not to be in favour and the community might not accept this change in their scope of practice.

To implement task shifting most obstetrician-gynaecologists recommend engaging with all professional Associations/Syndicates/Unions (terms are used interchangeably) - including those for doctors, midwives, and nurses – to develop a consensus on appropriate task shifting practices.

Nevertheless, the prevalent view is that the implementation of changes in practice will be challenging. ‘*Conditions required*’ is a term frequently used and most often includes ‘*training*’ and ‘*protocols*’ to guide practice.

Opportunities for task shifting are perceived to include the need (shortages of human resources), decreasing the workload for general doctors and obstetrician-gynaecologists, knowledge that some health committees are already in favour of task shifting, and there are experienced midwives working in NES who could take on additional responsibilities.

Perceived barriers to implementation include the private sector, midwives’ not wanting to take on more tasks, health committees being against this, lack of resources required for long/additional training of midwives. In addition, some obstetrician-gynaecologists believe it would be very hard to harmonize the work across the three sectors currently active (public, private and NGO-supported).

Table 6: Illustrative Quotes by Theme - Task shifting

Illustrative Quotes by Theme - Task shifting
Midwives
There has been much development and task changes in the last decade. (FGD 1)
Only when I was working with (...Partner...), they added tasks to midwives. (FGD 3)
Not all midwives are able to use a ventouse, only those who work in hospitals. (FGD 3)
Previously, labour induction was not allowed, now the NGO allows it for midwives. (FGD 4)
We are in favour of adding duties to the midwife and with legal protection. (FGD 4)
Task shifting is good, it might increase the experience and knowledge of midwives. It may decrease neonatal deaths because midwives are on the first line. (FGD 5)
You should speak with the Ministry of Health because the Health Committee takes instructions from them. (FGD 2)
Obstetrician-gynaecologists, Managers
Encourage the transfer of tasks to midwives. (FGD 7)
Important, but there must be effective training. (FGD 7)
By establishing specific protocols for each case, how to perform the procedure. (FGD 7)
The Union itself, the Ministry of Health in coordination and consultation with all Unions and the Ministry. (FGD6)

Through the presence of a Union for Midwives, we can consult them, which is the most important thing, and through them we determine the tasks and work of the midwives, what are the permissible tasks and what are not, because they waste their time with work that someone else can do. (FGD 6)

Gynaecologists must be consulted. We must choose a specific group of doctors who work with midwives, because there are doctors who only work in a clinic. (FGD 6)

The organization may have special reasons why the midwife cannot do some work

Therefore, we must communicate with them to reach a unified formula in Northeast Syria for midwives. (FGD7)

Health Committee because there is no Ministry or Union. (FGD9)

C) Key Informant Interviews (KII)

A total of 16 Key Informant Interviews were conducted with a range of Stakeholders including Health Managers and Staff from 8 international NGOs, Health Working Groups, Midwifery Pre-service Training Institutions, and the Local Health Authorities. (Table 7)

Table 7: Characteristics of Participants of Key Informant Interviews (KII)

KII Number	Number of Informants	Characteristics
1	1	Reproductive Health Specialist
2,6,8,11,13	5	Medical Coordinator
3,4	2	Health Programme Manager
5,7,10	3	Medical Officer
9,12	2	Health Working Group
14	1	Health Authority
15	1	Pre-service Training Institution
16	1	Professional Association
Total	16	

A narrative summary of findings of the KII is provided by theme and with selected quotes. Additional illustrative quotes are provided in [Supplementary Table 2](#).

Scope of Practice and Policies or Guidelines

The scope of practice of midwives working in NES was explored in the KII. In general, there was consensus that this was *'not available'*, *'not well defined'* and *'not clear'*. There are some suggestions that before the conflict the situation was clearer and better regulated. Most organisations use a 'Job Description' or 'Terms of Reference' for Midwives employed by them - but each actor/organisation has their own job description and there is no standardised version.

Tasks that a midwife is expected to carry out and what she is or is not allowed to do varies across organisations. In addition, this varies depending on the level of the health system the midwife works in - PHC or CPHC or a Hospital level. There is also variation depending on whether she works in the Government, NGO-led health sector or the private sector. Finally, there are different *'instructions'* from the various Health Authorities in each Governorate which are *'not harmonised'*. A midwife's expected scope also seems to depend on *'what is needed'* e.g., if there are no doctors at a PHC, midwives are expected to do more tasks and have a broader scope of practice.

Job Descriptions are largely developed by managers of NGOs some of whom are doctors. They are expected to be *'based on international guidance'* but in practice none of the KI could confirm this or was certain exactly where this was decided. There was consensus among stakeholders that the Job Description does not capture, and is not representative of, the scope of practice.

KI from Health Authorities and Union report that there are *'internal guidelines'* and *'official instructions'* from the Ministry of Health – Syria under which a midwife is allowed to open a practice. A work permit is temporary for 2 years after that approval is sought from the Midwifery Union and MOH which include *'instructions on what is allowed and what is not'*.

Only a small minority of other KI are aware of the legal framework which permits midwives to open a practice or that guide midwifery practice in general.

There is also mention of a *'Committee'* (*'three gynaecologists and one surgeon'*) which makes decisions on malpractice or *'mistakes'* and who will *'decide what is wrongand they can testify in front of a court'*.

Table 8: Illustrative quotes by theme – Scope of Practice and Policies and Guidelines for this

Illustrative Quotes by Theme
Scope of Practice
<p>In the NGO we have some specific areas of practice for midwives which is providing ANC and PNC, normal delivery in addition. But in their private practice they are doing a lot more even sometimes some of the tasks that should be done by a doctor. (KII 1)</p> <p>It is not clear; it is not well defined. (KII 5)</p> <p>Midwives’ roles are not clear. (KII 10)</p> <p>It should be clear, but this is not the situation. (KII 16)</p> <p>In the NES, the midwives’ tasks for now are different from old days. (KII 15)</p> <p>The scope of practice is unclear. Today midwives can open clinics in which she can offer antenatal and postnatal care, and normal vaginal delivery, she can treat sexually transmitted infections and other types of infections with no clear boundaries to her tasks, what is legal or illegal ... mostly midwives do not know their scope of work ... In (our organisation) many times midwives are asking if it is legal to do tasks without doctors as supervisors. (KII 2)</p> <p>Midwives should do the permitted work for her only. If she did something out of her tasks, the authorities don’t allow this ... a committee meeting will be conducted to follow the legal case ... sometimes the clinic will be closed... and we stop the work permission say for 2 years. (KII 14)</p>
Job Descriptions
<p>I don’t know, not me who wrote it but maybe they depend on WHO, this is the usual way with us. (KII 10)</p> <p>Commonly we are trying to go with global instructions. Even to lead in this. (KII 2)</p> <p>Yes, there is a job description, but it is difficult to follow, due to lack of staff.... Midwives will do doctors job, and she could cover nurse and vice versa. (KII 14)</p> <p>I think scope of practice is not well defined, it is not clear cut, the scope of practice is different in different facilities and different from one NGO to another. (KII 12)</p> <p>On the national clinical guidelines, no, I searched, but I couldn't find anything. (KII 1)</p> <p>No, there is no unified reference for the midwife’s tasks. (KII 3)</p> <p>We reviewed and adapted a national one and are checking international ones. (KII 13)</p>

Policies and Legal Framework

I have searched for some kind of manual or some kind of guidelines – related to practice in Syria – some national guidelines but I could not find any. (KII 1)

I am not aware of any policies or legal framework, and this may lead to problems and is a gap. (KII 10)

There are no legal guidelines in the NES and in Syria to my knowledge. (KII 3)

Midwives should follow the guidelines of the facility. (KII 10)

We (the HA) are following the Damascus policies and guidelines, WHO recommends us to use the Damascus policies which are following the WHO guidelines. (KII 15)

Sadly, no we do not have a legal framework, no midwife’s association, no regulations, it’s up to me. (KII 13)

Capacity of Midwives

There was consensus that Midwives were ‘good’ and ‘capable’ when it came to ‘normal birth’ or ‘natural birth’ as well as providing ANC, PNC and this is generally considered their main scope of practice and area of expertise.

