

## Journal of Asian Midwives (JAM)

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Volume 2 | Issue 1

Article

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6-2015

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### Recommended Citation

Ireland, J, Teijlingen, E, & Kemp, J. Twinning in Nepal: the Royal College of Midwives UK and the Midwifery Society of Nepal working in partnership. *Journal of Asian Midwives*. 2015;2(1):26–33.

## **Twinning in Nepal: the Royal College of Midwives UK and the Midwifery Society of Nepal working in partnership**

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### **Abstract**

The midwifery association of the United Kingdom, the Royal College of Midwives (RCM), has twinned with the Midwifery Society of Nepal (MIDSON) to help strengthen the latter association, through its Global Midwifery Twinning Project (GMTP). The GMTP aims to strengthen midwifery and develop leadership, advocacy, and campaigning skills both at the level of the association and at the individual midwife level. Reciprocity is an important aspect of twinning as the RCM also hopes to strengthen midwifery in the UK through greater engagement of its members and a raised profile of global maternal and new-born health. This paper describes the importance of collaboration between established national midwifery organisations and newly established ones. It includes a case study outlining the experience of a UK midwifery volunteer in Nepal. The paper ends with some thoughts on the effects of the GMTP project on midwifery in Nepal.

### **Keywords**

International cooperation, development, empowerment, midwifery profession, Asia

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## **Introduction**

The International Confederation of Midwives suggests that a strong midwifery profession rests on three pillars: (1) education; (2) regulation; and (3) association.<sup>1</sup> Education is required to provide a highly competent, qualified workforce; regulation sets forth the legal basis for professional practice; a strong association supports and advocates for its members. Twinning is a method to strengthen a midwifery association in a country, thereby, helping it to benefit fully from its midwifery workforce.<sup>2</sup>

The Royal College of Midwives (RCM) is the only trade union and professional organisation in the United Kingdom (UK) led by midwives, for midwives and those who support them (i.e. maternity support workers). The RCM represents the interests of midwives in all four UK countries (Scotland, England, Wales, and Northern Ireland), individually and collectively, promoting excellence, and innovation and leadership in the care of childbearing women, the newborn and their families, nationally and internationally.

The vast majority of UK midwives belongs to the RCM because of the combined professional, trade union, and educational benefits that it offers. It is committed to promoting, supporting, and influencing a maternity service that meets the needs of women and their families throughout pregnancy, labour, and the postnatal period. A maternity service based on woman-centred care is a vital contribution to public health and an essential investment in the well-being of tomorrow's citizens anywhere in the world.<sup>3-4</sup> Professional associations are an important bridge connecting the needs of service users, policy makers, and health workers. A strong professional association sets standards of care and advocates for users while motivating staff to continually improve the quality of their care.<sup>5</sup>

## **RCM Global Midwifery Twinning Project**

The RCM has worked with three low-income countries (Nepal, Cambodia, and Uganda) through the Global Midwifery Twinning Project (GMTP), a three-year initiative funded by the UK Department for International Development which aims to strengthen midwifery associations through twinning. The GMTP aims were to strengthen different areas of each midwifery association and develop leadership, advocacy, and campaigning skills at the level of the association and the individual midwife level. Reciprocity is an important aspect of twinning; whilst endeavouring to strengthen the capacity of its twinned associations in influencing midwifery regulation, education, and practice the RCM also hopes to strengthen midwifery in the UK through greater engagement of its members and a raised profile of global maternal and new-born health.<sup>6</sup> The two Asian countries (Nepal and Cambodia) have been 'twinned' with Scotland and England respectively.

Nepal is in need of more and better midwifery education to train skilled birth attendants, since, currently, midwifery is not formally recognised by the government.<sup>4</sup> Interestingly, as long ago as 1928, Nepal sent four women for midwifery training to India, whilst in 1978 a two-year midwifery course was established in Nepal but after two years it disappeared. In 2006, the Government of Nepal showed the first signs of realising the need for professional midwifery. However, despite support from UNFPA (United Nations Family Planning Association) and the Government of Sweden, little progress has been made in the status of midwifery as a profession since 2006.

After completing the ICM's Member Association Capacity Assessment Tool each twinned-midwifery association developed an action plan to address various aspects of organisational development.<sup>7</sup> Since 2012 GMTP has included specifically designed workshops, in-country and remote support by the RCM's global team, and the placement of expert UK midwife volunteers for periods of two to four weeks to work with national counterparts on specific areas of development. The following case study reflects one of the authors' experiences in Nepal as a UK volunteer midwife.

