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A Seminar on Pregnancy Monitoring for Midwives and Evaluation of the Antenatal and Postnatal Care Services Provided in Northwest Syria

ABSTRACT

Background and Aims

Midwifery, one of the oldest professions in human history, is an independent healthcare discipline focused on maternal and child health. This study aimed to assess the existing healthcare services provided by a limited number of midwives in Northwest Syria. The assessment was conducted through a seminar designed to share knowledge on antenatal and postnatal care, using the questionnaire titled "Antenatal and Postnatal Monitoring Services Provided in Northwest Syria", which was developed to evaluate the scope and quality of maternal health services delivered by midwives.

Methods

A total of 80 midwives who met the inclusion criteria and agreed to participate were included in the study. Data were collected using a two-part questionnaire entitled "Antenatal and Postnatal Monitoring Services Provided in Northwest Syria."

Results

The mean age of the participants was 33.80 ± 9.15 years. Among the participants, 66.3% (n = 53) were employed in hospitals, and 43.8% (n = 35) had more than 10 years of professional experience.

Conclusion

Improving the quality of healthcare services in the region by enhancing midwives' knowledge and skills, providing appropriate working conditions, and addressing social determinants of health may lead to significant improvements in both maternal and child health outcomes. Such interventions may also help mitigate the adverse effects of war on physical and psychological well-being.

Keywords: Antenatal care, Midwife, Postnatal care, Pregnancy, Syria

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Introduction

Midwifery, one of the oldest professions in human history, is a specialized, professional, and independent healthcare discipline focused on maternal and child health. A midwife is a certified healthcare provider who serves women and newborns simultaneously, assuming critical responsibilities to ensure their well-being (1,2). Midwives play a vital role in maintaining and promoting health by providing education and counseling not only to women and children but also to families and communities, thereby contributing to the protection, promotion, and advancement of public health. According to the World Health Organization (WHO), a midwife is a trained and certified professional responsible for providing care and counseling during pregnancy, childbirth, and the postpartum period, as well as independently managing normal deliveries and caring for newborns (1).

In well-resourced healthcare systems, adequately planned and effectively implemented midwifery practices can have a substantial positive impact on maternal and neonatal health outcomes, potentially preventing approximately two-thirds (66%) of maternal deaths. Investments in midwifery services are therefore considered

essential for building healthier and more prosperous societies (2).

It is well documented that wars and armed conflicts adversely affect public health, particularly among women and children, highlighting the importance of social stability as a key determinant of health. The conflict in Syria represents a striking example. Prior to the war, Syria had achieved notable public health successes, including low infant mortality rates and high vaccination coverage. However, these indicators deteriorated rapidly following the onset of conflict. The severity of the impact on child health is illustrated by the increase in infant mortality rates from 14 per 1,000 live births in Syria in 2010 to 290 per 1,000 live births among Syrian refugees in Lebanon. In the post-conflict period, Syria has faced profound setbacks in maternal and child health, resulting in major public health challenges (3).

This study aimed to assess the healthcare services provided by a limited number of midwives in Northwest Syria by evaluating a seminar designed to share knowledge on antenatal and postnatal care. The findings are expected to inform future midwifery training programs and contribute to improving health outcomes in communities affected by war.

Materials and Methods

Study Design

This study was a cross-sectional study conducted through face-to-face interviews with midwives working in Northwest Syria. The aim of the study was to assess prenatal, antenatal, and postpartum health surveillance services and to provide recommendations for improving midwifery practices in the region. A total of 267 midwives were employed in hospitals and health centers in Northern Syria. Due to security concerns, midwives working in inaccessible areas could not be included; therefore, the target sample size was set at 123 midwives.

Ethical approval for the study was obtained from the Noninterventional Research Ethics Committee of Hatay Mustafa Kemal University (Date: 06.05.2021, Decision No: 22). In addition, necessary permissions were obtained from local health authorities and relevant organizations. The study was conducted in accordance with the principles of the Declaration of Helsinki issued by the World Medical Association.

Study Setting

The study was conducted among midwives working in various health centers and hospitals in Northwest Syria. In this region, healthcare services have been largely restructured following the war, and healthcare professionals provide services to a large patient population under limited-resource conditions. The study focused on midwifery practices, particularly those related to prenatal and postpartum surveillance services.