In discussion it became apparent that there is diversity of opinion among KI regarding what midwives could or could not do. For some areas of care the consensus is clear – midwives are expected to provide ‘normal birth’, antenatal and postnatal care, and family planning services and are generally considered to be competent in these areas. In emergency situations midwives are expected to provide first line treatment certainly ‘if there are no doctors around’.

For other tasks and specific components of the care packages there is a large variety of opinion ranging from ‘can do’ to ‘definitely can’t do even with training’ with no clear consensus emerging other than that the current situation is confusing. However, KII agree that it is important to agree on the tasks that midwives should be expected to do and those that are limited to obstetrician-gynaecologists and/or ‘general doctor’s’ scope of practice.

In discussions about specific tasks, only a minority of KI agree that midwives should be able to provide magnesium sulphate (IV and IM or IM only), conduct an assisted vaginal delivery (after training and if experienced) and/or start a blood transfusion (mostly only if a doctor is present). At the same time there is a majority awareness and expectation that a midwife will need to provide care in an emergency when a woman presents with complications to a healthcare facility. Regarding D&C (for incomplete miscarriage, retained products) there is almost unified agreement that this is ‘not allowed’.

Pethidine (for pain relief during labour) is mentioned as *‘not available’* and *‘not allowed’*. Similarly, most KI consider that *‘complicated pregnancies’* (such as twin and breech delivery) should not be managed by a midwife. Cases of infertility could perhaps be managed by midwives if there is a supervising gynaecologist. Drugs such as magnesium sulphate, misoprostol, oxytocin, antibiotics are considered *‘restricted’* by some KI.

Supervision (by a doctor) and training are frequently mentioned as being required for midwives in NES.

Table 9: Illustrative quotes by theme – Tasks and Capacity of Midwives

Illustrative Quotes by Theme
Tasks agreed
They are good at antenatal care, screening for risks in pregnancy, treating pregnancy diseases such as urinary tract infection, vomiting, abdominal discomfort. Also, they can do postnatal care, examine babies, and provide family planning care. (KII 8)
Doing normal deliveries, receiving women for antenatal care, and the usual visit of and checking babies. But they are not doing well, not following all standard indicators. (KII 11)
Antenatal and postnatal care, family planning and it depends on the midwife and her knowledge and experience, but these are the tasks the midwife does well. (KII 7)
Tasks about which there is diversity of opinion
Can midwives conduct assisted delivery? Yes, they should, but in CPHC. (KII 14)
For drugs prescriptions we are limiting prescription power of midwives, because most of them are alone in the facilities (KI6)
Can midwives give IV/IM Magnesium sulphate? They can do that but under doctor supervision in high level CPHC not in private clinic. (KII 15)
Can midwives start a blood transfusion when needed? No, they need doctors with them. (KII 4)
Midwives are not allowed these tasks. (... relating to CS, ectopic pregnancy, complicated miscarriage....) (KII 10, KII 8)
Doing a CS, giving magnesium sulphate, blood transfusion, complicated D&C are not allowed. Pethidine is not available and not allowed. The tasks need more training. (KII 7)

Task shifting – Opportunities for and Barriers to Implementation

Many KI had not previously heard of task shifting or had heard about it *'informally'*. A minority of KI had good knowledge of task shifting with examples of settings where this was being practiced or had been in the past.

The majority of KII consider that task shifting has important advantages – improved coverage of services especially in rural areas, to fill *'gaps'* in human resources, to improve the quality of care and reduce risk for mothers and babies. Financial advantages include consideration that this would be cost-effective.

There is consensus that there is considerable need and opportunity for introducing task shifting in the NES with health authorities being *'collaborative'* and would *'accept'* this approach. NGOs are generally in support. In addition, the KI report that there are many midwives in NES (although some are working as nurses) working across the public, private and NGO sectors and that midwives themselves would welcome task shifting. It was mentioned that one of the NGOs working in NES is starting a program to develop the 'Health Law' for NES and this might be seen as an opportunity to work on task shifting.

Stakeholders realise that implementation of task shifting might be difficult. Suggested barriers included midwives not wanting to take on additional tasks because of extra workload, especially in the absence of good regulation to protect them and might require higher salary compensation if they took on more responsibilities. Agreement would be needed on a (new) legal framework and guidelines including to define scope of practice clearly. Mention was made of *'old system bureaucracy'* which would need to be overcome. Doctors may also block task shifting if it means they have less opportunity to financially benefit from their work (losing tasks) but also because they may consider midwives to be insufficiently capable of taking on additional tasks because of *'weak pre-service training'*, being less experienced and not having opportunity to train sufficiently or sufficiently well.

When asked what would be required for the introduction and implementation of task shifting in the NES stakeholders generally advised wide consultation with all stakeholders including the health authorities, doctors (unions) and midwives themselves. Having a clear legal framework, policy guidance and protocols were also mentioned as being of key importance. Awareness will need to be raised in the communities served to gain acceptance of new practices.

When asked to consider specific areas for task shifting KI agreed that midwives should be able to manage all types of vaginal births, treat sexually transmitted infections, provide all components of antenatal and postnatal care, offer screening for cancer (breast and cervix), treat simple conditions, and conduct a basic ultrasound scan. More than half of KI agreed that midwives should be able to conduct assisted delivery alone (but after training and legalization of this task)

and (for some KI only with a doctor supervising). Most KI accepted that giving IV/IM Magnesium sulphate (for (pre-)eclampsia) should be possible although some would insist on a doctor’s presence or just being allowed to give the first dose only. The majority of KI agreed that midwives should be able to give IV/IM antibiotics, however, a few KI were afraid of ‘*abuse*’ and ‘*failure to consider contraindications*’ so preferred that midwives would only be able to prescribe simple oral antibiotics. Most KI accept that midwives need to be able to start a blood transfusion, especially in case of haemorrhage. However, several KI mentioned that blood transfusion is available only in hospitals and that doctors would in any case be present then.