### **Case study**

In December 2013, the first author was placed with the Midwifery Society of Nepal (MIDSON) to help build their capacity for advocacy and to strengthen midwifery education and practice, working alongside national counterparts. In the same visit two other RCM volunteers were placed in a hospital and a university, respectively, which gave the three an overall view of maternity care. The principle of co-presence is very important to sustainable volunteering in projects such as GMTP.<sup>8</sup> The volunteers had to be flexible and willing to adapt to several different settings and a variety of expectations in Kathmandu. They got used to plans changing frequently! Maclean suggests the ideal short-term midwifery consultant is flexible and can see the big picture; teams of consultants can help review a situation and offer advice from different perspectives.<sup>9</sup>

Nepal has still not recognised midwifery as a separate profession. Therefore, the members of MIDSON are originally trained as nurses working in the field of maternity care, so-called nurse-midwives. MIDSON (with input from UNFPA) has been campaigning since its inception in 2010 for a (1) separate education programme; and (2) official recognition of midwives. Midwives are needed to bring maternity care to those getting none/too little and to limit unnecessary interventions for those getting the wrong kind of medicalised care. The latter is a growing problem in the mushrooming commercial hospitals in Kathmandu, something which is disempowering women receiving care in the private sector. There is a creeping rise in unnecessary surgical interventions (especially Caesarean Sections in women who would have benefited from psycho-social support to help deliver their baby naturally) in the private hospitals.<sup>3</sup> The first author had visited MIDSON in 2012 on a scholarship from the UK-based Iolanthe Midwifery Trust to deliver workshops, so her initial 'settling in' period was shortened by this exposure.<sup>10</sup> The Iolanthe Midwifery Trust supported workshops focused on reflection and 'emotion work'. The latter is a concept reminding us that the world of work includes an element of emotions and we need to pay attention to this 'feeling' aspect if we want to understand work and jobs properly.<sup>11</sup>

The MIDSON's office is currently two borrowed rooms within the nurses' home, close to a major Kathmandu maternity hospital. Finding more suitable and sustainable premises is a pressing need. The first author's role was to work with a MIDSON member to assist in advocacy work. Her experience as an RCM learning representative in the UK enabled her to support Nepali midwives in their development and learning in the workplace.

After the first few days in Kathmandu the GMTP volunteers felt a bit 'at sea', (although 1,350 metres *above the* sea level!). This is likely a common feature of overseas volunteers and workers alike. There seemed so much to do that it fostered a feeling of helplessness, yet, there was also the weight of responsibility to use one's time effectively. It took time for them to realise that they were a part of a wider project within distinctive historical, geographical, cultural, and

political contexts, the outcomes of which would be based on the sum of ALL the RCM volunteer placements. Walking around the historical centre of old Kathmandu with its ancient buildings made them feel the importance of preserving history and culture and not changing things unnecessarily. They discussed that if women's lives improved these artefacts would still stand!

During this volunteer's visit to Nepal, Nelson Mandela died on 6<sup>th</sup> December 2013. They discussed his life and work and reflected on his messages:

a) The volunteers felt a bit overwhelmed by the situation of women in Nepal. MANDELA SAID: "It always seem impossible until it's done."

b) They felt small and inadequate and felt that women in Nepal are powerless.

MANDELA SAID: "Our greatest fear is not that we are inadequate, that we are powerful beyond measure." This was the statement that created most discussion as it was not what one would have expected. Perhaps deep down we fear that we can do it, and that we then have to do it and be responsible for our action.

c) The volunteers were very conscious of the possibility of causing offence by offering their own opinions and suggestions for change. MANDELA SAID: "As we let our own light shine, we unconsciously give others permission to do the same."

These inspirational messages helped the RCM midwives to make some sense of the state of midwifery and maternity care around them in Nepal.

The volunteers were given the opportunity to run their workshop 'the Midwifery Model in Action', in which they conveyed to a group of Nepalese maternity care providers the nature and strength of the midwifery model. The midwifery model refers to a more psycho-social model rather than a very medical model of pregnancy and childbirth.<sup>12-13</sup> Ten people (including 4 obstetricians) participated and laughed at our role plays. Doing role play didn't appear to be a common way of learning amongst professionals in Nepal.

