

CONTINUITY OF MIDWIFERY CARE AS AN EFFORT TO PREVENT PREMATURE BIRTH: SYSTEMATIC REVIEW

Faridah Hariyani¹

¹Doctoral Program Faculty of Public Health, Hasanuddin University, Makassar, Indonesia

E-mail: faridahhariyani@gmail.com

Abstract

Premature birth is associated with poor quality of life for babies and increased cost of care. The continuity model of midwifery care supports a woman during antenatal, intranatal, and postnatal times and provides healthy parenting practices to all women both low and high risk. The purpose of this paper is to verify evidence of the effectiveness of continuity of obstetric care in preventing preterm birth. This research method is systematic review, article search using pubmed, science direct and proquest from 2016-2020, for assessment of the quality and substance of articles using PRISMA. A total of 10 articles meet the inclusion criteria. There were differences in outcomes in the continuity model of care, the rate of preterm birth was lower in the model of midwifery continuity compared to standard care. The conclusion in this systematic review is that continuity of midwifery care decreases premature birth. Decreased preterm birth can improve a baby's quality of life, reduce care in intensive care units (NICU), reduce hospital and social costs.

Keywords: *Continuity, midwifery care, premature*

INTRODUCTION

Preterm birth is a birth that occurs at a gestation of <37 weeks. Premature birth is associated with poor quality of life for babies and increased cost of care. Some of the known risk factors associated with preterm birth include previous premature birth, history of abortion and cervical surgery. Another unknown cause of spontaneous prematureness is about 40-50%¹. WHO has identified improving the quality of maternal and infant health as one of its priority goals worldwide. A high-quality maternity care system should provide optimal care with the principle of effective, safe care and support useful practices². Midwives as foster care providers responsible for pregnancy, childbirth and postpartum have a central role in physiological management³. Midwives are part of a multilevel perinatal team that provides a holistic approach to women's upbringing during pregnancy⁴. The continuity model of midwifery care supports a woman during antenatal, intranatal, and postnatal times, facilitating pregnancy and childbirth and healthy parenting practices to all women both low and high risk by monitoring the physical, psychological, spiritual and social well-being of women and families during the birth cycle⁵. Continuity of midwifery care minimizes unnecessary technological interventions, identifies, refers to and coordinates care for women who need the attention of obstetric or other specialists. The continuity model of midwifery care exists in a multidisciplinary network where consultations and referrals to other service providers are

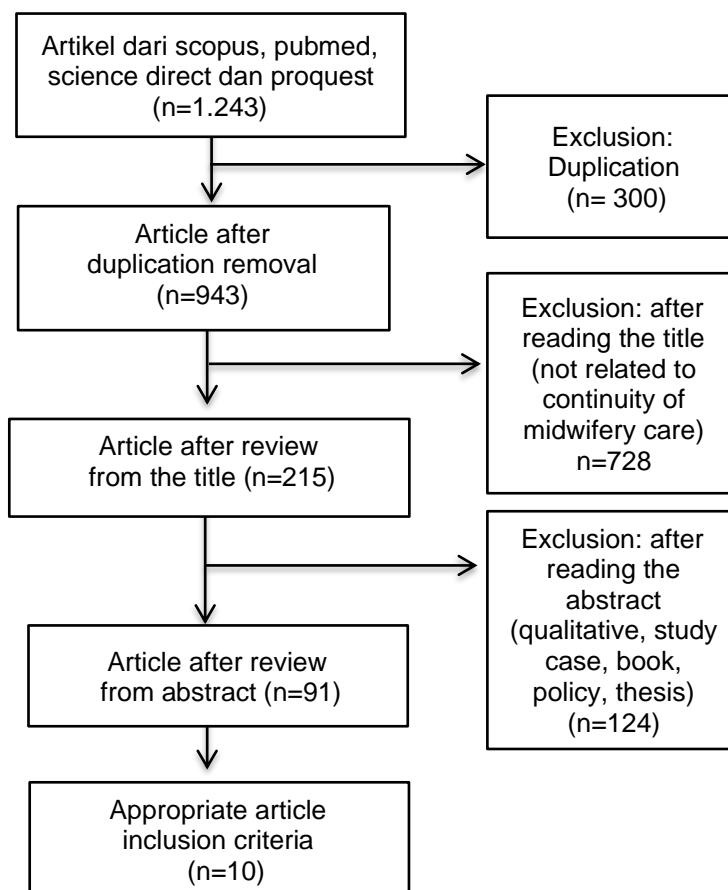
carried out when necessary^{2,5}. Continuity of care provided in the form of information continuity, continuity of care and relational continuity³. The purpose of writing is to verify evidence of the effectiveness of continuity of midwifery care in preventing premature births.