Table 10: Illustrative quotes by theme – Task shifting

Illustrative Quotes by Theme
Opinions on Task shifting
With experience and knowledge, with clear protocol and a clear plan, yes, it is good. Not for all tasks, not for CS and not for D&C. (KII 6)
No, I have not heard of it formally, informally only. (KII 7)
I always support the idea, in most countries in remote areas you cannot find highly trained doctors. (KII12)
Opportunities for Implementation
We need to have task shifting, we need to provide the services, and for financial reasons – it is better and cost efficient for the community and for better coverage. (KII 15)
There are a lot of benefits for the people and in rural areas, better services’ quality, and decrease dangers for mother and baby. (KII 14)
We have collaborative Health Authorities, and task shifting will be a joy for donors as well as Actors. (KII 9)
There are several opportunities including, willingness to do task shifting by NGOs, acceptance by Local Authorities and there is need because of gaps of healthcare providers. (KII 12)
Opportunities are using doctor`s time better and increase the capacity for midwives. (KII 5)
We can gather the midwives and check with them the issues and to know their complaints, some midwives are working as nurses, in public and private sectors as well as in the NGOs. We are having a new system, and we should check with the field, the needs. We need trainings and periodical trainings and to check the updates. (KII 16)
Barriers to Implementation
The barriers are social norms, lack of experience and lack of supervision. (KII 4)

Community acceptance could be a problem mainly in the beginning. Some of the midwives are not able and may refuse to take more responsibilities to avoid problems. They may ask for more salary if we increase their tasks. (KII 10)

Legal framework and policies are not available, there is no union for midwives, doctors have no trust in midwives, like what happened with the doctors' unions to prevent midwives from writing any descriptions. (KII 2)

Midwives sometimes refuse to increase their tasks because they are afraid of the workload and tasks with no protection. (KII 5)

Legal framework and policies are not available, there is no union for midwives, doctors have no trust in midwives, like what happened with the doctors' unions to prevent midwives from writing any descriptions. (KII 2)

Approaches to Implementation

The approach would mean to bring the Health Authority on board, to involve a lot of stakeholders, to introduce something new in the NES needs acceptance to do that and community views will also need to be considered. (KII 8)

Community resistance, a lack of training and conflict between the professionals, private organisations and government are barriers. Midwives should have salary incentives, and a legal framework. So, we need to convince doctors, who are leading the health authorities, and maybe there is a doctors' lobby to discuss with. Inclusion of all actors will be important. (KII 11)

While the barriers are social norms, lack of experience, lack of supervision, a law and stating legal responsibilities as well as protocols should be there. A midwife will have a lot of tasks on her shoulders, needing more appreciation from certain doctors, and with a clear policy. (KII 6)

We should review the scope of practice, to know our place and where we want to go. We should have an Association and continuous training to teach more, and midwives should educate themselves continuously, to develop practice and sure we need training. (KII 13)

Every NGO should give EF a list of midwives who are able to handle task shifting so we can choose capable ones only and depending on the need, assessments in the facilities and check with professional midwives only. Task shifting to all midwives is difficult. (KII 13)

The first thing is we need to speak with the Health Authorities, we should have a law to protect midwives. Now midwives are not able to do a lot of things because they don't have legal coverage. There is no Midwifery Union to monitor their work, at least the Union is not known. (KII 2)

Discussion and Recommendations

A survey of Midwives working across the NES at various levels of the health system reveals that the respondents had multiple years of experience, are qualified and registered and provide components or all the main care packages in the continuum of care. Least well provided are Emergency Obstetric and Newborn Care signal functions including providing magnesium sulphate for women with pre-eclampsia, managing a woman with severe bleeding, providing assisted vaginal delivery and manual vacuum aspiration for retained products. Giving Pethidine for pain relief during labour is not permitted. Midwives are generally well trained and confident in the tasks they perform. Midwives with no training in specific components are less likely to perform these and are significantly less confident about providing such components. For midwives trained and confident in providing components of care 'not being permitted' to carrying out the task was the main limiting factor. For example, 63.8% of Midwives report being able to start and give a blood transfusion, 14.4% reported being trained and able to provide assisted vaginal delivery (ventouse delivery) and 10.9% were trained and able to give Magnesium sulphate when required but (in all cases) they also reported they were 'not permitted' to provide these services to a patient. Similarly, 97.7% of midwives reported they are able to perform abdominal ultrasound with 36.8% able to provide a vaginal ultrasound

Focus Group Discussions (FGD) with midwives, obstetrician-gynaecologists, and managers reveal the absence of a defined scope of practice or job description for midwives. The tasks a midwife is permitted to do vary according to geographic location, type of healthcare facility, and sector (public, private or NGO). While there is consensus on certain tasks such as supporting uncomplicated pregnancy and vaginal birth, there is no consensus regarding other essential components of care, with midwives often requiring permission from doctors to perform key tasks, particularly in emergency care and/or to provide basic care during labour such as providing pain relief.

In Key Informant Interviews (KII) stakeholders (including health authorities, NGOs, and professional associations) are agreed that task shifting is needed and there are opportunities to implement this in NES. Similarly, both obstetrician-gynaecologist and midwives themselves consider task shifting as an important and generally helpful approach. Perceived barriers to task shifting include community acceptance, doctor reluctance due to concerns about midwife competency and potential loss of income, midwife workload concerns, and the absence of clear regulatory frameworks. The need for adequate pre-service as well as continued medical training was highlighted to be able to expand midwifery tasks. Organisations which need to be included in further discussion include the Health Committee or Authority, a technical committee (composed of individuals with responsibility in the field of reproductive health (midwives,

physicians, managers, and supervisors) and Professional Associations. Particular consideration is to be given to the Doctors' Association (some degree of functioning reported at time of study and allocated 'per district' rather than centrally) and the Health Professionals Association(s) (includes nurses, medical technicians, and midwives - for each district).

Recommendations

Based on dissemination of the findings of the study recommendations were developed by all stakeholders which are summarised below:

Clarify and define the tasks of the Midwife

- Expand the current scope of practice and 'permissions' of the Midwife.
- Hold a series of meetings and workshops with health actors and health committees working in the field of RMNCH and agree on scope of practice and tasks.
- Form a specific Committee to develop a list of Midwives' tasks including a list of medicines allowed to be prescribed by midwives.
- Ensure there is a legal framework (and 'legal protection clauses') for the Midwife.
- Develop a clear and detailed job description which sets out the tasks and duties that a Midwife is required to adhere to (in Arabic and English). Develop a 'pro-forma' job description which could be adjusted for the different levels of the health system (PHC, CPHC, Hospital)
- Circulate this 'pro forma' job description to all Managers, Midwives and their Supervisors for easy follow-up and control of work.
- Disseminate and display the (many) tasks of a Midwife to emphasize commitment and draw attention to the work of the Midwife more widely.
- Ensure at the healthcare facility level clinical protocols and management systems are in place to clarify and ensure the tasks of the midwife are clear and can be carried out safely by the Midwife. Doctors can then involve the Midwife more in decision making, giving more 'space' to the midwife in the workplace and respect her work and experience.
- Support the formation of local specialized committees to support the work of midwives. Conduct periodic follow-up through supportive supervisory visits for midwives.

This will enable organisation to agree on clearly defined responsibilities, reduce 'mistake rates' and help with the correct, fast, and efficient orientation of the midwife, as well as a fair distribution of tasks.

Provide continuous training and professional development opportunities for Midwives

- Ensure Midwives receive competency-based practical training that supports evidence-based clinical practice (both in-service and pre-service training) .

- Train midwives on the methods and dosages for administering a range of medicines and according to a correct initial assessment of needs (requires assessment) and in line with agreed clinical guidelines and protocols (see next point).
- Provide printed textbooks and other relevant publications and distribute these to all facilities including training manuals and clinical guidelines.
- Ensure sufficient and competent Trainers are available and who are supported to provide training including in remote areas.

For 'Midwives' who are practicing but have not been certified and/or are incompletely or not formally trained:

- Establish an intensive and comprehensive educational program to improve capacity and boost the level of knowledge (skills) of experienced midwives who are not qualified and do not hold any midwifery certificates. Agree the specific educational curriculum and determine the required time period for training to be undertaken under the supervision of a skilled and specialized team.
- Establish laws (regulatory framework) to facilitate their incorporation into healthcare facilities.
- Supervise the educational process and ensure comprehensive examinations are undertaken and passed overseen by a specialized committee prior to integration of these midwives into the health service.

This will result in an increased number of confident and skilled Midwives, and improved quality of services provided with better health outcomes for newborn babies and mothers. An increased number of timely and correct interventions will be provided with a reduction in the number of medical errors and the 'random use' of medicines.