Due to illness one of the MIDSON liaison midwives, did not have much time to spend with the first author. Hence, the latter set to work preparing presentations which could be useful for the MIDSON Executive, such as: (a) writing for publication; (b) writing in English as a second language; (c) preparing a press release, (d) how to be an advocate; (e) strategic planning for a professional organization; (f) RCM membership; and (g) the Midwifery Model in Action. Unfortunately, not all of these could be shared in the workshop, although they have been saved and stored. A point worth mentioning here is that the eleven members of the MIDSON executive all have other jobs to go to, as do all its general members, hence, it is difficult for them to come together for the association's activities.

Volunteers ran a 'Midwifery Model in Action' workshop at Patan Hospital that had been requested by the then Vice president of MIDSON, who is a retired director of nursing at the hospital, owner of a birth centre, and a skilled birth attendant trainer. The nurses are used to coming together (a few from each ward) every day for training and we quickly had an audience of about 35 to take part in this workshop.

We later met the medical director, a very affable obstetrician. He is in favour of free-standing birthing units (rather than ones situated within a maternity hospital) for two reasons:

- a) There is too much pressure on beds in the main hospital. The space previously set aside for a birth centre is consistently having to be used for ‘overspill’ postnatal women and babies;
- b) When doctors see women in their private practices (outside the hospital) they have the tendency to ‘visit’ and then the urge to ‘interfere’. This medical director was refreshingly honest and his views were in perfect keeping with recent evidence supporting midwife-led care from the Birthplace in an England study.<sup>14</sup>

A final report was presented to the MIDSON Executive and the Nepal Government Minister for Health and Population. The report highlighted issues of volunteers and volunteering, cultural differences between midwifery in the UK and Nepal, as well as wider issues, such as the role and position of women in society. The report especially highlighted the under-usage of the more junior midwives in MIDSON.

### **Conclusions & Recommendations**

Improving the organisational and management skills of a profession requires a large investment of time and effort. Somehow that is complicated when an association such as MIDSON does not have funding for full-time staff and is largely run by volunteers, who have full-time jobs elsewhere. Its members have competing priorities and limited time and energy to invest in their association’s activities. While the benefits of belonging to a professional association are often apparent in the long term, associations may only be able to provide short-term incentives to their members because of funding insecurity.

There are many different ways to help strengthen professional associations in low-income countries. GMTP itself included a range of different ‘little’ interventions by different midwives at different times, customised to the needs and context of midwifery in Nepal, in general, and MIDSON, in particular.

An external evaluation of the project in March 2015 found that the programme had had beneficial effects on midwifery practice, education, and regulation in Nepal. It had strengthened and increased MIDSON’s commitment to improving maternity and newborn care; it had created strong twinning relationships and enabled networking and sisterhood between midwives in Nepal and three other countries; it had raised awareness of midwifery issues in low-income countries and the importance of international engagement among volunteer midwives, their employers, RCM staff and members, policy makers, and other stakeholders in the UK; and it had given many volunteers greater confidence in their own skills and knowledge, and renewed their commitment to midwifery in the UK.

Perhaps, innovations such as GMTP need to learn from the principles of research in low-income countries.<sup>15</sup> For example, by considering (some of) the key elements of research partnerships as outlined by the Swiss Commission for Research Partnership with Developing Countries (see Table 1).<sup>16</sup>

**Table 1**

Principles of research partnerships

Decide on the objectives together
Build up mutual trust
Share information, develop networks
Share responsibility
Create transparency
Monitor and evaluate the collaboration
Disseminate the results
Apply the results
Share the profits equitably
Increase research capacity
Build on achievements

Associations for female-dominated professions, such as nursing and midwifery, are able to provide women with a mechanism to take on leadership roles that might otherwise be unavailable to them. We would agree with Quimby and Mantz<sup>17</sup> that empowerment is a by-product of stronger associations whereby individuals (in MIDSON's case women) gain courage and strength by working together in groups toward a common cause.

**Postscript**

We like to think that this three-year capacity building project has helped MIDSON in its response to the recent earthquakes in Nepal. MIDSON now has the networks and systems in place as well as the skills to react in a timely manner to the needs of pregnant women and newborn babies after the earthquakes. At the same time the RCM has set up an appeal in the UK to raise funds to support MIDSON in its valuable work.

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