Somaliland Nursing and Midwifery Association (SLNMA)

2020

VOICES OF NURSES AND MIDWIVES

NEWS LETTER 2020

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SLNMA RESPONSE TO COVID-19

Somaliland Nursing and Midwifery Association (SLNMA) is a member led professional association established in November 16, 2004. The mandate of the Association is to act as both the professional organization and a representative for the nurses and midwives by protecting, developing and building their capacity in order for them to deliver quality healthcare services. Since Covid-19 recognized emerging public health problem globally, SLMA is committed to keeping you informed about our actions in response to the Coronavirus Disease (COVID-19) pandemic and national emergency. However, Keeping nurses and their families safe is a top priority of the association.

It is doubtless that we are living in a world with a bundle of public health problems. We are all watching and witnessing the devastating effects of Covid-19 pandemic. Somaliland is one of the African countries affected by the Coronavirus. The president of Muse Bihi Abdi announced that the country is in a state of partial emergency and lockdown. The government established National Coordination Committee taskforce for COVID19 response led by the Vice President of Government of Somaliland. SLNMA is an active member working with the 9 members of civil society working with the national taskforce.

Given the rapidly evolving situation, SLNMA launched first Covid-19 online awareness and prevention raising program. First batch of Trainer of Trainee for Covid-19 online awareness and prevention sessions in Somaliland. In total 106 Nurse and Midwife participants (74 female, 32 male) from six regions of Somaliland (Awdal, Marodijeh, Sahil, Togdheer, Sool and Sanaag) recruited and trained them on how to organize covid-19 online awareness raising and prevention sessions. This programme Covid-19 online awareness and preventions sessions was developed to enable existing mid-level Nursing and Midwifery professionals to get updates of Covid-19 on a daily basis, understand emerging knowledge of the disease, identify its symptoms, summarize how it spreads, and promote social distancing to the clients and their families who are visiting hospitals and clinics. That means a large number of our nurses and midwives are teleworking.

Our desire is to help stop the spread of the virus and protect our nurses, midwives, and their families. Therefore, we are closely observing and monitoring and following the WHO guidelines for social distancing. Nurses answer the call to serve their country and communities during times of crisis. We know that clear communication, collaboration, resilience and innovation are key to navigating the challenges of effectively responding to COVID-19. We stand with you and will continue to advocate on behalf of our nation's nurses and midwives.

On International Nurses Day, Somaliland Nursing and Midwifery Association (SLNMA) is closely monitoring the situation of frontline nurses and midwives in both public and private hospitals in Somaliland. Prior to this, SLNMA plans to discuss with its partners and key stakeholders to commission the first-ever report on Nursing and Midwifery workforce situation analysis in Somaliland by the end 2020. The report will provide accurate statistics of nursing and midwifery workforce, knowledge gaps and support evidence-based planning to optimize the contributions of this workforce to improve health and well-being for all. The report will set the agenda for national Nursing and Midwifery Continuous Professional Programs (CPD) and investment in the health workforce for generations to come to make healthcare simple.

Happy Anniversary! To all Somaliland Nurses and Midwifery Professionals for their commitment and contributions to improve healthcare services in Somaliland. Our promise is to advocate and support the ministry of health and development make health care are accessible and affordable for everyone.

By: Fouzia Mohamed Ismail ,

Chief Executive Director

Information sharing

The Somaliland Nurses and Midwives Association in partnership with the International Council of Nurses and the WCEA is now providing all members with a Continuing Professional Development (CPD) online platform and Mobile Application.

The App now contains FREE branded COVID 19 and CPD Resources from the Royal College of Nursing, the Royal College of Midwives, Jhpiego, Aga Khan University and many other respected educators.

The COVID-19 course was given to 106 midwives and nurses through a Mobile App. Those who have taken the course so far are from different regions within Somaliland.

We will keep registering more for the program to upgrade them on new trends, new development, other evidence based information and best practice guidelines

2020 INTERNATIONAL YEAR OF THE NURSE AND THE MIDWIFE

CELEBRATE
DEMONSTRATE
MOBILISE
UNITE

The World Health Organization (WHO) has designated 2020 as the "Year of the Nurse and Midwife", in honour of the 200th birth anniversary of Florence Nightingale. The year 2020 is significant for WHO in the context of nursing and midwifery strengthening for Universal Health Coverage. WHO is leading the development of the first-ever State of the World's Nursing report which will be launched in 2020, prior to the 73rd World Health Assembly.

Furthermore, supported by the United Nations Population Fund (UNFPA), an update to the "State of the World Midwifery Report3" will be published. The production of these reports will offer a major opportunity for nursing and midwifery to raise our profile and highlight the many solutions the professions can offer to improve the health and welfare of individuals worldwide.

Nurses and midwives make up the largest numbers of the NHS workforce. They are highly skilled, multi-faceted professionals from a host of backgrounds that represent our diverse communities. 2020 is our time to reflect on these skills, the commitment and expert clinical care they bring, and the impact they make on the lives of so many. This year is also an opportunity to say thank you to the professions; to showcase their diverse talents and expertise; and to promote nursing and midwifery as careers with a great deal to offer. For the first time, countries across the world will unite in recognition of the essential role that midwives play in achieving the Sustainable Development Goals and Universal Health Coverage.

THEME

The International Year of the Nurse and the Midwife is mainly focusing on **celebrating** the work of midwives globally. **Demonstrating** through evidence the impact of midwives and the case for investing in midwives. **Mobilising** midwives, midwives' associations, women's groups and the wider global community to advocate for midwife-led care. **Uniting** midwives and women towards a common goal of gender equality.

KEY MESSAGES

International Year of the Midwife provides the opportunity to advocate for the strengthening of midwives and the midwifery profession globally.

- Building a strong partnership between women and midwives is key to delivering quality maternity care that is based on respectful care.
- Care from a competent and qualified midwife during pregnancy, birth and the postnatal period is a human right for women and newborns everywhere.
- Midwives deserve enabling environments to deliver quality care worldwide.
- Midwives unite with women to protect and progress women's rights globally.

JANUARY 2020

Somaliland Nursing and Midwifery Association (SLNMA) Together with photographers from Youth-Peer, and with the support from United Nations Population Fund (UNFPA) in Somaliland showcased the first babies born on 1 January 2020 under the care of a midwife to commemorate the heroic work of those in the frontline delivering our babies and saving lives. The below are some Images shared with short facts about the new babies, mothers, midwives, place, time and delivery by providing informed consent to the mothers before the photo and information are shared.

Data collect Delivery form

Celebrating the year of nurse and midwifery 2020

Name of mother	Najah Abdilahi Hussein
Name of midwife	Edna Omer Ma'alin
Sex of New born	Female
Delivery Date	01/01/2020
Mode of Delivery	Normal Delivered by midwife
Delivery Time	12:03 AM
Delivery location	Edna Adan Hospital

Name of mother	Deeqa Ismael Jama
Name of midwife	Amal Abdi Iidan
Sex of New born	Male
Delivery Date	01/01/2020
Mode of Delivery	Normal Delivered by midwife
Delivery Time	1:10 Am
Delivery location	Dr. Khalid MCH

Name of mother	Sahra Hussein
Name of midwife	Hafsa Mouse
Sex of New born	Male
Delivery Date	01/01/2020
Mode of Delivery	Normal Delivered by midwife
Delivery Time	04:30 PM
Delivery location	Gargaar Multi Specialty Hospital

Name of mother	Ayaan Abdi Shaybe
Name of midwife	Edna Omer Ma'alin
Sex of New born	Male
Delivery Date	01/01/2020
Mode of Delivery	Prolonged Labour Delivered by midwife
Delivery Time	12:23 AM
Delivery location	Edna Adan Hospital
Additional information	The baby has been cared 8 hours in NICU and get recovered

Name of mother	Safiya Abdi Diriye
Name of midwife	Muna Omer
Sex of New born	Female
Delivery Date	01/01/2020
Mode of Delivery	Normal Delivered by midwife
Delivery Time	02:00 PM
Delivery location	Edna Adan Hospital

Name of mother	Eido Mouse Ali
Name of midwife	Hamda Kayd Mohamed
Sex of New born	Male
Delivery Date	01/01/2020
Mode of Delivery	Normal Delivered by midwife
Delivery Time	03:25 PM
Delivery location	Edna Adan Hospital

Name of mother	Mushtaq Hussein
Name of midwife	Ayan Saleban
Sex of New born	Female
Delivery Date	01/01/2020
Mode of Delivery	Normal Delivered by midwife
Delivery Time	01:09 AM
Delivery location	Gargaar Multi Specialty Hospital

Name of mother	Hibaq Nour
Name of midwife	Ifrah Adan
Sex of New born	Male
Delivery Date	01/01/2020
Mode of Delivery	Normal Delivered by midwife
Delivery Time	07:00 AM
Delivery location	Gargaar Multi Specialty Hospital

Name of mother	Milgo Farah
Name of midwife	Hafsa Mouse
Sex of New born	Female
Delivery Date	01/01/2020
Mode of Delivery	Normal Delivered by midwife
Delivery Time	09:00 AM
Delivery location	Gargaar Multi Specialty Hospital

Name of mother	Fatuma Hassan
Name of midwife	Layla Abdoo
Sex of New born	Male
Delivery Date	01/01/2020
Mode of Delivery	Normal Delivered by midwife
Delivery Time	10:15 AM
Delivery location	Gargaar Multi Specialty Hospital

Name of mother	Fardus Eid Jama
Name of midwife	Sahra Warsame
Sex of New born	Female
Delivery Date	01/01/2020
Mode of Delivery	Normal Delivered by midwife
Delivery Time	01:00 PM
Delivery location	Gargaar Multi Specialty Hospital