Develop Clinical Guidelines and Protocols

- Coordinate with health working groups and health committees to standardize clinical guidelines and protocols.
- Place copies of the clinical guidelines in all consultation and treatment rooms in the hospitals and health centers.
- Develop algorithms (clear protocols) and display these (in poster format) for the use of emergency medication in labour and delivery rooms so that these are clear and visible.
- Establish clear controls for the prescription of medication. Provide each healthcare provider (Midwife, Doctor, Pharmacist) with the necessary instructions and guidelines (manuals) for this purpose and provide Supervisors with a list of the most common morbidities and their treatment to ensure the correct diagnosis and treatment are provided and to prevent overmedication (particularly antibiotics).

- Build the capacity of midwives to administer medicines as needed (within their scope of practice and remit) and to be able to prescribe these in emergency cases.
- Provide support, assistance and coordination between doctors and midwives.
- Provide all the necessary medicines in the health centers and hospitals.

Set Standards for and Audit Clinical Practice

- Develop and agree Standards for service delivery for important care areas. (By end of 2024 available for Skilled Birth Attendance, Emergency Obstetric and Newborn Care, Antenatal and Postnatal Care. (In English and Arabic)
- Expand the number of healthcare facilities and organisations able to conduct Standards-based (clinical) Audit standards and develop and share appropriate standards and audit tools (including checklists)

Priority Areas for task shifting and/or clarification of roles and policies were identified. (Table 11) - Provided there are clear and agreed protocols for diagnosis and treatment

Table 11: Priority tasks identified by Stakeholders.

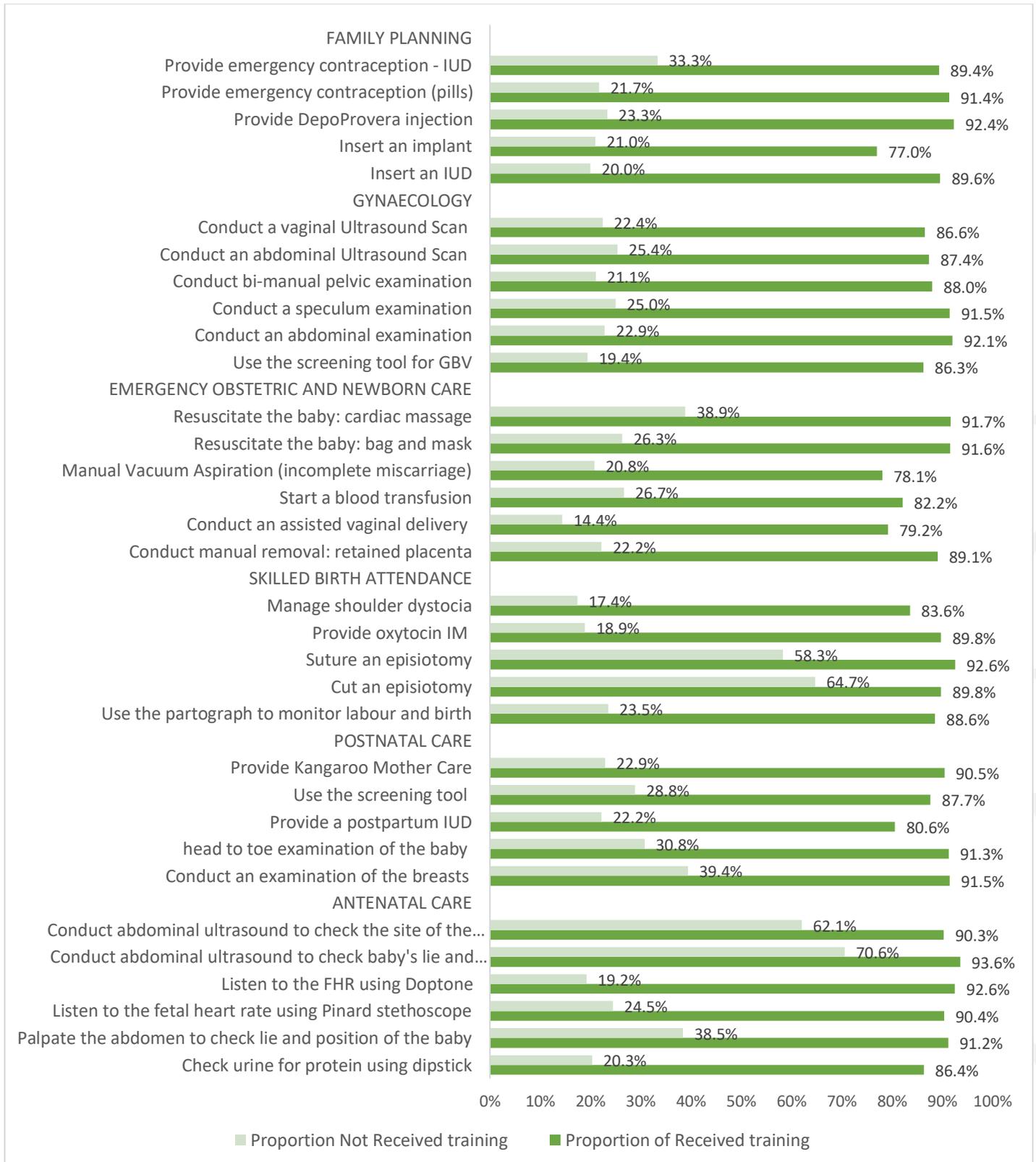
Skilled Birth Attendance	Emergency Obstetric Care	Newborn Care	Antenatal and Postnatal Care	Reproductive Health
- Episiotomy and repair	- Start a blood transfusion - Prescribe antibiotics - Prescribe antihypertensives - Provide misoprostol - Magnesium sulphate IM and IV - Resuscitation of the newborn using a bag and mask, and cardiac massage if required - Manual removal of a retained placenta - Assisted vaginal delivery (using vacuum extractor)	- Prescribe antibiotics - Resuscitation of the newborn using a bag and mask, and cardiac massage if required	- Provide prophylaxis for and treatment of anaemia - Prescribe antibiotics - Prescribe antihypertensives	- Prescribe antibiotics - Take a cervical smear (Papanicolaou (Pap) smear) - Provide emergency care and drugs for women who have experienced GBV including rape (Case Management of Rape) - Insertion of contraceptive implants

Challenges and Opportunities to address these were identified by Stakeholders as follows (Table 12).