Participant Selection

The study included midwives working in Northwest Syria who were actively engaged in providing prenatal and postpartum surveillance services. Inclusion criteria were being aged 18 years or older, actively practicing midwifery in Northern Syria, and providing voluntary informed consent to participate. A total of 123 midwives met the inclusion criteria. Forty-three healthcare personnel were excluded because they declined participation, were under the age of 18, or did not provide direct midwifery services. Ultimately, 80 midwives who met the inclusion criteria and agreed to participate were included in the study.

Data Collection

The questionnaire titled “Antenatal and Postnatal Monitoring Services Provided in Northwest Syria” was developed in Turkish following a comprehensive review of the literature and subsequently translated into Arabic by sworn translators. The clarity and appropriateness of the questions were evaluated by Syrian specialist physicians experienced in regional healthcare practices. Following a pilot study conducted with 20 participants, questions that were misunderstood were removed, and the questionnaire was finalized.

The questionnaire consisted of two sections. The first section addressed sociodemographic characteristics, including age, education level, marital status, and working conditions. The second section assessed knowledge, attitudes, and practices related to prenatal care, pregnancy, and postpartum surveillance services.

Participants were informed about the purpose of the study, and guidance was provided to ensure complete and accurate responses. Collected data were recorded in a digital format suitable for statistical analysis and subsequently analyzed.

Statistical Analysis

Statistical analyses were performed using JASP (version 0.19.0) and R (version 4.4.1). In R, analyses were conducted using the stats and rstatix packages. Descriptive statistics were reported as mean ± standard deviation, median (minimum–maximum; interquartile range [IQR]), and frequency (n, %). Normality was assessed using the Shapiro–Wilk and Kolmogorov–Smirnov tests.

Comparisons among more than two groups were performed using the Kruskal–Wallis test. When significant differences were detected, pairwise post-hoc comparisons were conducted using Dunn’s test with Benjamini–Hochberg false discovery rate (FDR) adjustment. Comparisons between two groups were performed using the Mann–Whitney U test. Effect sizes were calculated as $r = Z/\sqrt{n}$ for Mann–Whitney U tests and eta-squared $(\eta^2) = (H - k + 1)/(n - k)$ for Kruskal–Wallis tests. Categorical variables were analyzed using Pearson’s chi-square test or the Fisher–Freeman–Halton exact test, as appropriate. Proportions were presented with 95% confidence intervals calculated using the exact binomial (Clopper–Pearson) method. All p-values were two-sided and reported to three decimal places ($\alpha = 0.050$).

Results

A total of 80 midwives participated in the study. Of these, 66.3% (n = 53) were employed in hospitals, and 43.8% (n = 35) had more than 10 years of professional experience. The mean age of the participants was 33.80 ± 9.15 years. Regarding educational level, 35.0% (n = 28) held an associate degree, 27.5% (n = 22) held a bachelor's degree, and 23.8% (n = 19) had completed high school education. In addition, 66.2% (n = 53) were married, and 60.0% (n = 48) had children.

Regarding place of residence, 42.3% lived in urban areas and 33.3% (n = 26) in rural villages. Most participants (95.0%, n = 76) lived in private homes, while 5.0% (n = 4) resided in camps. The distribution of midwives' practices and perspectives related to pregnancy, childbirth, and postpartum care is presented in Table 1.

The median monthly income was 2,550 TRY (range: 500–12,750). A statistically significant increase in income was observed with higher educational attainment. Midwives with a high school diploma reported a median income of 1,000 TRY (800–3,700), whereas those with postgraduate education reported a median income of 2,975 TRY (900–7,650) (p = 0.026). Home visit practices differed significantly by education level, with 72.7% of bachelor's degree holders conducting home visits compared with 18.2% of those with postgraduate education (p = 0.003). This finding may suggest that bachelor-level midwives are more involved in fieldwork, whereas those with postgraduate qualifications may assume more advisory or administrative roles. A significant difference was also observed in ultrasound usage (p = 0.005), with usage rates highest among midwives with postgraduate education (Table 2).