Name of mother	Iftu Mohamed
Name of midwife	Fardus Mohamed
Sex of New born	Male
Delivery Date	01/01/2020
Mode of Delivery	Normal Delivered by midwife
Delivery Time	03:00 PM
Delivery location	Hargeisa Group Hospital

Name of mother	Istahil Dahir Ali
Name of midwife	Filsan Hussein Yousuf
Sex of New born	Female
Delivery Date	01/01/2020
Mode of Delivery	Normal Delivered by midwife
Delivery Time	12:00 Am
Delivery location	Hargeisa Group Hospital

Name of mother	Khadija Ali
Name of midwife	Nimao Adan Dacar
Sex of New born	Female
Delivery Date	01/01/2020
Mode of Delivery	Normal Delivered by midwife
Delivery Time	6:58 Am
Delivery location	Hargeisa Group Hospital

Name of mother	Hibaq Mohamed
Name of midwife	Rahma Haibe
Sex of New born	Female
Delivery Date	01/01/2020
Mode of Delivery	Normal Delivered by midwife
Delivery Time	09:30Am
Delivery location	Hargeisa Group Hospital

Name of mother	Ikran Adan
Name of midwife	Sahra Adan
Sex of New born	Male
Delivery Date	01/01/2020
Mode of Delivery	Normal Delivered by midwife
Delivery Time	10:30Am
Delivery location	Hargeisa Group Hospital

Name of mother	Umalkhair Hassan
Name of midwife	Shugri Hussein
Sex of New born	Female
Delivery Date	01/01/2020
Mode of Delivery	Normal Delivered by midwife
Delivery Time	12:00 PM
Delivery location	Hargeisa Group Hospital

Name of mother	Hamda Mouse
Name of midwife	Fardus Mohamed
Sex of New born	Male
Delivery Date	01/01/2020
Mode of Delivery	Normal Delivered by midwife
Delivery Time	04:30 PM
Delivery location	Hargeisa Group Hospital

Throughout the year 2020, we will be highlighting the stories of heroic and outstanding mid wives who have shown courage, ingenuity, determination or compassion. We need to celebrate the midwives who have contributed greatly to the development of the midwifery profession and the advancement of women's rights and gender equality in Somaliland.

The babies born in 1/1/2020 with the midwives at Burao Regional Hospital

SLNMA got invitation from International Confederation of Midwives (ICM) and will participate 32nd Triennial Congress in Bali, Indonesia between from 28 May – June 3, 2020. The Congress will provide an opportunity to harness the global attention on midwifery in 2020. This is an important opportunity to bring together stakeholders and midwives from diverse regions to outline the priorities in their own communities and countries.

The International Year of the Nurse and Midwife has given us an opportunity to command the spotlight. As we all know nurses and midwives are experts in solving problems so it is imperative that we take up the challenge to raise our voices, share our expertise and make measurable differences.

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HASHTAGS Main hashtags:
#Midwives2020
#With Women
Other hashtags:
#Midwives United With Women
#Midwives Voices
#My Body My Choice
#SRHR

TWITTER

@World Midwives

FACEBOOK

@International Confederation
of Midwives

INSTAGRAM

@WorldMidwives

YOUTUBE

@WorldMidwives

LINKEDIN

@international-confederation-of midwives-icm

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1 World Health Organization (2019) Executive Board designates 2020 as the "Year of the Nurse and Midwife". Geneva, World Health

2 United Nations General Assembly (2015) Transforming our world: The 2030 Agenda for Sustainable Development. New York, United Nations General Assembly.

UNFPA (2014) The State of the World's Midwifery: A universal pathway, a woman's right to health. New York, NY, United Nations Population Fund.

Evaluating the effects of pre reading on nursing students learning achievement In Edna Adan University Hargeisa, Somaliland

Introduction

Pre reading is an important way to help student's learning achievement and class performance, because pre reading supports student's dedication to learn and achieve effective learning (Hwang 2011).

This study determined that the pre reading material before the class helped student's performance significantly and those who did not engage in pre-reading exercises or pre-read materials such as textbooks and online materials did not indicate a higher effective learning performance.

Therefore pre-reading before the class with relevant reading materials designed to focus the student's attention to learn the topic supported the students' understanding concept on the topic in advance before the session. (Yuna H. Lyons 2017).

This study finds out how the students prior knowledge and early preparation before class used by textbooks and web based learning studies can assisted student's understanding during class.

According to Salehi and Abbaszadeh (2017) the pre reading actions can facilitate the students to acquire necessary informations which can activate appropriate understanding during the class and provide knowledge that the students lacks.

Purpose of intervention:

The purpose of this intervention is to try to improve student's reading behavior and writing skills, by using textbooks, online materials, and supporting documents for learning achievements. The aim of pre reading is to promote student's reading and learning perception, and also to improve their class participation, communication skills, and their confidentiality to express their comments during the class.

Specific Purpose

- To assess how pre reading affects student's understanding during the session
- To examine the influence of pre reading on student's learning achievement
- To describe the difference between pre reading and non pre reading students by observing their participation and explanations

METHOD & DATA COLLECTION

group discussions. The scale applied was grey method which is measured the process of the input and output of the evaluation. Contents was educational methods and Material, pre reading materials was textbooks, handouts and online materials

Data collection

The method of data collection was contained:

- Quizzes conducted by pre reading and non pre reading students
- Class observations done during the session to assess student's involvement during the session and
- FGD focused a number of students selected randomly from the class attendance
- This study was used qualitative & quantitative methods, such as observations, quizzes, and focus

DATA COLLECTION AND RESULTS

Categories	No. of Students	Mean	Max	Min	St Deviation	Correlation	Sig

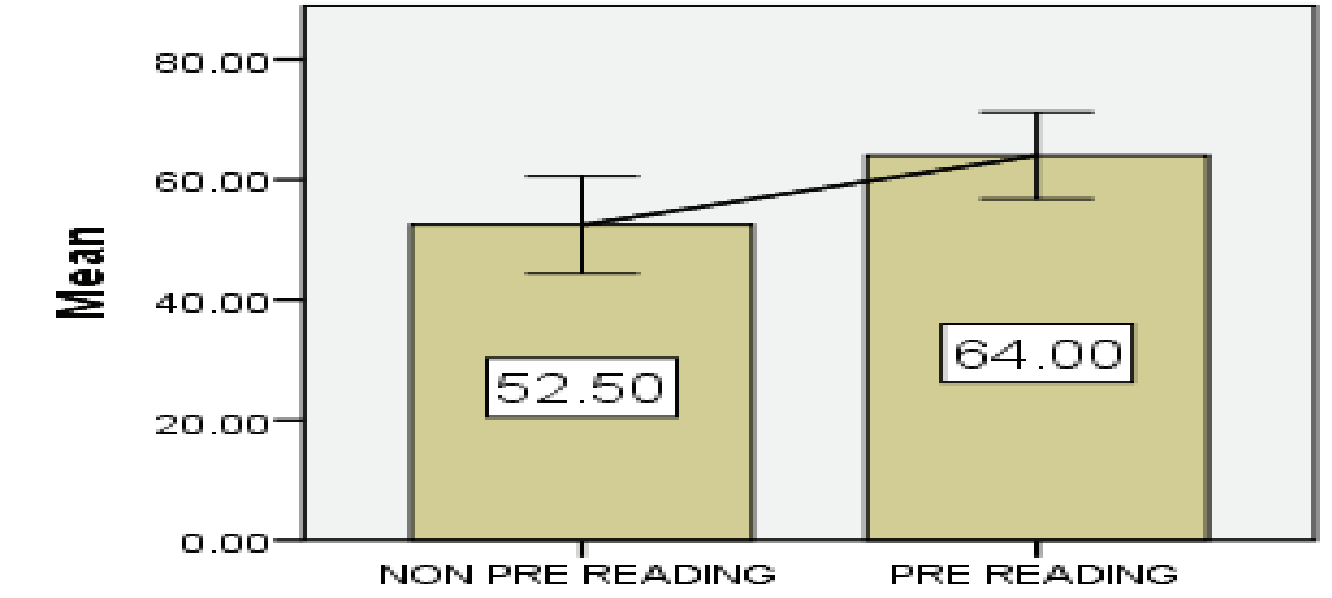
As the above table showed us the results of pre reading and non pre reading students tests, used by T test statistical analysis, indicated the maximum score of pre reading students was 100 and minimum 20, while non pre reading maximum score was 100 and minimum 10, and the average mean scores of pre reading students were 64, while non pre reading students scored average mean was 52, This implies that there is mean difference between scores of pre reading and non pre reading quizzes, the higher mean of pre reading treatment group reflected that pre reading affected the score performance of the intervention group.

The Std Deviation of pre reading students results were 22.6, while the Std Deviation of non pre reading results were 25.3. Therefore the St Deviation pointed out that there is significance difference between the two test scores. This refers that pre reading manipulated the scores and caused the difference of the grades between two quizzes conducted.

According to the Significance difference of the study found that (P.value = 0.000 and correlation of 0.96) which shows that there is significant difference between the intervention group and non intervention group scores, since $P<0.001$, which means scores of student's with pre reading intervention was significantly different non pre reading student's results.

With the comparison the number of students above the pass marks of two tests and those below are: 68% of pre reading students were above the pass mark while 32% were below the pass marks, this was indicated a higher learning performance due to the an advance learning materials. The non pre reading tested students results showed that 40% were above the pass mark, while 60% below the pass mark. Comparing the results of the two quizzes shows us the difference of learning performance of pre reading and non pre reading groups, in reference with their grades. The students received pre reading materials in advance scored higher grades than the non pre reading students. Therefore pre reading before the class helps students learning performance.