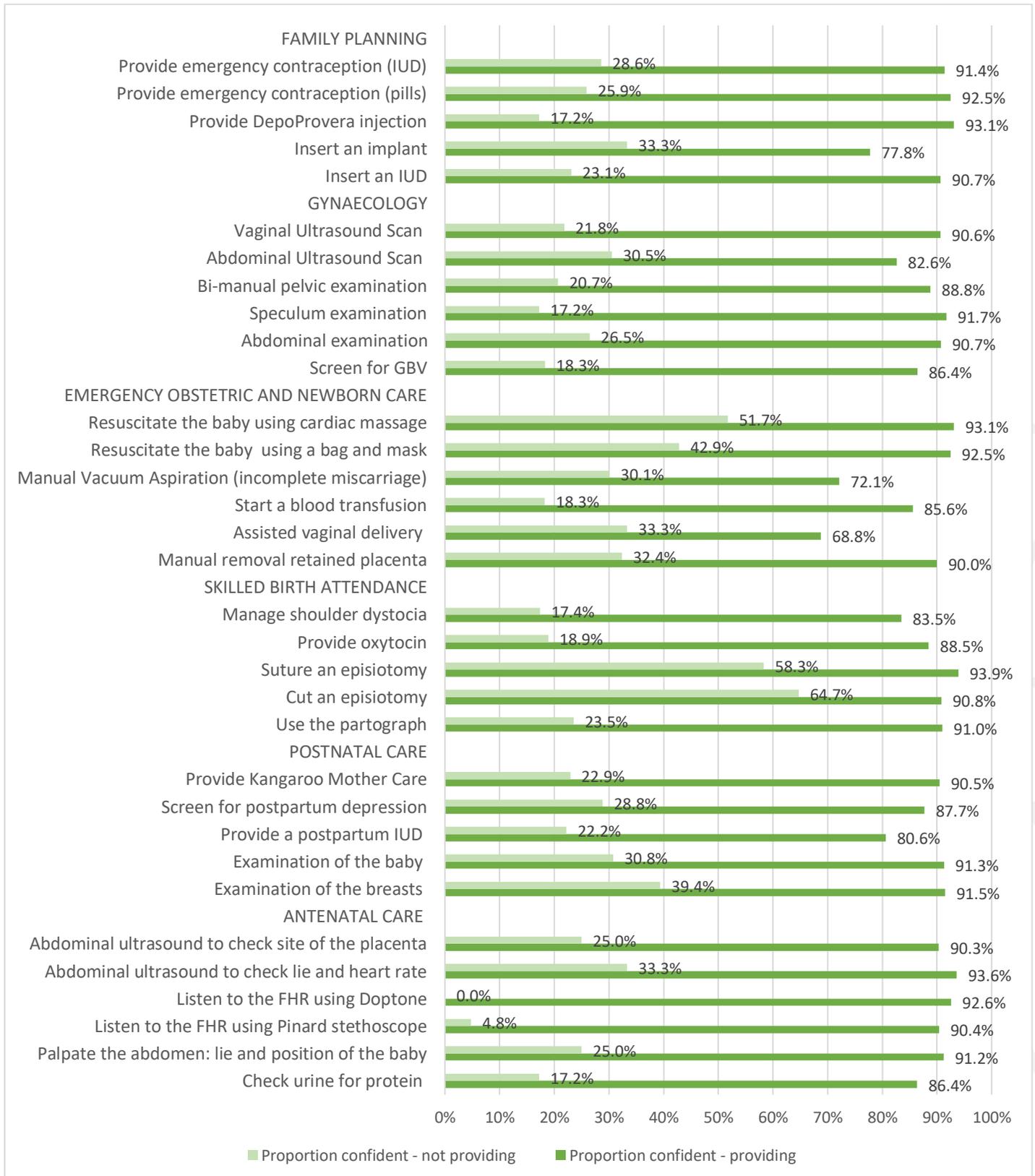
Challenges	Opportunities and Possible Solutions
<ul style="list-style-type: none"> - Lack of funding - Difficulty in securing qualified trainers (especially in remote areas). - Lack of training centers - Difficulties accessing training - Lack of midwives. - Lack of trained and qualified staff - Policies of organizations that restrict the work and powers of the midwife. - Lack of a unified policy between organizations and health authorities - Poor interaction with the subject by the Health Authorities - Lack of Medicines and Equipment in healthcare facilities - Lack of (knowledge of) scientific evidence of permissible practices - Lack of acceptance by society in the absence of legal protection for midwives 	<ul style="list-style-type: none"> - Participation in training courses and workshops covering all areas of reproductive health. - Provide centers dedicated to training - Provide transportation for staff to access training - Set up a follow-up system and continue with update training (continuous medical education) - Encourage and support midwives to participate in scientific research and gain experience. - Work on preparing trained people to spread knowledge within all facilities. - Coordinate with other organizations to develop a unified policy and unified terms of reference for midwives - Provide the necessary medicines and equipment by allocating sufficient funds - Ensure legal consent for applicability of these tasks by midwives and build trust with the community

Supplementary Figures and Tables

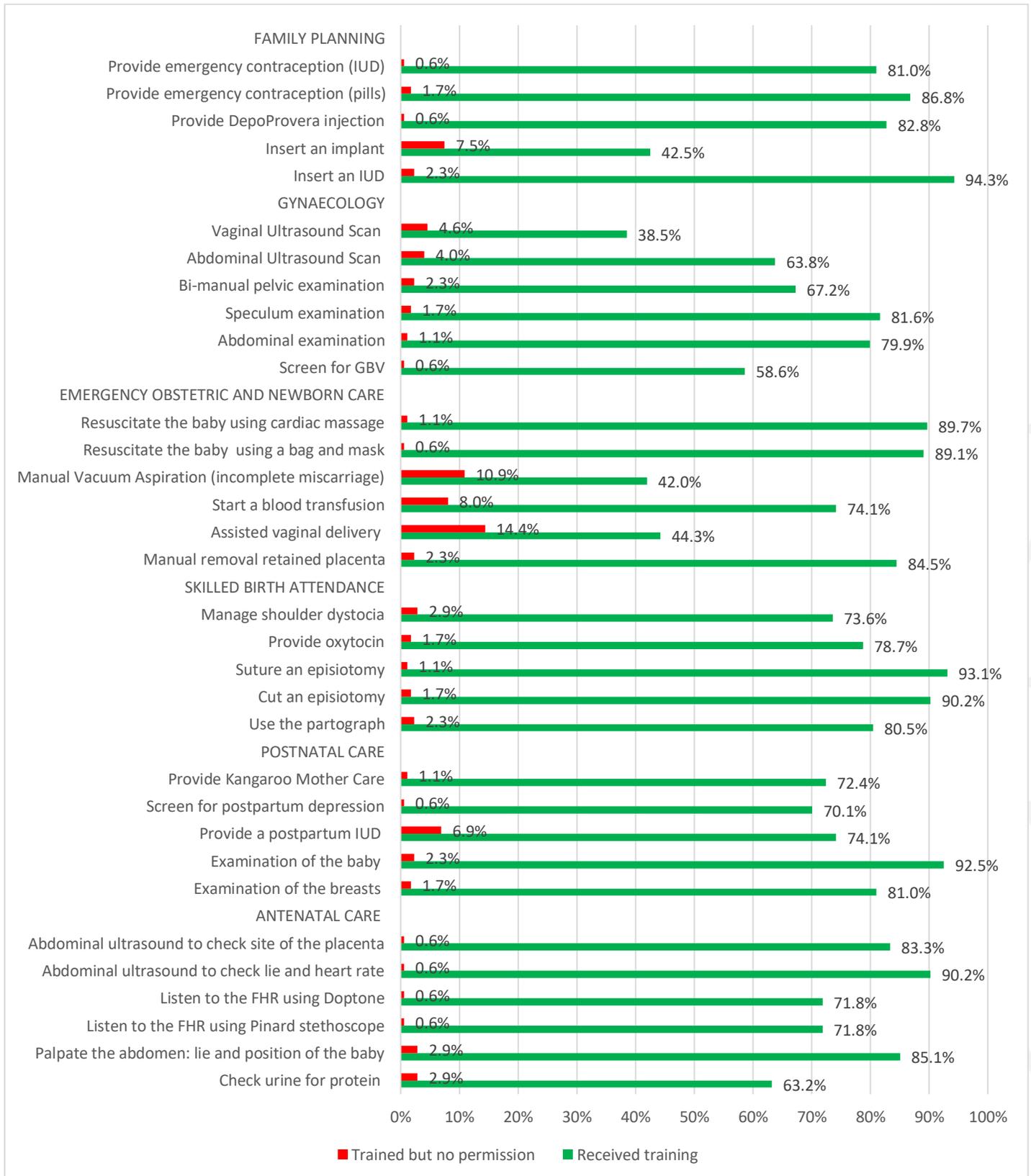
Supplementary Figure 1: Proportion of midwives who reported being confident to provide a component comparing those who were trained in the component with those who were not trained. (Confident is taken as agreed or strongly agreed on Likert scale)