MATERIAL AND METHODS

Systematic Review uses PRISMA guidelines, article search using, pubmed, science direct, and proquest. Article searches cover research around the world between 2016-2020. Articles that have been obtained from the data base are then imported into the ministry. Keyword combinations used in searches are Midwife or midwifery and continuity of care or caseload or team midwifery, and preterm or premature. The inclusion criteria of the article included are focusing on obstetric care, and premature birth, in normal pregnancy and risk pregnancy, analyzed using statistical tests (qualitative studies, case studies, books, policy summaries or thesis issued).

RESULTS

Picture 1. shows a summary of the study, with cohort, RCT and systematic review types of study.



Picture 1. Prism Diagram

Table 1. Characteristics of studies included in Systematic Review (n = 10)

No.	Author	Method	Findings
1	Sue Kildea et al	Prospective Cohort	Women who receive a new service (caseload) are less likely to give birth to a premature baby than women who receive it. standard care
2	Berit Mortensen et al	Cohort	In the midwife-led care model, in outcome fewer mothers underwent planned C-sections, fewer had anemia and postpartum transfusion. In outcome fewer babies who experience premature births, birth weight < 1500 grams, and infant mortality in the NICU
3	Daphne N McRae et al	Retrospective Cohort	SGA births, premature births and BBLR are reduced in antenatals performed by midwives compared to those performed by GPs/other models.
4	Sandall J et al	Systematic Review	Women who receive midwives' care are less likely to experience epidural anesthesia, episiotomy, instrumental labor, women less likely to give birth prematurely, the risk of losing a baby < 24 weeks is lower, the rate of spontaneous vaginal birth increases.
5	Daphne N McRae et al	Retrospective Cohort	Premature labor was lower among patients with obstetric versus physician care models in patients who did not experience mental disorders and the use of addictive substances. The association between obstetric care versus physician care was likely to be lower, but the effect was statistically not significantly different for women with a higher or lower psychosocial risk.
6	Yiska Leowenberg W et al	Retrospective Cohort	Low-risk women who receive prenatal care from midwives have a lower risk of induction labor, epidural analgesia, caesarean, and risk of preterm birth.
7	Daphne N McRae et al	Retrospective Cohort	SGA births, premature births and BBLR are reduced in antenatals performed by midwives compared to those performed by GPs/other models.
8	Cristina Fernandez et al	Retrospective Cohort	women's group for midwives-led antenatal care continuity models less likely to have preterm birth
9	Bernadette M.Lack et al	Retrospective Cohort	In remote areas of lower preterm birth (6%) and low birth weight babies (5%) compared to population-based data
10	Y Tony Yang et al	Retrospective Cohort	Women in states with autonomous practices have a lower chance of cesarean delivery and low birth weight (compared to women in states without autonomous practices).

DISCUSSION

Decreased premature births and BBLRs in the continuity model of midwifery care is important because premature causes are the leading cause of infant disability and death. Decreased preterm birth and low birth weight can reduce care in intensive care units (NICU)⁷. The continuity model of midwifery care aims to strengthen the relationship between women and midwives, improve mutual care, improve the skills, experience and autonomy of midwives and improve scientific interdisciplinary cooperation between levels of care⁷. The possible impact of the continuity model of midwifery care during pregnancy and childbirth is associated with information, education, trust and empowerment. If women feel more confident and relaxed before and during labor, it can have an indirect impact on medical intervention. The continuity value of midwifery care for women, among others, women are more relaxed, confident, more understanding and open. The continuity of midwifery care makes women's beliefs grow and women don't have to repeat their stories to different midwives. For midwives continuity of care makes midwives more confident, reflective, gives understanding to women, tells what women need. Women and midwives trust each other, empower, value, secure support and agree⁸. Female midwifery relationships are the means by which personalized care, trust and empowerment can be achieved in the continuity of the midwifery care model. Relational continuity is an important component of continuity of foster midwifery services and midwives should prioritize the development of relationships with women in their care⁹. The study's limitations were related to the risk of information bias whether women on continuity models also received treatment elsewhere and also lacked information on the level of continuity of how many times women met the same midwife.

CONCLUSION

Continuity of midwifery care is associated with a reduction in premature births. This can contribute to improving the baby's quality of life and reducing hospital and social costs. More research is needed to produce an expansion of the model on other types of risk factors.

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