Figure1: This below graph shows us the mean different of pre reading and non pre reading students



Pre reading	40	64	100	20	22.623		
Non pre reading	40	52	100	10	25.293	0.959	0.000

Focus Group Discussion pre reading students responded that their understanding and confidence during the session is very high, while non pre reading students responded low understanding and low confidence during the session.

Pre reading had more influence on the class participation and discussion, while the non pre reading students showed poor class participation and discussion.

Results from the observation indicated that pre reading students had high participation to the lecture, good communication with confidence while non pre reading students had poor class participation, low confidence in communication, no comment to the lecturer's questions and discussions.

DISCUSSION

This evaluation aims to explore the effect of pre reading on student's learning achievement,

Regarding to, Zhicheng, Zhang (1992), the introduction of different systems and approaches of pre reading instructions helps to the students and build up active interaction among the students in the class, also pre reading creates an active mental process and better position to maintain their learning achievement. More-

over, the activation of previous knowledge, the use of prediction strategy and images called for more cognitive investment on the part of the reader and thus could make the reading process more challenging and interesting.

according to the results of the study, the evaluator found that the pre reading students with given reading materials and other related documents before the session improved student's learning performance, because students with pre reading material were got higher score than the non pre reading students. The students with pre reading materials in advance obtained higher scores in the quiz tests, while the students with non pre reading had low grade performance in the quiz test.

Conclusion

The evaluation explores the effects of pre reading on nursing students learning achievement and it aims to improve student's reading behavior and writing skills, with using textbooks, online materials, and supporting documents for learning achievements.

The results of the intervention was recognized that pre reading students were better than non pre reading students, for instance students with pre reading materials showed high score performance than the non pre reading students.

In the qualitative data the study was demonstrated that the relevance pre reading materials before the session improved student's class involvements and promoted searching skills which may influence their learning achievements, having active class participation with confidence, good communication and discussion which may have more interest to the lecturers explanation during the session.

This study was highlighted the importance of pre reading materials whether traditional textbooks or online documents before the class in order to understand the core concepts in the topic or text.

By: Mr. Hassan Ibrahim Jama (Hassan Caare)

MHPE, MEDP, BBA, NT & RN

Title: Educational specialist

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4.*Zhicheng, Z., 1992. The Effects of Teaching Reading Strategies on Improving Reading Comprehension for ESL Learners*

Good practices in nursing and midwifery exist, supporting Health 2020 implementation –

A variety of new healthcare models and innovative practices have been implemented in various settings across the Region, ranging from small-scale projects to nationwide nursing and midwifery reforms. The good practices and innovation that exist, however, are not always well documented or rigorously evaluated and are rarely shared within or across countries.

- Nurses and midwives enhance health – The case studies demonstrate a large range of contributions of nurses and midwives in improving health and preventing disease, spanning from health promotion throughout the life-course, to empowering individuals and communities. The roles of nurses and midwives have often evolved and expanded in response to changing healthcare needs of the population. This demonstrates how nurses and midwives are a vital and versatile resource towards achieving the goals of 2020
- Evidence-based practice and inter-professional collaboration facilitate innovation – Collaboration within multidisciplinary teams is proven to be effective and feasible. Nurses and midwives are playing an increasing role in developing evidence-based practice, conducting health research and developing innovative practices as part of interdisciplinary teams
- •Enabling policies to maximize nursing and midwifery potential – The nursing and midwifery workforce has the expertise and potential to improve population health and much of this is still untapped. The case studies revealed that effective policies and workforce planning, strong professional leadership, regulatory frameworks, educational standards and supportive managerial practices are essential to enable nurses and midwives to work to their highest potential.

2019- 2020 COVID 19 Pandemic and nursing and midwifery Care

Nurses are expected to be intimately involved with the care of the public regarding health matters such as prevention of disease, healthy lifestyles, and the treatment of disease and conditions. This care and exposure is not without direct risk to the nurse. There are many inherent risks to nurses that include potential physical risks. Nurses must be constantly vigilant in their practice of infection prevention to keep themselves protected in the ever-changing environment of healthcare.

Through the use of evidence-based practice and studies related to the prevention of disease, nursing has come a long way and has to lead the charge of decreasing risks to the profession. Appropriate hand hygiene is the number one measure to prevent contracting and passing infectious pathogens. Studies have shown that institutions that educate nurses on basic hand hygiene and require a demonstrated competency have the least amount of hospital-acquired infections and illness to staff. Another measure is to reinforce to nurses not to touch their face, nose or hair with their hands in an effort to reduce the spread of pathogens. While washing the hands with soap and water is an extremely effective method to kill most pathogens, the use of hand sanitizer gel agents can be as effective as soap and water (but not for all pathogens).

Personal Protective Equipment (PPE) is designed to prevent exposure from the infectious agent or person to the nurse or caregiver.

Types of PPE include:

- Gloves to protect the hands
- Gowns/aprons to protect the skin or clothing
- Masks to protect the mouth and nose
- Respirators to protect the respiratory tract from airborne agents
- Goggles to protect the eyes
- Face shields to protect the face, nose, mouth, and eyes

A key component of the proper use of PPE is when and how to put it on (don) and how to take it off (off). PPE should be donned prior to exposure to the patients. Gloves, masks, and other equipment must

be securely fastened and fitting well before coming into exposure with infectious agents. Some PPE plans for highly infectious agents such as Corona virus require a second nurse or team member to watch and critique the PPE donner to ensure maximum protection. Removal of the PPE is usually at the point of least exposure to the public, or in the room where the nurse is caring for the patient. PPE should be disposed of in the appropriate receptacles based on the institution's policies. Appropriate hand hygiene always follows the removal of PPE.

Nurses and Midwives please be careful and protect yourselves while serving our people and those who need our services at all Somaliland regions and districts

Nurses Wearing PPE

Prepared by: *Fouzia Mohamed Ismail*

RESPECTFUL MATERNITY CARE IN SOMALILAND

The World Health Organization (WHO) 2012 reports that reproductive health problems account for more than one third of the total burden of disease in women. WHO further estimates that 287,000 women die every year from complications of pregnancy, including abortion and virtually all these deaths occur in developing countries, which accounts for 99% of all these deaths. Maternal mortality is defined as "the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes." The Millennium Development Goals (MDGs) and later the sustainable development goals (SDG's) established by the United Nations in 2000 made improving maternal health an international priority. (UNFPA, 2011)

The complications of pregnancy and childbirth are the major causes of death and disability among women of reproductive age in developing countries. The most common fatal complication is post-partum haemorrhage, sepsis, prolonged or obstructed labour, and the hypertensive disorders of pregnancy, especially eclampsia claiming further lives (Insert ref). These complications, which can occur at any time during pregnancy and child-birth without forewarning, require prompt access to quality obstetric services equipped to provide life-saving drugs, antibiotics and transfusions and to perform the caesarean sections and other surgical interventions that prevent deaths from obstructed labour, eclampsia and intractable haemorrhage.

Maternal and new-born mortality in Somaliland is one of the highest in the world although estimations are difficult to make due to lack of valid statistics. The maternal mortality ratio is estimated at 1,044 per 100,000 and infant and under-five mortality Ratio at 72 and 90 per 1,000 live births respectively. Since the outbreak of civil war in Somalia 1991, the destruction of infrastructure and the insecurity have greatly impeded the development of basic health services for the population. About 25% of the population has been uprooted. There is a reported lack of medical equipment, medicines, reliable running water and electricity in the hospitals. During the war there was a dramatic loss of qualified health care providers (Pyone et al, 2014).. Reproductive health in Somaliland is a major challenge. Malnutrition, hemorrhage, prolonged and obstructed labor and infections are the major causes of maternal deaths. The high level of illiteracy among women impedes their access to health information and the available health facilities are limited.

Dignity is a vital part of obstetric care, not a luxury reserved only for the well off in the society. All women have the same rights and access to the childbearing facility-based health care before, during, and after pregnancy, regardless of geographical location or social class. Yet women in the most vulnerable stage of pregnancy and labour are subjected to different types of both verbal and physical abuse, disrespect, and mistreatment.

In 2000, at the International Conference on the Humanization of Childbirth held in Brazil, the activist moved away from the medicalization-based approach but instead using a" women-cantered approach." With the goal to return to humanized birth and better aid women by providing obstetric care, free of violence. In 2010 a landscape analysis was conducted by Brown and Hill (2010), describing an increasing global prenominal of disrespect and abuse during obstetric care. These new findings of disrespect and abused were loosely correlated to obstetric violence. Brown and Hill's categorized into seven areas of disrespectful and abusive during maternal care; which included "physical abuse, non-consented clinical care, non-confidential care, non-dignified care, discrimination, abandonment, and detention in health facilities." This has laid the foundation for all the efforts invested in reducing disrespectful maternity care today. Following these results, perception shifts and the need to protected women rights from these childbearing disrespect and abuses on a global level were further explored. This article highlighted to me the levels to which disrespect reaches as women were found to be given treatment with explanation or consent. If women had no supplies, they would for example receive perineal repair without anaesthesia subjecting the women to immense pain. This is vital information to give an insight into the importance of this topic.

In 2011 The White Ribbon Alliance launched a global movement to end human indignities against all childbearing woman on by categorizing it as a

universal human right offense. Respectful Maternity Care Charter (RMC) was developed to protect women global human rights to dignity, and respected when seeking facility-based childbearing services across the globe. RMC Charter is also known as The Universal Right for all Childbearing Women. Over the years RMC has encompassed several areas related to women's maternal rights. RMC first inheriting its earliest roots from the 1990s the movement Childbirth Activism in Latin American, which revealed and shade light to changed women were facing after facilities based childbearing maternity care increased. These significant changes caused primarily by medicalization-based approach dehumanized childbirth, treating it as a pathological condition. This drastic shift of in mediatized childbirth care linked to increased obstetric violence and the number of the caesarean section performed.