A statistically significant association was found between place of residence and the ability to contact pregnant women who missed follow-up appointments (p = 0.015). Success rates were 33.3% in urban areas, 35.3% in districts, 69.2% in villages, and 100% in other settings (Table 3).

Differences in monthly income and working hours according to education level and professional experience are shown in Table 4. The Kruskal–Wallis test revealed a significant difference among education groups (p = 0.026). Pairwise comparisons indicated significant differences between Group 1 and Groups 2, 3, and 4. A significant difference was also observed between professional experience groups (p = 0.006), particularly between midwives with 1–5 years and those with more than 10 years of experience.

Discussion

Midwifery has evolved into a professional healthcare discipline grounded in scientific knowledge, ethical principles, and evidence-based practice. Midwives provide monitoring, care, counseling, and education throughout pregnancy, childbirth, the postpartum period, and the neonatal stage, thereby contributing significantly to the health of women, families, and communities (2).

Wars and conflicts pose severe threats to public health, particularly for women and children. In Syria, prolonged conflict has led to increased preventable disabilities, communicable diseases, and mortality (3). Despite limited resources and challenging conditions, midwives demonstrated strong professional commitment, although the lack of equipment and training negatively affected the quality of care. These findings underscore the urgent need to improve working environments.

Regular prenatal care is essential for reducing maternal and neonatal morbidity and mortality (4,5). In the present study, although attendance rates were relatively high, home visits remained underutilized. Expanding home visit services may improve access to prenatal care, particularly for women facing barriers to healthcare facilities.

Refugee women often experience limited access to reproductive health information and services due to sociocultural and economic constraints (5,10). In this study, malnutrition was the most common health problem among pregnant women, followed by hypertension and gestational diabetes. These conditions are largely preventable through education and early intervention, highlighting the critical role of midwives in community-based healthcare.

Conclusion

In Northwest Syria, prenatal and postnatal care services provided by midwives have been significantly disrupted by ongoing conflict. Although midwives remain committed to providing care, environmental limitations, financial constraints, and insufficient community awareness hinder effective service delivery.

Strengthening midwives' knowledge and skills through in-service training, improving working conditions, and addressing social determinants of health may enhance the quality of maternal and child healthcare services. Such efforts have the potential to mitigate the long-term physical and psychological effects of war on vulnerable populations.

Declarations

The authors declare that there are no conflicts of interest, financial support, or commercial relationships that could be perceived as influencing the research presented in this manuscript. Ethical approval was obtained from the Noninterventional Research Ethics Committee of Hatay Mustafa Kemal University (Date: 06.05.2021, Decision No: 22).

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Tables

Table 1. Distribution of Midwives' Practices in Pregnancy, Delivery, and Postpartum Care in Northwestern Syria

	N (%)
Years of Professional Experience	
1-5 years	27 (33.8)
5-10 years	18 (22.5)
10 years and above	35 (43.8)
Which institution do you currently work for?	
Hospital	53 (66.3)
Hospital + Health Center	4 (5.0)
Health Center	22 (27.5)
Health Center + Private Clinic	1 (1.3)
Average monthly working hour? *Mean SD,Median(Min-Max)*	245.66 78.99 240 (90-520)
How many times do pregnant women attend follow-up visits during 9 months?	
1-2	2 (2.5)
2-4	11 (13.8)
4-6	34 (42.5)
6-8	33 (41.3)
If you work at a health center, do you conduct home visits?	
Yes	44 (55.0)
No	36 (45.0)
Can pregnant women obtain prescribed medications free of charge?	
They can afford them	13 (16.3)
They cannot afford them when the medication is out of stock	42 (52.5)
They can never afford them	16 (20.0)
Missing	9 (11.2)
Do you request blood or urine tests from pregnant women?	
Yes	71 (88.8)
No	3 (3.8)
Missing	6 (7.5)
If your answer is "Yes", please indicate the tests you request:	
Hemogram	46 (16.6)
ABO + Rh typing	58 (20.9)
Hepatitis	46 (16.6)
Toxoplazmosis	24 (8.7)
Rubella	4 (1.4)
CMV Ig testing	9 (3.2)
TSH	4 (1.4)
Urine test	57 (20.6)
Other	4 (1.4)
What are the most common health problems you encounter in pregnant women? (You can select multiple options)	
Hypertension	63 (17.0)
Gestational Diabetes	47 (12.7)
Preeclampsia	39 (10.5)
Heart diseases	13 (3.5)
Nutritional deficiency	67 (18.1)
Pregnancy under 18 years of age	40 (10.8)
Multiple pregnancy	32 (8.65)
Vaginal infections	25 (6.76)
Urinary tract infections	43 (11.6)
Other	1 (0.3)
Do you refer pregnant women with detected risks to the hospital?	
Yes	74 (92.5)
No	2 (2.5)
missing	4 (5.0)
Do you use ultrasound?	