Supplementary Figure 2: Proportion of midwives who reported being confident to provide a component comparing those who provide the component with those who do not provide the component in practice. (Confident is taken as agreed or strongly agreed on Likert scale)



Supplementary Figure 3: Proportion of Midwives for each component of care who are trained but do not provide this component because they are not permitted to do so. (proportion no permission is out of number trained for that component)



Supplementary Table 1: Illustrative Quotes from Focus Group Discussions (FGD) by Theme

Illustrative Quotes by Theme
<p>Scope of Practice, Policies and Guidelines</p>
<p>Midwives</p> <ul style="list-style-type: none"> - The first thing is natural births. (FGD 1) - The midwife has the right to deliver Natural births. (FGD 3) - We almost specialize in natural births only. (FGD 5) - The misoprostol requires a signature and stamp, oxytocin too. (FGD 1) - In the area I am in, I am only allowed to do normal vaginal deliveries, even though I can do other things. (FGD 2) - The health committees have a list of things that are allowed and prohibited for midwives. (FGD 2) - There is something (instructions/ policies) but oral. (FGD 2) - I have a book about obstetrics and midwifery that I studied and kept, which contains instructions. (FGD 3) - We know it (the guideline) according to the needs of the area we have, according to what is available, or what we practice in our centres. (FGD 4) - The Medical Director then the Centre Manager, and then the Health Authority. (...regarding supervisors) (FGD 4) - They said (in the NGO), according to the midwife’s protocols, it is not allowed. but I did not see anything written. (FGD 4) - Yes, before 2010, there was something called an internal system. (FGD-5) - We have a written document, when to call an obstetrician-gynaecologist. (FGD 5) - At the beginning of our job, supervisors told us our tasks, but nothing written. (FGD 8) - All the power is in the hand of doctors. (FGD 8) - We are members of the Nursing and Midwifery Association. However, they are collecting fees only. (FGD8) <p>Obstetrician-gynaecologists, Managers</p> <ul style="list-style-type: none"> - There are things like legal advice, the Health Law and a nursing union called the Medical Professions Union. (FGD6) - In general, we have three sectors: the public sector, the private sector, and the work sector of humanitarian organizations. They are not united by reference and authority. (FGD6) - We need the approval of the three sectors for the decision to be effective. (FGD6) - The leading sector is the Government sector, such as the Health Committee. (FGD6) - There is no supervisor, and when a mistake is made, there is no one to hold her accountable. (FGD7)

- Nursing and midwifery in coordination with doctors. There must be a council of doctors to determine the work. (FGD7)
- These committees exist everywhere: administrators, general doctors, gynaecologists, other specialties, or nursing midwives. (FGD7)
- The main component (of the committee...) is a gynaecologist, and it may be more than one doctor, as well as midwives, health administrators, and administrators from organizations. (FGD7)
- Through the distribution of midwives and tasks are given by the Director of the medical facility. (FGD9)
- It is by the Donor or the Administration. Our work system is arranged according to the organization's protocol previously established by it. There is a doctor and an administrator. If I make an error, the administrator is the one who supervises. (FGD9)
- The Director of the medical facility is the one who gives you tasks. (FGD9)

Discussion on what is Allowed or Not Allowed

Midwives

- We alone know what we are not allowed to do. We tell the patient because there is nothing to protect us. (FGD 1)
- Through studying at the nursing or midwifery school, they determine what is permitted and prohibited. (FGD 1)
- In our NGO, we have written documents for allowed tasks and not allowed tasks. (FGD-8)
- Some organizations allow the midwife to prescribe antibiotics, while others do not. (FGD4)
- There are two types of midwifery practitioners in the region. There are educated midwives who have been taught scientifically and are highly experienced, and there are also midwives who have not received education. (FGD 4)
- I don't know who wrote what is permissible and what is not permissible. (FGD-4)
- It is allowed after managers and doctors permission. (FGD-5)
- Midwives are only allowed to give vitamins and painkillers. (FGD 2)
- Sometimes pregnancy monitoring (antenatal care) is prohibited. (FGD 2)
- In general, midwives are capable of monitoring pregnancy (providing antenatal care). (FGD 3)
- Ultrasound, as example, can be done by midwives but not allowed. (FGD 3)
- Misoprostol was allowed to be given for a short period after which they prevented us from prescribing it. (FGD 3)
- Giving misoprostol and labour induction are not allowed, even if the midwives are able to do it. (FGD-8)
- At least we should have permission to give the initial procedures until you reach the hospital. (FGD5)
- We need training on IUD insertion, then practice it several times to be ready. (FGD-8)

Obstetrician-gynaecologists, Managers

- Allowed are labour management, natural childbirth. (FGD 6)

- Labour management, breastfeeding advice. (FGD6)
- Family planning methods, using the Partograph (to monitor labour). (FGD 6)
- A primiparous patient needs an episiotomy and the midwife may not be able to make this decision without consulting the doctor. (FGD 6)
- Her mission is to listen to the foetus and communicate with the doctor. (FGD 6)

- If the patient needs an episiotomy, the midwife informs the doctor and then performs an episiotomy. (FGD6)
- A midwife is allowed to give antibiotics, but a midwife is not allowed give magnesium sulphate intramuscularly. (FGD 7)
- She is allowed to give blood when needed. But with the organization's system, you cannot open two intravenous lines, no matter how critical, and then inform the doctor. (FGD 7)
- A midwife is not allowed to support natural birth after one caesarean section (trial of labour after one CS), support twin pregnancy, malpresentation or induction of labour. (FGD7)
- Allowed are - natural childbirth. Not allowed - for example, a patient who has a history of caesarean sections is prohibited from giving birth in the centres, meaning that any multiparous patient who is high risk or who is young is considered high risk for us. (FGD 9)
- As for those who have a history of caesarean sections, it is forbidden to insert an IUD after a caesarean section except under the supervision of a doctor. (FGD9)
- Allowed - in the event of any abnormal findings when using a partograph to monitor labour and delivery such as decreased foetal heart rate, decrease in the patient's blood pressure, the doctor must be informed immediately. (FGD 9)
- Allowed - family planning, obstetrics, and provide care during pregnancy and after birth. Not allowed - magnesium sulphate - No, it is not allowed. (FGD 9)

Opinions on Task shifting

Midwives

- There has been much development and task changes in the last decade. (FGD 1)
- No, the situation is for the worse, less tasks given for midwives now. (FGD 2)
- Only when I was working with (...Partner...), they added tasks to midwives. (FGD 3)
- (.. in an emergency...) Putting two cannulas wasn't allowed, we didn't know what to give. (FGD 1)
- She implements after the doctor decides on giving Magnesium sulphate. (FGD-8)
- Not all midwives can use ventouse, only those who work in hospitals. (FGD 3)
- Previously, labour induction was not allowed, now the NGO allows it for midwives. (FGD 4)
- We are in favour of adding duties to the midwife and with legal protection. (FGD 4)
- Task shifting is good, it might increase the experience and knowledge of midwives. It may decrease neonatal deaths because midwives are on the first line. (FGD 5)
- There is lack of interest in the midwives` tasks. (FGD-8)
- Task shifting will help more people because we will be able to do it. (FGD-8)