Skilled birth attendant (SBA) is defined to be an accredited health professional such as a midwife, doctor or a nurse- who has been educated and trained to proficiency in the skills needed to manage normal uncomplicated pregnancies, childbirth and the immediate postnatal period and the identification, management and referral of complications in women and new borns. The constraints to scale up access to SBAs in low resource settings are huge and include shortages of trained staff, enabling environment (policies,organised and effective health care system), lack of competence among SBAs to provide evidence based midwifery careLawn et al, 2014, Dickson et al, 2014). Many low resource settings, such as Somaliland, has to rely on non-professional Traditional Birth Attendants (TBAs) who are persons with acquired skills through assisting mothers during home based childbirth. In Somaliland changing the role of the TBA to support facility-based births assisted by SBAs has shown to be feasible and acceptable (Pyone at al, 2014). The TBAs play an important role in the provision of midwifery care and other maternal and child health services. In Somaliland it is estimated that 80% of deliveries are being conducted by TBAs at homes [16]. Hence, the high number of maternal mortality and morbidity (Pyone at al, 2014).

In the Somaliland context health services are available both in the urban and rural areas, accessible with ambulances available to transport women in the case of emergencies. Things become a little more complicated when you talk about acceptability of services and the quality of the services provided because these two aspects are very interconnected. Women seem to avoid going to the services for as long as possible and when they go they do not trust the Doctors and midwives' medical advice. This has many negative consequences to the uptake of services; it causes patients to go back and forth between public and private health services hoping to get better advice at non-public settings which causes further delays.

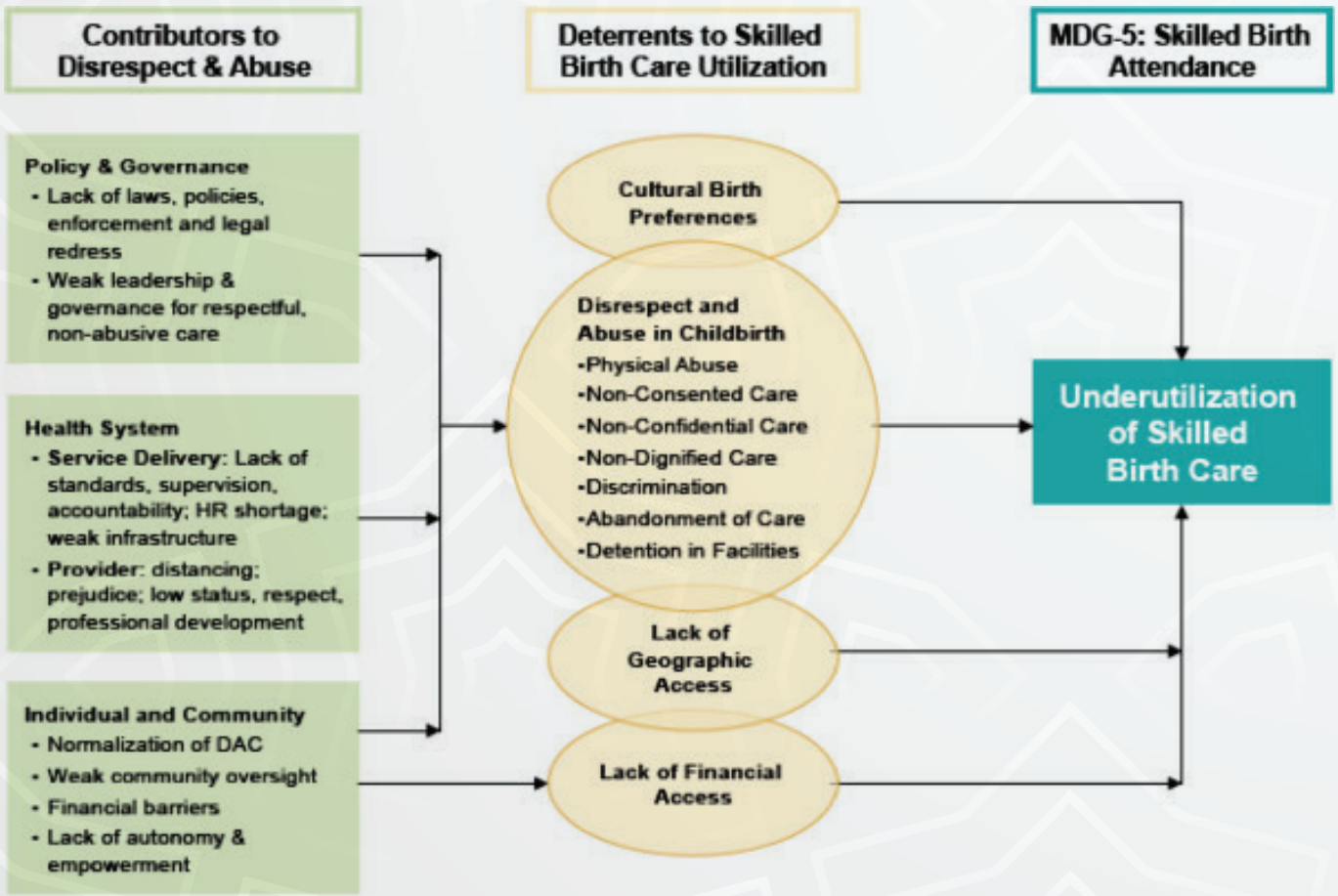
The aim of the ministry of Health in Somaliland is to increase the uptake of maternity services throughout the country. This would increase opportunities to discuss family planning options with women, it would encourage women to visit centers during the pregnancy which would enable health care staff to deal with complications and prepare for the birth efficiently and perform tests for infectious diseases. Also, when women are encouraged to seek health services during pregnancy it creates an opportunity to develop a bond with health professionals to encourage trust in their advice which is vital for example during emergencies during labor when cesarean section is required women many women die while refusing to consent as they don't trust the health care providers. Unfortunately, research findings suggest that women's experiences in the health care facilities is causing them to choose to deliver at home or at least stay away from the health settings for as long as the can which cause women to come in in a very critical stage.

Knowing the significance of public health issues on the international development agenda and the importance of increasing the number of women seeking health care services with the trained health care professionals it is vital to gain more understanding of what is hindering this even after extensive training has been given to the staff within these settings. Therefore, it is essential to examine the institutional barriers facing these frontline health care professionals to provide respectful maternity care for their patients. With a particular focus on governance and accountability in health care settings in Somaliland. Based on two assumptions which are that all mothers have the right to respectful care that allows the development of a bond with the midwife and secondly that all health care professionals aim to provide good care that leaves them with a satisfied feeling about their work performance.

Access only is not the answer to saving mothers lives

as access to trained health professionals does not ensure that the care they provide is safe, respectful and of highest possible quality. Care facilities have to aspire to provide best care possible, keep learning from mistakes and improve practice through audits and research. Every woman has the right to these three components this is called the rights based maternity care. The Dominican Republic is a good example of the importance of quality of care, they still have a high maternal mortality rate compared to developed countries even though they have achieved 95% of access to skilled birth attendance.

Respectful maternity care is not examined or talked about much as many people believe that it has not much to do with the quality of care and also people like to focus on the bigger issues causing maternal mortalities. However, I believe that respectful treatment with dignity and privacy is the up most important aspect Somaliland mothers are lacking and after many imterviews with mothers in Somaliland I have come to the conclusion that Somaliland mothers believe that anything can happen to them and their babies in pregnancy, labour and the postnatal period. They have firm believe in their maker and are not focused on blaming anyone but they will never forget the midwife that was good to them when they were in pain and confused. Somestimes, respectful care is also giving the women the time to inform them about prosedures They fight for their privacy, respect and dignity which is the reason why they choose not to access the services provided for them at the Mother and Child health centres or deliver at the health facilities. Therefore, I would like to call for all Midwives in Somaliland to focus on this very important aspect of their professional practice and understand that change requires all of us to work together in supporting our mothers.



CATEGORIES OF DISRESPECT AND ABUSE

- Physical Abuse
- Non-Dignified Care
- Non-Consented Care
- Non-Confidential Care
- Discrimination
- Abandonment or Withholding of Care
- Detention in Facilities

-Bower and Hill (2010)

POSITION STATEMENT

safe motherhood for all

RESPECTFUL MATERNITY CARE
THE UNIVERSAL RIGHTS OF CHILDBEARING WOMEN

Motherhood is a social justice and human rights issue.

In every country and community worldwide, pregnancy and childbirth are momentous events in the lives of women and families, representing a time of great joy, but also intense vulnerability. The concept of 'safe motherhood' is usually restricted to physical safety, but childbearing is also an important rite of passage, with deep personal and cultural significance for women and their families.

Because motherhood is specific to women, issues of gender equity sit at the core of maternity care. The notion of safe motherhood must be expanded beyond the prevention of morbidity or mortality to encompass respect for women's basic human rights, including respect for women's autonomy, dignity, feelings, choices, and preferences, including decisons about who is present at birth.

All childbearing women deserve respectful care and protection; this includes special care to protect the mother-baby union as well as women in cases of heightened vulnerability, for example adolescents, ethnic minorities, and women living with physical or intellectual disabilities or HIV.

Its Universal Rights of Childbearing Women Charter addresses the disrespect and abuse to which women seeking maternity care are sometimes subjected.
It provides a platform for change via:

- Raising public awareness regarding the inclusion of childbearing women's rights in the human rights guarantees recognised in internationally adopted United Nations and other multinational declarations, conventions, and covenants;
- Highlighting the connection between human rights language and key program issues relevant to maternity care;
- Increasing the capacity of maternal health advocates to participate in human rights processes;
- Aligning childbearing women's sense of entitlement to high-quality maternity care with international human rights community standards; and
- Providing a basis for holding the maternal care system and communities accountable to these rights.