Yes	40 (50.0)
No	40 (50.0)
Do you know how to apply and interpret NST (Non-Stress Test) for pregnant women?	
Yes	43 (53.8)
No	37 (46.2)
Do you assist with home births?	
Yes	22 (27.5)
No	58 (72.5)
In your opinion, do women prefer to give birth at home or in a hospital more?	
At home	19 (23.8)
İn a hospital	61 (76.3)
What is the most common issue you encounter with births you attend?	
Preterm birth	49 (26.1)
Breech presentation	35 (18.6)
Shoulder dystocia	21 (11.2)
Vaginal infection	17 (9.0)
Macrosomia (large baby)	25 (13.3)
Prolonged labor	34 (18.1)
Other	7 (3.7)
What problems do you encounter during the postpartum period?	
Atony	34 (18.1)
Infection	29 (15.4)
Other	16 (8.5)
Is postpartum follow-up provided to mothers?	
Yes	60 (75.0)
No	11 (13.8)
Missing	9 (11.3)
If your answer is "Yes", how many times is the follow-up conducted?	
1	4 (12.1)
2	16 (48.5)
3	7 (21.2)
4	6 (18.2)
Do you provide breastfeeding and counseling services to postpartum women?	
Yes	70 (87.5)
No	6 (7.5)
Missing	4 (5.0)
Do you have patients who approach you for postpartum depression?	
Yes	40 (50.0)
No	33 (41.3)
Missing	7 (8.8)
What is your approach when a patient approaches you with postpartum depression?	
Referral to a social support specialist	48 (60.8)
Referral to a psychological counselor	18 (22.8)
Referral to a psychiatrist	10 (12.7)
Other	3 (3.8)
What are the most common health problems you encounter in newborns?	
Low birth weight	50 (25.6)
Congenital anomalies	17 (8.7)
Respiratory problems	52 (26.7)
Feeding problems	19 (9.7)
Jaundice	53 (27.2)
Other	4 (2.0)
Do you like your profession?	
Yes	73 (91.3)
No	1 (1.3)
Missing	6 (7.5)
What do you need to perform your midwifery profession better?	
Ultrasound device	35 (34.3)
Surgical instruments for family planning	24 (23.5)
In-service training	38 (37.2)
Other	5 (4.9)

What topics would you like to receive in-service training on?	
Pregnancy examination and follow-up	48 (14.6)
High-risk pregnancies	42 (12.8)
Ultrasound/NSTusage	55 (16.7)
Childbirth/ High-risk childbirth	49 (14.9)
Episiotomy	11 (3.3)
Postpartum period	20 (6.1)
Neonatal care	37 (11.3)
Education for women/Family planning methods	63 (19.2)
Other	3 (0.9)