- You should speak with MOH, because the Health Committee takes instructions from the Ministry of Health. (FGD 2)

Obstetrician-gynaecologists, Managers

- For me, I think that gynaecological consultations should be provided, which is pre-pregnancy care, post-pregnancy care for women, or post-partum care for women, family planning, and counselling, in addition to treating common gynaecological conditions such as urinary infections, vaginal system infections. (FGD 6)
- In addition, the role of the midwife must be a substitute and a reference for the health awareness workers. When the health awareness employee gives a session on family planning, there must be a midwife present with you at the session who attends the session if there is a difficult question or if one of the beneficiaries intervenes. If you do not know the answer, the midwife must be present and answer. (FGD 6)
- The fourth thing is the filtering process before the gynaecologist. For me, it is assumed that the gynaecologist does not see any case until the midwife sees it. (FGD6)
- Developing the job description according to the need (this means that the job description changes every six months because there are things that change according to the need). (FGD 6)
- Not for all midwives, only the trained midwife is allowed (FGD 6)
- Important, but there must be effective training. (FGD 7)
- With referral due to the presence of midwives in remote areas. (FGD 7)
- Monitoring high-risk pregnancy, such as a patient with high blood pressure or pre-eclampsia, can be managed, especially for remote areas. (FGD 7)
- Management of minor to moderate postpartum bleeding because severe bleeding requires a doctor. (FGD 7)
- Because we are close to them, we will be able to provide assistance rather than having them go to a far place where there is no doctor. (FGD9)
- In recent years, due to events, we have had a shortage of doctors and personnel, and we were forced to train people in midwifery and nursing without certificates. In contrast, nursing that has a certificate is certainly better. (FGD 9)
- They trained and educated women and distributed brochures to carry out the birth process in any place, given the circumstances and in anticipation of births at any moment or place, not on appointment. (FGD 9)

How to Implement Task shifting

Midwives

- You should consult the Hospital Administration and Health Director. The administration gives the department head a choice and she will tell us. (FGD-1)
- Specialist doctors influence the managers' decision to add tasks to midwives. (FGD-1)
- I suggest that there be courses, trainings, examinations and testing for the midwife. Whoever passes the test is entitled to open a clinic. (FGD-2)

- There are a large number who practice the profession of midwifery, but they were unable to complete their education due to the circumstances in Syria. (FGD-2)
- We want to create a midwifery union. (FGD-3)
- Maybe gynaecologists do not accept task shifting. (FGD-3)
- The problem we face is that if the midwife acts, even if she is correct, and problems occurs that is not the cause, that midwife will be blamed. (FGD-4)
- We want the midwife's tasks to be like those of other countries. (FGD-4)
- If there is a law that protects me, I can do many things. (FGD-4)
- Gynaecologists may obstruct task shifting. We need proper trainings, with certificates protected by law. (FGD-5)
- Maybe the community will not accept task shifting. (FGD-8)
- From long time, nursery and midwifery association are merging as one union. (FGD-8)
- We are members of Nursing and Midwifery Association; however, they are collecting annual fees only. (FGD-8)

Obstetrician-gynaecologists, Managers

- The Union itself, the Ministry of Health in coordination and consultation with all Unions and the Ministry. (FGD6)
- As instructions or internal regulations, you will receive the Ministry of Health in Damascus, legal administrators. (FGD6)
- Health Committee because there is no Ministry or Union. (FGD9)
- Nursing and Midwifery Union. (FGD 9)
- Through the presence of a Union for Midwives, we can consult them, which is the most important thing, and through them we determine the tasks and work of the midwives, what are the permissible tasks and what are not, because they waste their time with work that someone else can do. (FGD 6)
- We consult gynaecologists, specialist doctors, and midwives, and after taking questions and collecting common points, we must obtain the approval of the three sectors. (FGD6)
- Gynaecologists must be consulted. We must choose a specific group of doctors who work with midwives, because there are doctors who only work in a clinic. (FGD 6)
- Encourage the transfer of tasks to midwives. (FGD 7)
- Encouragement through training and amending the organizations' system protocols. (FGD 7)
- By establishing specific protocols for each case, how to perform the procedure. (FGD7)
- The organization may have special reasons why the midwife cannot do some work. Therefore, we must communicate with them to reach a unified formula in Northeast Syria for midwives. (FGD7)
- There is a chance if we undertake this initiative (FGD9)
- It is a positive opportunity because the situation has changed, and we are supposed to be allowed to carry out tasks. (FGD 9)

Supplementary Table 2: Illustrative Quotes from Key Informant Interviews (KII) by Theme.

Illustrative Quotes by Theme
Scope of Practice, Policies and Guidelines
<ul style="list-style-type: none"> - I don't know, not me who wrote it but maybe they depend on WHO, this is the usual way with us. (KII 10) - Commonly we are trying to go with global instructions. Even to lead in this. (KII 2) - In the NES, the midwife's tasks for now are different from the old days. The tasks were specific, in certain areas and in others it is not specific. In the NGOs is clearer, in other areas it is not clear. (KII 15) - Yes, there is a Job Description, but it is difficult to follow. Due to lack of staff, a midwife will do a doctor's job, she could cover nurse and vice versa. (KII 14) - I would say no harmonisation of Job Descriptions- every NGO has their own and their own salary scales. The Job Description is based on the scope of work of the NGO and is not the general one in the NES. So, depending on the project. (KII 9) - I think scope of practice is not well defined, it is not clear cut, the scope of practice is different in different facilities and different from one NGO to another. (KII 12) - On the national clinical guidelines, no, I searched, but I couldn't find anything. (KII 1) - No, there is no unified reference for the midwife's tasks. (KII 3) - We reviewed and adapted a national one and are checking international ones. (KII 13) - Sadly, no we do not have a legal framework, no midwife's association, no regulations, it's up to me. (KII 13) - We (the HA) are following the Damascus policies and guidelines, WHO recommends us to use the Damascus policies which are following the WHO guidelines. (KII 15) - There is no legal framework. So, we will have different instructions from every health committee; in Hassakeh, Raqqa and Menbij etc. (KII 2)
Tasks and Capacity of Midwives
<ul style="list-style-type: none"> - Medical officers in general, and the obstetrician-gynaecologist working in that facility specifically will supervise midwives. (KII 5) - Their tasks are to monitor pregnancy, telling and knowing the date of delivery and age of pregnancy and normal vaginal delivery, giving tonic, antenatal and postnatal care in general. (KII 5) - In the NES, basic ultrasound, and monitoring during pregnancy, assist at normal vaginal delivery. They can do more family planning, and it is important to educate them about that. And they need refresher training for antenatal and postnatal care. Training is needed. (KII 10) - They are good at antenatal care, screening for risks in pregnancy, treating pregnancy diseases such as urinary tract infection, vomiting, abdominal discomfort. Also, they can do postnatal care, exam babies and provide family planning care. (KII 8) - Normal deliveries, receiving women for antenatal care, and the usual visit of and checking babies. But they are not doing well, not following all standard indicators. (KII 11)