The Charter purposely focuses specifically on the interpersonal aspects of care received by women seeking maternity services. A woman's relationship with maternity care providers and the maternity care system during pregnancy and childbirth is vitally important.

These relationships are the vehicle for essential and potentially lifesaving health services. Equally, women's experiences with caregivers at this time can either empower and comfort, or inflict lasting damage and emotional trauma; adding to or detracting from women's confidence and self-esteem.

Imagine the personal treatment you would expect from a maternity care provider entrusted to help you or a woman you love give birth. Naturally, we envision a relationship characterised by caring, empathy, support, trust, confidence, and empowerment, as well as gentle, respectful, and effective communication to enable informed decision making. Unfortunately, too many women experience care that is anything but.

A growing body of research evidence, experience, and case reports collected in maternity care systems - from the wealthiest to poorest nations worldwide - paints a different and disturbing picture.

In fact, disrespect and abuse of women seeking maternity care is becoming an urgent problem and creating a growing community of concern that spans the domains of healthcare research, quality, and education; human rights; and civil rights advocacy.

Disrespect and abuse during maternity care are a violation of women's basic human rights.

Human Rights are recognised by societies and governments around the globe and are enshrined in international declarations and conventions. Bowser and Hill (2010) described seven major categories of disrespect and abuse that childbearing women encounter during maternity care. These categories occur along a continuum from subtle disrespect and humiliation to overt violence:

- Physical abuse
- Non-consented clinical care
- Non-confidential care
- Non-dignified care (including verbal abuse)
- Discrimination based on specific patient attributes
- Abandonment or denial of care
- Detention in facilities

Until now, no instrument has specifically delineated how human rights are implicated in the childbearing process or affirmed their application to childbearing women as basic, inalienable rights. The White Ribbon Alliance for Safe Motherhood is promoting respectful maternity care through tackling disrespect and abuse defining the Seven Rights of Childbearing Women, in seeking and receiving maternity care.

Every woman has the right to:

1. Freedom from harm and ill treatment
2. Information, the right to provide informed consent and refusal to consent, and respect for choices and preferences, including companionship during maternity care
3. Privacy and Confidentiality
4. Dignity and respect
5. Equality, freedom from discrimination and access to equitable care
6. Healthcare and the highest attainable level of health
7. Liberty, autonomy, self-determination, and freedom from coercion

The seven rights are drawn from the categories of disrespect and abuse identified by researchers and rights advocates in the current literature. By drawing

on relevant extracts from established human rights instruments, the Charter demonstrates the legitimate place of maternal health rights within the broader context of human rights.

All rights are grounded in established international human rights instruments, including the Universal Declaration of Human Rights; the Universal Declaration on Bioethics and Human Rights; the International Covenant on Economic, Social and Cultural Rights; the International Covenant on Civil and Political Rights; the Convention on the Elimination of All Forms of Discrimination Against Women; the Declaration of the Elimination of Violence Against Women; the Report of the Office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights; and the United Nations Fourth World Conference on Women, Beijing. National instruments are also referenced if they make specific mention of childbearing women.

Safe Motherhood for All calls for maternity care that is comprehensive, participatory, rights based, using evidence-based best practice.

Safe Motherhood for All, now and into the future, because healthy women make healthy babies make healthy nations.

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Safe Motherh

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Male involvement of birth spacing in Somaliland.

Men's participation of birth spacing decision making is crucial concern to health, wellbeing and women's empowerment. It is associated with better outcomes in reproductive health such as contraceptive acceptance and continuation, traditionally; men are the heads of households and decision makers in all issues in their respective households. findings have shown that since men were the decision makers they should be involved on decisions on birth spacing as well as how to use.Somaliland has one of the highest maternal mortality rates worldwide, the maternal mortality rate stands at 732/100,000 live births. Women die due to pregnancy related complications such as bleeding, obstructed and prolonged labor, postpartum hemorrhage, Anemia, and infections. Male involvement in birth spacing decision making is of the highest problems that exists in the context of Somaliland, Men are also responsible for the lack of contraceptive acceptance and usage, they also have a hand in its effective use and continuation.

The knowledge, attitude, and practice of modern contraceptive methods determine the level of spousal communication about birth spacing decision making and investigate the correlates of men's opinion about their roles in birth spacing decision. There are many myths and misconception about birth spacing usage. It is even difficult to talk about it freely within the Somali community; men believe that using modern contraceptive methods is against Islamic religion, others believe it can cause permanent infertility. Furthermore some Somali's believe in large families and opt to have many children regardless of the women's health staus. Men's participation of reproductive health is not

a big concern in this context; male involvement refers to any activity that seeks to enhance the provision of reproductive health services including information provided through activities targeted to males of all ages, either individually or as part of a sexually active group Using interpersonal communication strategies involving counseling sessions to provide men with relevant information can help them to be more supportive of contraceptive use and more aware of shared decision making. As study conducted Found that contraceptive use and continuation nearly doubled among couples that received husband and wife counseling compared to when women were counseled alone. In Somaliland, husbands' involvement in the counseling process contributed to reduced rates of pregnancy and abortion among couples.

To improve male involvement of birth spacing and other reproductive health right of women in children bearing age to avoiding worsening women health situation and reduce mortality and morbidity is an important issue which needs to be emphasized. Male participation of birth spacing decision making should improve through behavior change communication, group and individuals also number factors, male interpersonal communication sessions is also good, health education session, presentation of case studies, decision of birth spacing for religious leaders, elders mosque imams, More research will improve the basic and understanding of birth spacing of the government and other cooperating partners which are involving campaign.

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BY: Muna Awil Wa'is
Qualified Nurse/ Midwife

Preeclampsia During Pregnancy

Preeclampsia is becoming an increasingly common diagnosis in the developed world and remains a high cause of maternal and fetal morbidity and mortality in the developing world. Delay in childbearing in the developed world feeds into the risk factors associated with preeclampsia, which include older maternal age obesity, and/or vascular diseases. Inadequate prenatal care partially explains the persistent high prevalence in the developing world.

Concept and Classification

Hypertensive conditions during pregnancy can be classified as arterial hypertension prior to gestation or with manifestation before 20 weeks and arterial hypertension starting at or after 20 weeks. The first group includes:

i.essential chronic or secondary arterial hypertension;
ii.white coat hypertension;
iii."Masked" hypertension.

The hypertension group, which appears at 20 weeks or more, includes:

i.transient gestational hypertension;
ii.gestational hypertension;

iii.preeclampsia, which can be isolated or superposed on chronic hypertension. In this group, arterial hypertension is defined as systolic blood pressure equal to or greater than 140 mmHg and/or diastolic blood pressure equal to or greater than 90 mmHg, which should be measured on two distant occasions at least 4-6 hours apart, in a calibrated and adequate blood pressure monitor for the biotype of the woman under evaluation and managed by a trained professional . When it comes to preeclampsia, one of the following conditions must coexist:

a.Proteinuria (demonstrated by the ratio of proteinuria/creatininuria above 0.3 mg/mg, or by urine dipstick test equal to or above 1+, or by 24-hour proteinuria above 300mg / 24h);

b.Dysfunctions of maternal organs which can be renal insufficiency, characterized by creatinine above 1.02 mg/dL; hepatic impairment, characterized by an elevation of transaminases two times above normal levels, or pain in the right hypochondrium, or epigastralgia; neurological complications, characterized by scotomas or persistent cephalgia accompanied by hyperreflexia or confusional states or eclampsia or cerebrovascular accident or amaurosis; and haematological complications consisting of thrombocytopenia or hemolysis;

c.Uteroplacental dysfunctions: fetal growth restriction; changes in the Doppler velocimetry studies of the umbilical artery, especially if combined with alterations in uterine arteries

Reducing the risk of hypertensive disorders in pregnancy Symptoms of pre-eclampsia

Advise pregnant women to see a healthcare professional immediately if they experience symptoms of pre-eclampsia.

Symptoms include:

- Severe headache
- Problems with vision, such as blurring or flashing before the eyes
- Severe pain just below the ribs
- vomiting
- Sudden swelling of the face, hands or feet.

Conclusion

As has been said, preeclampsia is still one of the main causes of death and severe maternal morbidity. The complexity of its pathophysiology is a challenge for future studies and it may help with prevention measures and with the conduction of cases already defined as preeclampsia. Identifying risk groups for preeclampsia through accessible and effective technology, especially in developing countries, can result in better maternal and perinatal public health outcomes since prenatal care would be implemented prior to the establishment of the grievance. To that end technologies have been further studied so that they can broaden the preeclampsia understanding as a whole and, particularly, its prediction.

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J. Mayrink, M. L. Costa, and J. G. Cecatti

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Prevention and management of COVID-19 with a pregnancy woman

Introduction:

COVID-19 was initially found in Wuhan, China in December 2019. This viral causes acute respiratory syndrome (SARS) also known coronavirus 2 or COVID19 (SARS-CoV-2/COVID-19) is a global public health emergency, and could cause devastating health issues during pregnancy. Pregnant women have a high risk to acquire this infection due to their changed physiological and immunological functions. Previous studies have indicated that SARS during gestation is linked with a high risk of spontaneous miscarriage, preterm birth and intrauterine growth restriction. Studies in pregnant women with COVID-19 have indicated few maternal and neonatal complications. Importantly, viral respiratory illnesses, such as influenza, can easily develop during pregnancy, which means pregnant women may be more vulnerable to COVID-19 and require prioritized medical care.

(Omer_et_al-2020) Signs and Symptoms of COVID-19
symptoms may appear first 5-6 days when the person infected, but may also take up to 14 days. . COVID-19 symptoms range from mild to severe, and commonly include fever, tiredness, shortness of breath, cough, myalgia, fever and severe pneumonia Some may also have aches and pains, Nasal congestion, runny nose, sore throat |and Diarrhea. Injury to vital organs (kidney, heart, liver). has also been observed. The severity of infection may depend on the underlying health of the individual [16], with patients with pre-existing illnesses, such as diabetes

Prevention

COVID-19 guidelines for the effective counseling and education of pregnant women are currently important and should be available at health centers so that women understand the value of preventive and precaution measures. See following guidelines:

- Avoid people who are sick or who have been exposed to the virus and observe social distancing
- Frequent hand washing,
- Refraining from excessive outdoor activities unless an emergency, and avoiding infected individuals,
- Avoid crowded places and public gatherings, that should be strictly followed by pregnant women
- Check your temperature regularly and immediately inform available health care team if you have fever
- if you experience shortness of breath, cough or fever
- Women who have a travel history or COVID-19 symptoms should be kept in isolation for at least 14 days.
- No evidence is currently available to confirm the transfer of COVID-19 to breast milk. Pregnant women should closely monitor their vital signs (pulse rate, respiration rate and temperature).
- Importantly, they should inform their maternity-care provider regarding their health status and seek advice regularly. Extracorporeal membrane oxygenation and oxygen inhalation (60–100% concentration with a flow rate of 40 L/min) should be used if hypoxia occurs.

Managing COVID-19 in pregnancy for effective management, pregnant women with suspected COVID-19 should be isolated and then transferred to a hospital equipped with sufficient health facilities and fully trained clinicians to take proper care of critically ill obstetric patients.
Pregnant women do not appear more likely to contract the infection than the general population. Pregnancy itself alters the body's immune system and response to viral infections in general, which can occasionally cause more severe symptoms. This will be the same for COVID-19 and all pregnancy women should aware that.

Prepared by: Khadra Ahmed

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The Importance of Hand-washing in Nursing

Nurses are aware of the rationale for hand hygiene procedures. Nurses represent a large working group that performs the greatest amount of direct patient care in Health Services.

Hand hygiene is one of the most effective measures to prevent hospital acquired infections.

The clean Care is **Safer Care'** compliance to hand hygiene is widely acknowledged as the most important way of reducing infections in healthcare facilities and the spread of antimicrobial resistance.

Failure to perform appropriate hand hygiene is considered to be the leading cause of Health Care Associated Infections and the spread of multi-resistant organisms and has been recognized as a significant contributor to outbreaks.

Good personal hygiene plays a major part in reducing and eliminating the spread of germs and infections from person-to-person. It also helps in reducing the spread of infectious illnesses, including colds, flu and other upper respiratory illnesses.

A big part of personal hygiene is hand hygiene and incorporating safety measures in developing habits that will stave off illnesses can help to further reduce the spread of germs and infections.

The best time to wash would be after any of the following:

1) If the person has been exposed to germs via someone coughing or sneezing,
2) If the person is in health care and need to wash frequently to reduce your exposure to germs,
3) if a person handles raw meat or other substances that can transfer bacteria,
4) After using the restroom, touching doorknobs or handles on doors. Although there are many situations that warrant the need to frequently wash hands, there are also other times when it may not be so obvious, but is necessary.

When should hand hygiene be performed?

- Before the beginning of the shift and after the end.
- Before and after contact with any patient, their body substances or items contaminated by them.
- Between different procedures on the same patient.
- Before preparing, handling, serving or eating food or feeding a patient/resident.
- After assisting patients with personal care (e.g. assisting patient to blow nose, toileting or doing wound care).
- Before and after performing invasive procedures.
- Before putting on and after taking off gloves.
- After performing personal functions (e.g. using the toilet, blowing your nose).
- When hands come into contact with secretions, excretions, blood and body fluids (use soap and running water whenever hands are visibly soiled).

Use of soap and water

The mechanical action of washing, rinsing and drying removes transient bacteria present on the hands.

Hand washing with soap and running water must be performed whenever hands are visibly soiled. Bar soaps are not acceptable in health care settings except for single patient personal use.

Liquid soap containers should be used until empty and then discarded. Soap containers must not be topped up, as there is a risk of contamination of residual soap.

Antibacterial soaps may be used in critical care areas, or wherever invasive procedures are performed. Brush or hot water should not be used for hand washing, because they cause bruises and skin dryness creating environment to develop microorganisms.

Immediate advantages:

- Elimination of the majority of germs
- The short time required for action (20-30 secondsAvailability of the product at the point of care
- Better skin tolerability
- No need for any particular infrastructure.

Benefits of hand hygiene

The transfer of bacteria from cadavers to the patients from the staff's hands was the culprit in the deaths. Ensuring that today's medical professionals make hand washing a priority is essential.

Simple activity of frequent hand washing has the potential to save more lives than any single vaccine or medical intervention.

It is one of the most effective and inexpensive ways to prevent diarrheal diseases and pneumonia, which cause more than 3.5 million deaths worldwide in children under the age of 5 every year. Although people around the world clean their hands with water, very few use soap to wash

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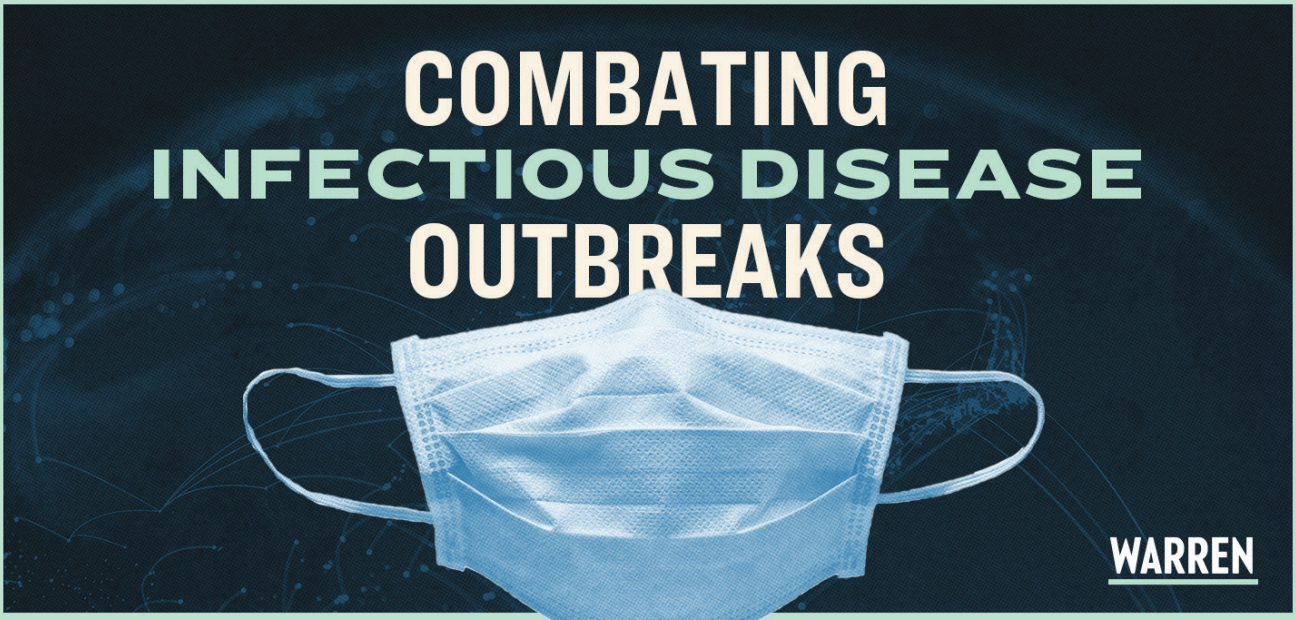
How do we prevent the spread of infectious diseases