- Antenatal and postnatal care, family planning and it depends on the midwife and her knowledge and experience, but these are the tasks the midwife does well. (KII 7)
- Can midwives give IV/IM Magnesium sulphate? They can do that but under doctor supervision in high level CPHC not in private clinic. (KII 15)
- Can midwives start a blood transfusion when needed? No, they need doctors with them. (KII 4)
- Midwives are not allowed these tasks (... relating to CS, ectopic pregnancy, complicated miscarriage....) (KII 10, KII 8)
- Doing a CS, giving magnesium sulphate, blood transfusion, complicated D&C are not allowed. Pethidine is not available and not allowed. The tasks need more training. (KII 7)
- Vacuum (assisted) delivery - they are afraid to do - and D&C are tasks not allowed. Midwives want to use Manual Vacuum Aspiration (MVA), but we don't have it, and it is not allowed. (KII 6)
- Regarding assisted delivery.... legally she is not allowed, and she did not train to do that. In Syria, forceps is not used and ventouse is used in rare occasions. (KII 2)
- Assisted delivery is just for experienced and skilled midwives and should be done near hospitals. (KII 10)
- Can midwives conduct assisted delivery? Yes, they should, but in CPHC. (KII 14)
- For drugs prescriptions we are limiting prescription power of midwives, because most of them are alone in the facilities (KI6)

Regarding Task shifting

General

- A good approach to distributing tasks well, to alleviate the burden of the lack of staff. (KII 3)
- With experience and knowledge, with clear protocol and a clear plan, yes, it is good. Not for all tasks, not for CS and not for D&C. (KII 6)
- I always support the idea, in most countries, in remote areas you cannot find highly trained doctors. (KII 12)
- Yes, why not, surely, we should prepare her for that. Training, equipment, protocols, agreement, and coordination are needed. (KII 7)
- I am in support, mainly in rural and far areas, we should decide what tasks to transfer to her. comprehensive and extensive training is needed and follow-up with the midwives before the task shifting. (KII 16)
- No, I did not hear any plan, but... (organisation)... is trying task shifting and piloting this. (KII 8)
- No, I have not heard of it formally, informally only. (KII 7)
- No, informally I heard about it a long time ago. From doctors to nurses because of low number of doctors in the NES. (KII 10)

Opportunities

- Opportunities are there is a need for services and a lack of doctors. (KII 4)

- We need to have task shifting, we need to provide the services, and for financial reasons – it is better and cost efficient for the community and for better coverage. (KII 15)
- There are a lot of benefits for the people and in rural areas, better services' quality, and decrease dangers for mother and baby. (KII 14)
- We have collaborative Health Authorities, and task shifting will be joy for Donors as well as Actors. (KII 9)
- There are several opportunities including, willingness to do task shifting by NGOs, acceptance by Local Authorities and there is need because of gaps of healthcare providers. (KII 12)
- Opportunities are there is a need, lack of doctors, and remote area demand. (KII 13)
- There are opportunities with NGOs because they have needs and a low number of obstetrician-gynaecologists, so we can build on this experience. (KII 2)
- Opportunities are using doctor`s time better and increase the capacity for midwives. (KII 5)
- Task shifting is good to decrease the workload and to decrease costs for NGOs then for the patient, and to increase accessibility for the community, to enhance capacity building for midwives in the NES. (KII 10)
- It is possible, midwives are available, and large numbers of them, reducing time, they have good knowledge from school and practice. (KII 8)
- We can gather the midwives and check with them the issues and to know their complaints, some midwives are working as nurses, in public and private sectors as well as in the NGOs. We are having a new system, and we should check with the field, the needs. We need trainings and periodical trainings and to check the updates. (KII 16)
- NGOs are bringing comprehensive care and more team working, so they are pushing to comprehensive care to all, instead of centralized traditional model in which doctors are giving the care. We are in the crossroad to define the model for the NES. We are on the way to develop a system of model. There is a need because of lack of doctors and a large number of midwives. So, it is important to speak about task shifting. (KII 11)
- For opportunities, our new project, and as part of it we will support health technical institutes (technical support), to have clear new job descriptions. (KII 7)
- Opportunities are there is a need, lack of doctors, and remote area demand. (KII 6)

Barriers

- So, the opportunity is, involving them. In some practices that are done by doctors and training them, as I said. On managing complications because usually the thing that prevents us from giving them the authority to use some kind of drug is the complication. So, giving them like a full view and training them, how to manage those complications, I think that would come very handy. (KII 1)
- The barriers are social norms, lack of experience and lack of supervision. (KII 4)
- We need to check their attitude, practical training, length of experience in the area to do the training. The distance is an issue and old system bureaucracy. (KII 15)
- There is a low number of staff, and a lot of tasks, financial constraints and transportation are a burden too, low salaries in public places are a big issue. (KII 14)

- Task shifting might be a long process, there are a large number of stakeholders, and patterns, funding is going low. (KII 9)
- The overall security situation is a concern, identifying the candidates for task shifting, in some remote areas more resources are needed including technical and financial resources. (KII 12)
- Legal framework and policies are not available, there is no union for midwives, doctors have no trust in midwives, like what happened with the doctors' unions to prevent midwives from writing any descriptions. (KII 2)
- Midwives sometimes refuse to increase their tasks because they are afraid of the workload and tasks with no protection. Another barrier is the practicality, it is difficult, and training should be long and serious. Also, sometimes people refuse change, medical students are facing refusal by the staff because they are new and not well organized. So, we need to organize that very well. We need to do practical training on patients in hospitals which is a challenge too. (KII 5)
- Community acceptance could be a problem mainly in the beginning. Some of the midwives are not able and may refuse to take more responsibilities to avoid problems. They may ask for more salary if we increase their tasks. (KII 10)
- Some doctors are against that to have more work (themselves). Low education, and knowledge among some midwives because of weak pre-service training and the general, economic situation will need consideration. Some midwives are doing more tasks 'cross over their duties' especially in private clinics. (KII 16)
- After planning for task shifting, midwives themselves may refuse, and old persons will reject any changes. There are individual differences, the community, and the context to consider. (KII 7)
- The barriers are the context that we are in and the fact that there are different guidelines that are just adopted by organizations. (KII 1)

Approaches to Implementation

- The approach would mean to bring the Health Authority on board, to involve a lot of stakeholders, to introduce something new in the NES needs acceptance to do that and community views will also need to be considered. (KII 8)
- We should review the scope of practice, to know our place and where we want to go. We should have an Association and continuous training to teach more, and midwives should educate themselves continuously, to develop practice and sure we need training. (KII13)
- Every NGO should give EF a list of midwives who are able to handle task shifting so we can choose capable ones only and depending on the need, assessments in the facilities and check with professional midwives only. Task shifting to all midwives is difficult. (KII 13)
- Community resistance, a lack of training and conflict between the professionals, private organisations and government are barriers. Midwives should have salary incentives, and a legal framework. So, we need to convince doctors, who are leading the health authorities, and maybe there is a doctors' lobby to discuss with. Inclusion of all actors will be important. (KII 11)
- While the barriers are social norms, lack of experience, lack of supervision, a law and stating legal responsibilities as well as protocols should be there. A midwife will have a lot of tasks on

her shoulders, needing more appreciation from certain doctors, and with a clear policy. (KII 6)

- We need training for doctors and midwives; to inform doctors about the changes in the midwives' duties, obstetrician-gynaecologists should know that. To publish the new policies and protocols and inform them. HA, WHO in the NES, the HWG and all the NGOs working in the NES. (KII 6)
- The first thing is we need to speak with the Health Authorities, we should have a law to protect midwives. Now midwives are not able to do a lot of things because they don't have legal coverage. There is no Midwifery Union to monitor their work, at least the Union is not known. (KII 2)
- First, we need to agree with the forum and HA to agree on that and with WHO we need to agree on task shifting. Because we must recognise the MOH. (KII 9)
- We should decide the tasks to be shifted after the obstetrician-gynaecologists committee is ready with written documents, then conduct trainings on these tasks and identify which stakeholders would like to be consulted. (KII 16)