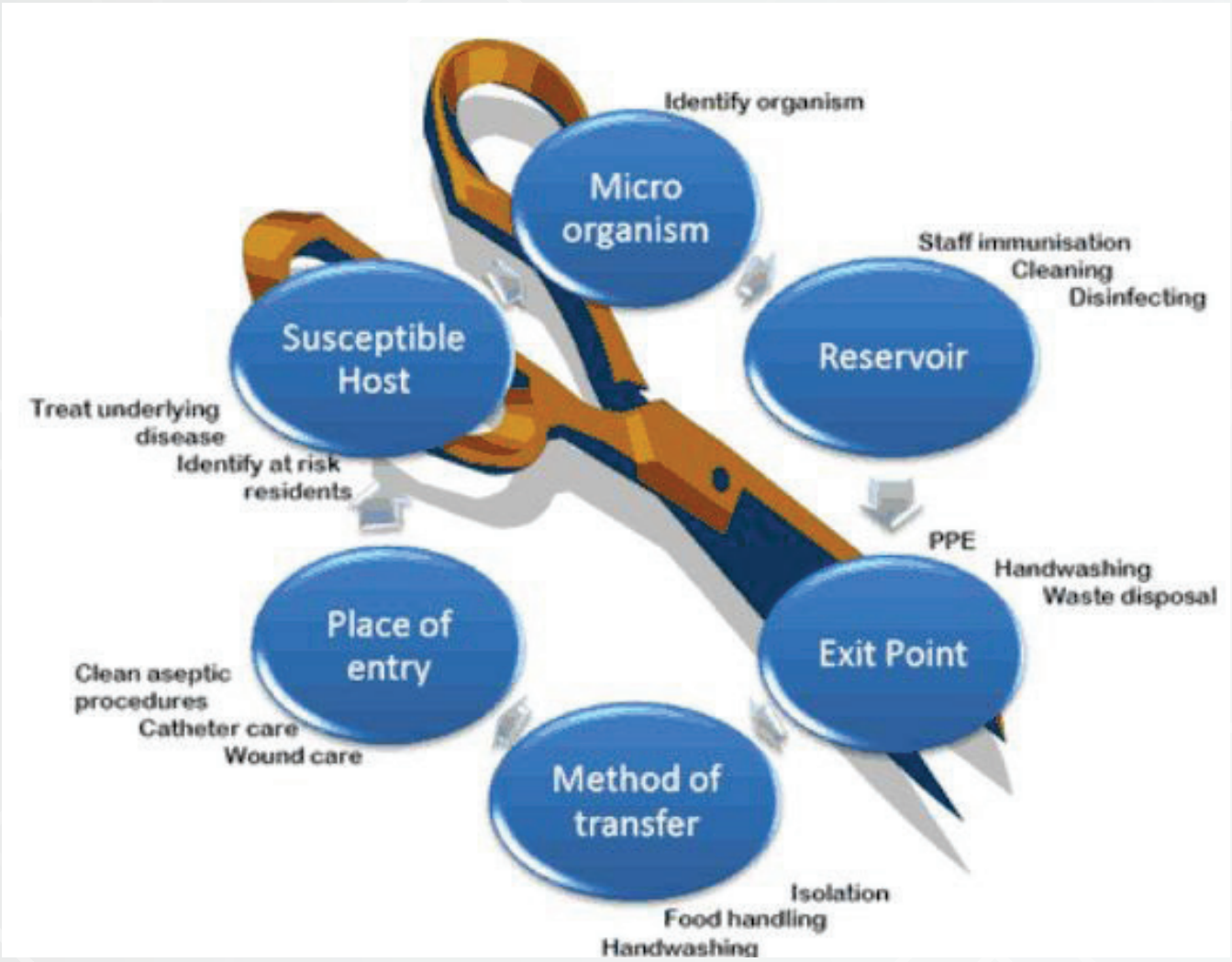


Decrease risk of infecting yourself, your loved once or others;

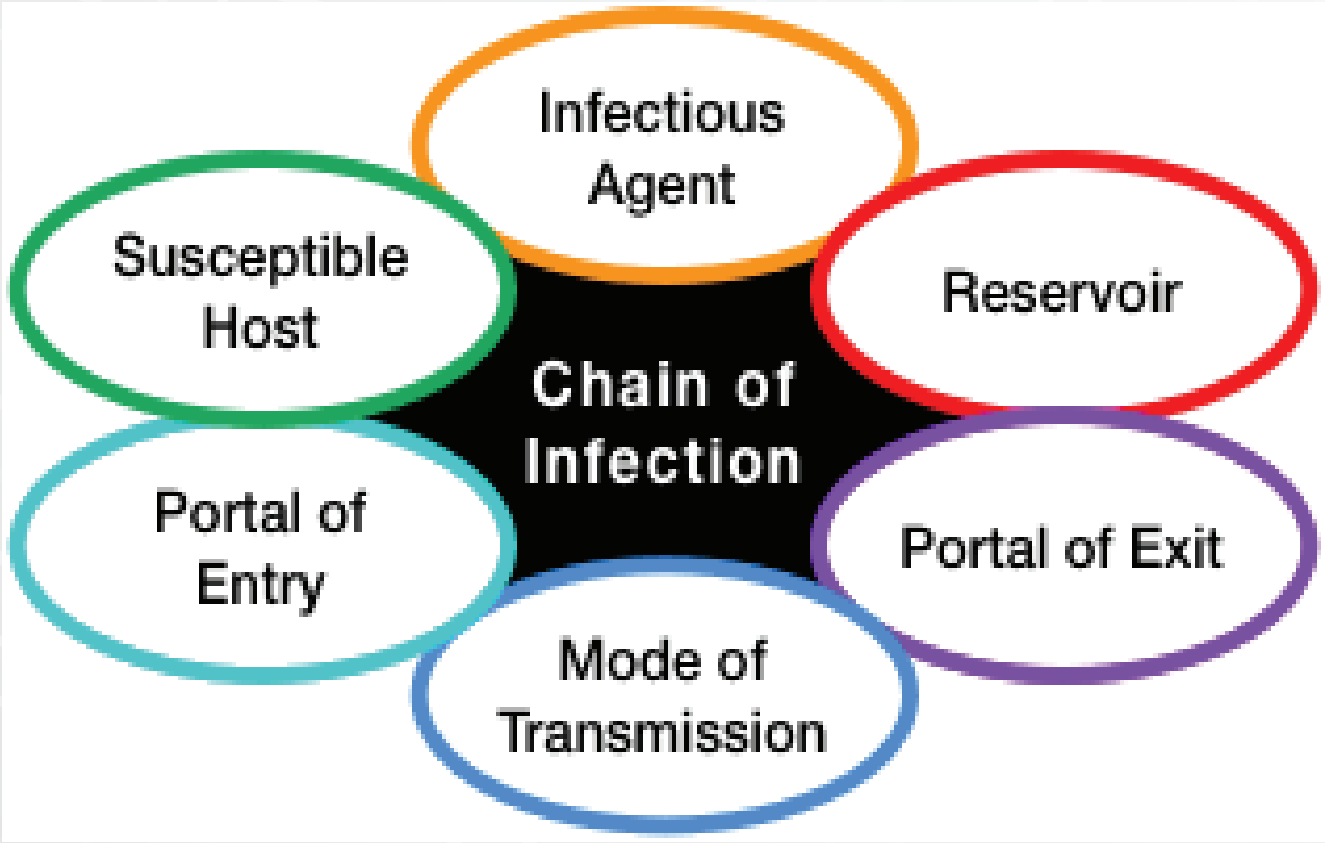
- Wash your hands often: this is especially important before and after preparing food, before eating and after using toilet.
- Get vaccinated: immunization can drastically reduce your chances of contracting many diseases. Keep your recommended vaccines up to date both you and you're loved once.
- Use antibiotic sensibly: antibiotic over use is global problem which increased the risk of resistance, therefore, take antibiotic only when prescribed, it is also wise to complete the dosage prescribed even when you feel better before completion of dose.
- Stay at home if you show signs and symptoms of an infection: don't go to work or class if you are vomiting, diarrhea, fever and cough. These rules will limit the spread of infection
- Disinfect the 'hot zones' in your residence. These include the kitchen and bathroom — two rooms that can have a high concentration of bacteria and other infectious agents.
- Practice safer sex. Get tested for sexually transmitted diseases (STDs), and have your partner get tested when you are getting married — or, abstain from sex before marriage
- Don't share personal items. Use your own toothbrush, comb or razor blade. Avoid sharing drinking glasses or dining utensils.

This is chain of infection which increase favor spread of infection when it is intact

Prepared by: Dr. Abdirahman Dahir Adan



Breaking the chain of infection to prevent the spread of the infection is one of the corner stone of infection prevention methods



Prevention and management of obstetric fistula

Obstetric fistula is a significant and often neglected problem in East, Central, and Southern Africa. More than 2 million women around the world are living with obstetric fistula, most of them in Sub-Saharan Africa.1 This number may be an underestimate, because data about the condition are often limited. One study has estimated that at least 33,450 new cases of obstetric fistula occur every year in rural Sub-Saharan Africa.

Obstetric fistula takes a heavy toll on women and society. The affected woman experiences constant leaking of urine and/or feces, she may also face other complications, such as dermatitis of the vulva and thighs, urinary tract infections, sexual dysfunction, and infertility. She loses her sense of dignity and is often stigmatized, even in her own family. Most of the time, her spouse abandons her. Society suffers because women are unable to attend school, contribute economically, or effectively care for their children.

Yet obstetric fistula can be prevented and treated. Access to safe obstetric care and family planning services can reduce the occurrence of obstetric fistula. Improved nutrition and education for girls and women can play a big role. Changes in traditional practices (such as early marriage, female genital cutting, and the environment in which such practices occur) can also reduce the magnitude of obstetric fistula. If a woman does have obstetric fistula, surgical repair can often cure the condition or lessen its consequences.

Physical Causes of Obstetric Fistula

Prolonged or Obstructed Labor: The most common cause of obstetric fistula in developing countries is prolonged or obstructed labor. Prolonged or obstructed labor can last for days or weeks before a woman receives obstetric care or dies. When labor is prolonged or obstructed, the fetal head exerts continuous pressure against the mother's pelvis, greatly reducing the flow of blood to the soft tissues surrounding the vagina, bladder, urethra, and/or rectum.

More over Trauma Caused by Sexual Violence Fistula can occur as the result of sexual violence generally from trauma or tearing caused by rape and/or forced insertion of objects into a woman's vagina often but not always in conflict and post conflict settings

Unsafe Abortions induced by poorly trained individuals or performed under unsanitary conditions can lead to dangerous complications, including visceral trauma—most commonly to the uterine wall, but also to the genitalia, rectum, and bladder—that can result in fistula.

Harmful Traditional Practices Female genital cutting or mutilation (FGC or FGM) also contribute to the risk for fistula. Such cutting is usually carried out under unsanitary conditions, often by removing large amounts of vaginal or vulval tissue, thus causing the vaginal outlet and birth canal to become constricted by thick scar tissue. These practises increase the likelihood of gynaecologic and obstetric complications, including prolonged or obstructed labour.

On top of that there is Contributory Factors Affecting Obstetric Fistula including

- Lack of Access to Health Care Services Most women who develop obstetric fistula during childbirth
- Lack of skilled birth attendants: Only half of the women in developing countries receive assistance from a skilled attendant during delivery
- Inadequate/incomplete antenatal care: Despite high attendance in most countries, clients frequently are not informed of what to expect, where to deliver, and the risks of possible complications if delivery is not done by a skilled attendant
- Inadequate monitoring during labour: Providers often fail to use the partograph to monitor labor at their health facility and make timely referral decisions
- Lack of prompt access to emergency obstetrical care: Fistula is more likely to occur in rural, rather than urban, settings. For rural women, health centers offering basic emergency obstetric care may be far away and transportation can be hard to access or unaffordable.

Myths and Misconceptions about Fistula

Myths and misperceptions can play a role in lack of fistula prevention, unwarranted stigma and discrimination, and poor access to treatment. Myths and misperceptions about the origin of fistula vary depending on cultural context. Below are some examples of beliefs that a woman (or others in her community) might have about why she has developed a fistula:

- She had an affair with a man who is not her husband.
- She came under a "spiritual attack" because she did not give birth under the care of a person who had the ability to protect her spiritually.
- She had a sexually transmitted infection.
- In some cultures, a woman is expected to deliver at home so that the placenta can be buried in the homestead.
- Because of her religion, a woman might feel that she must accept the fistula as her destiny and live with it for the rest of her life. She might believe that her suffering will be rewarded in heaven and therefore she should not seek treatment.

Social Consequences of Obstetric Fistula

Stigma Related to Stillbirth The delivery of a stillborn (which occurs in up to 90% of cases of prolonged or obstructed labor) is particularly distressing in societies that place a great emphasis on childbirth. The birth of a living baby is celebrated by a woman's family and community, whereas a woman who gives birth to a stillborn typically brings sorrow and shame to her family. Subjection to Myths and Misconceptions about Fistula **Social Isolation** Because of the unpleasant odor, women with fistula may be perceived as unclean, and thus they are often excluded, or they exclude themselves, from participating in community activities, including religious celebrations or public observances.

Hence Nurses and midwives play an essential role in the prevention and treatment of obstetric fistula. To prevent fistula we can educate women and their communities about the risks of prolonged and obstructed labor. We can provide good antenatal care. We must take actions during labour and delivery that help to prevent obstetric fistula. We can

Midwifery leadership and development in Somaliland

"A decade of progress and a future decade of action"

Somaliland is part of the East Africai region and reports one of the highest maternal and child mortality rates in the world. The total population is estimated at 3, 5 million inhabitants. Lack of health care providers, long distances to clinics and hospitals, poverty and other cultural and socio-economic barriers are constant challenges for women in need of care and also for midwives. A contributing cause of mortality and morbidity among women is the acute shortage of midwives, which means a high proportion of home births among women with the support of Traditional Birth Attendants. A majority of women are circumcised, knowledge of and use of contraception is low and women give birth to an average of about 6 children. Ten years ago, there were about 220 working midwives in Somaliland, while in fact at least 2,200 were needed and about 1100 women out of 100,000 died annually in connection with pregnancy. In recent years, Somaliland, which is a post-conflict area, has made significant progress in developing the country. Somaliland is more politically stable and safer than the rest of the Somali region (Puntland and the Federal State of Somalia) and has a functioning government that is constantly working to build sustainable health care systems to reach women and children especially in rural areas. In 2004 the Somaliland Nursing and Midwifery Association (SLNMA) was established and in 2012 the association became a members of the ICM.

In this context, we would like to highlight midwives such as Fouzia Ismail, president of SLNMA, Fadma Abdudakar, dean nursing/midwifery education Amoud University, Jama Ali Egal, PhD student, dean midwifrey education, Hargesia University, Roda Ali Ahmed, earlier dean for midiwifery, Edna Hospital and responsible for quality assurance, Hargesia Group Hospital. Together with their colleagues, they have been the driving force for the development of the midwifery profession in post-conflict Somaliland that has progressed strongly over the last decade. Their intensive work has built a progressive Midwifery Association (SLNMA) and they have taken the leadership in establishing schools of nursing and midwifery at local to strengthen the status of the profession and begin to develop strong educational and research environments. Sweden have had contact with Somaliland since 2008 and through Dalarna University's a collaboration with SLMNA and two local universities Hargesia University and Amoud University partnership was established 2010.

On a first visit to Sweden in 2011, SLNMA participated celebrating the Swedish Midwifery Association 125 year and 300 years of midwifery education. SLNMA meet with ICM President Bridget Lynch and discussed membership in the ICM. Individuals and SLNMA as professional associations have shown outstanding leadership since the start of the association and more specifically the last decade.

International partnership: Capacity-building of midwifery education and research in post conflict Somaliland

Being a post conflict setting the Somaliland cater for one of the highest maternal and child mortality rates worldwide, and one key issue is the shortage of qualified healthcare providers. There is an urgent need to educate qualified competent midwifery educators who can teach evidence-based midwifery care and practice in a manner that take into accounts the contextual situation of Somali region. A well-established partnership between University of Hargeisa, Amoud University, Ministry of health in Somaliland, and Dalarna University in Sweden has been the foundation for sustainable capacity-building

of midwifery educators in Somaliland between 2010-2016. The project covered the development, implementation and assessment of net-based master education in sexual and reproductive health care (SRH) in Somaliland. The program included courses in midwifery and SRH focusing on evidence-based practices, research methodology and thesis writing using net based learning. The program has increased the number of midwifery educators (n=84) who are central in building capacity in midwifery education and in-service training in the region. The competence of educators in nursing and midwifery education programme at the involved local and international universities has improved. The innovative use of net based learning has shown to be feasible and acceptable by students and local universities (1-3). The master theses produced provide deeper understanding about the context surrounding maternal health and provide important scientific evidence for policy makers to be used in planning and development of landthe maternal health care in the region (3-6). The result and the education program developed will be further introduced to relevant institutions in Somalia and Puntland and may be used to strengthen their capacity building within the Midwifery profession and increase the number of midwives trained and retained within the system. To move the agenda in the region and to provide insights into feasible implementation of high-quality midwifery education in the region "Midwifery education strategic planning workshop" was held the 16th august 2018 at the University of Hargeisa. Organizing bodies was Ministry of Health, UNFPA, WHO, Somaliland Nurses and Midwives Association – SLNMA, Hargeisa University and Dalarna University.

A decade of Action- 2020-2030 to reach Universal Health Coverage and SDG agenda 2030

The joint education initiative increased the number of midwifery educators and clinically working midwives (#50), who are now central in building the capacity of midwives in education and in-service training in Somaliland. Somaliland is making slow progress in terms of meeting the SDGs due to women's lack of access to effective and adequate healthcare in relation to their SRH. Achieving Universal Health Coverage (UHC), however, that still depends on how well nurses and midwives are empowered to build on and expand their knowledge and skills. Our proposed program in Somaliland is demand-driven and connects with the region's strategic agenda for strengthening midwifery. In 2019, a five-year strategy entitled 'The Somaliland Midwifery Strategy' was launched and adopted by the government, as midwifery is a key cornerstone of Somali reproductive, maternal, new-born, child, and adolescent health. The Somaliland Nursing and Midwifery Association (SLNMA) is an implementing partner to UNFPA and is key organization for facilitating the joint activities in the proposed Task force- Strengthening midwifery which is in line with government's national development- and health sector strategic plans. In order to reach sustainability in this setting, a change process led by midwives who are educated, motivated leaders and advocates for evidence- based midwifery care, will be required. The scope of our Midwifery Task force is to develop capacity-building for a sustainable change at faculty, facility and policy level. This is even more urgent in the light of COVID19 pandemic where midwives are at the frontline serving mothers and their babies.

The Swedish model of maternal and new born health care

Sweden has a long tradition of educated midwives and the cadre of skilled midwives- educated to high standards, regulated, and work closely with obstetricians/gynecologists—contributed to the decline in maternal mortality and the strengthening of sexual and reproductive health and rights (SRHR) in Sweden. **Increased midwifery competence and access to midwives before, during, and after pregnancy and childbirth have been centerpieces in Sweden's efforts to reduce morbidity and mortality. The academic institution based in Sweden cater for research capacity within the field of** maternal and new born health care**, implementation research within global health and academic networks relevant for moving the development of Midwifery care in Somaliland.**

Dalarna University (DU), School of Education, Health and Social Studies offers midwifery education that features a global profile. The research is organized under Reproductive Infant and Child Health (RICH) a global multidisciplinary research environment. DU has ongoing strategic partnerships with institutions in Ethiopia, Uganda, Bangladesh and Somalia that focus on capacity-building in midwifery education and research. DU also caters for a PhD program in

Health and Welfare with Focus on Evidence-Based Practice and implementation research. Core competencies in research are maternal and new born health, quality of care, quality improvement using implementation research. DU have strong national collaboration with Karolinska Institutet and Uppsala University.

Key factors for success

International partnership: We have been successful in capacity development and this in collaboration with a range of important stakeholders including professional organizations, Ministry of Health, Ministry of Education, local Universities, local NGOs and civil society. We have taken part in ongoing activities and initiated activities to harmonize education and training of nurses and midwives in Somaliland and Puntland and this to bridge higher education and research with policy, regulation and practice.

Diaspora involvement. The nursing structure completely broke down alongside the human and infrastructural disaster. In Somaliland there was no formal education for 13 years between 1987 and 2000. With support from voluntary national funding, Diaspora Somalis and international UN agencies and NGOs, great efforts have been made to re-open or set up new nursing and midwifery institutes to address the urgent demand of trained health care staff. In this partnership several Somali diaspora have been engaged and are still based in the region to continue local capacity building work.

Flexibility is created by using net based learning which enhances the students skills in critical thinking and independent learning. Being an international partner the Swedish team have strong commitment and engagement in supporting and mentor local faculty.

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NGL-Midwives(Next Generation Learning Midwives) film: https://youtu.be/YwUAoEo2-fc https://youtu.be/ARpvEVu-wqgE

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