Table 2. Comparison of Midwives' Practices by Educational Level

	Total	**High School**	**Associate Degree**	**Undergraduate Degree**	**Graduate Degree**	**p**
If you work at a health center, do you conduct home visits? n(%)						
Yes	44(55.0)	14(73.7)	12(42.9)	16(72.7)	2(18.2)	**0.003**[#]
No	36(45.0)	5(26.3)	16(57.1)	6(27.3)	9(81.8)	
Do you use ultrasound? n(%)						
Yes	40(50.0%)	8(42.1)	16(57.1)	6(27.3)	10(90.9)	**0.005**[*]
No	40(50.0%)	11(57.9)	12(42.9)	16(72.7)	1(9.1)	
Do you know how to apply and interpret NST (Non-Stress Test) for pregnant women? n(%)						
Yes	43(53.8)	12(63.2)	13(46.4)	14(63.6)	4(36.4)	0.323[*]
No	37(46.2)	7(36.8)	15(53.6)	8(36.4)	7(63.6)	
Do you assist with home births?n(%)						
Yes	22(27.5)	4(21.1)	7(25.0)	6(27.3)	5(45.5)	0.565[#]
No	58(72.5)	15(78.9)	21(75.0)	16(72.7)	6(54.5)	
Do you provide breastfeeding and counseling services to postpartum women? n(%)						
Yes	70(87.5)	15(78.9)	24(85.7)	20(90.9)	11(100.0)	0.835[#]
No	6(7.5)	2(10.5)	3(10.7)	1(4.5)	0(0.0)	
Do you like your profession? n(%)						
Yes	73(91.3)	18(100.0)	26(100.0)	18(94.7)	11(100.0)	0.651[#]
No	1(1.3)	0(0.0)	0(0.0)	1(5.3)	0(0.0)	

[&]: Kruskal Wallis, [#]: Fisher Freeman Halton Exact test, [*]: Chi-Square test

Table 3. Access to Health Services and Practices by Place of Residence

	Total	City	District	Village	Other	p
	n=80	n=33(42.3)	n=18(23.1)	n=26(33.3)	n=1(1.3)	
When pregnant women do not attend follow-up visits, do you have a chance to contact them? n(%)						
Yes	36(46.8)	11(33.3)	6(35.3)	18(69.2)	1(100.0)	0.015[#]
No	41(53.2)	22(66.7)	11(64.7)	8(30.8)	0(0.0)	
If you work at a health center, do you conduct home visits? n(%)						
Yes	44(55.0)	19(57.6)	9(50.0)	15(57.7)	0(0.0)	0.794[#]
No	36(45.0)	14(42.4)	9(50.0)	11(42.3)	1(100.0)	
Do you use ultrasound? n(%)						
Yes	40(50.0)	20(60.6)	5(27.8)	13(50.0)	1(100.0)	0.082[#]
No	40(50.0)	13(39.4)	13(72.2)	13(50.0)	0(0.0)	
Do you know how to apply and interpret NST (Non-Stress Test) for pregnant women? n(%)						
Yes	43(53.8)	19(57.6)	7(38.9)	16(61.5)	0(0.0)	0.269[#]
No	37(46.2)	14(42.4)	11(61.1)	10(38.5)	1(100.0)	
Do you assist with home births?n(%)						
Yes	22(27.5)	10(30.3)	7(38.9)	4(15.4)	0(0.0)	0.265[#]
No	58(72.5)	23(69.7)	11(61.1)	22(84.6)	1(100.0)	
In your opinion, do women prefer to give birth at home or in a hospital more? n(%)						
Home	19(23.8)	6(18.2)	3(16.7)	9(34.6)	0(0.0)	0.419[#]
Hospital	61(76.3)	27(81.8)	15(83.3)	17(65.4)	1(100.0)	
Is postpartum follow-up provided to mothers? n(%)						
Yes	60(75.0)	22(66.7)	17(94.4)	18(69.2)	1(100.0)	0.256[#]
No	11(13.8)	7(21.2)	1(5.6)	3(11.5)	0(0.0)	
Do you provide breastfeeding and counseling services to postpartum women? n(%)						
Yes	70(87.5)	28(84.8)	16(88.9)	24(92.3)	1(100.0)	0.583[#]

No	6(7.5)	2(6.1)	2(11.1)	2(7.7)	0(0.0)	
Do you like your profession? n(%)						
Yes	73(91.3)	29(100.0)	18(100.0)	23(95.8)	1(100.0)	0.594#
No	1(1.3)	0(0.0)	0(0.0)	1(4.2)	0(0.0)	

#: Fisher-Freeman Halton Exact test, &: Kruskal Wallis Test

Table 4. Comparison of monthly income and working hours by educational status and professional experience

Variables	Average Monthly Income Median(Min-Max)	Working Hours Median(Min-Max)
Education Level		
High School (1)	1000(800-3700)	216(120-312)
Associate Degree (2)	2150(500-11050)	240(144-424)
Bachelor's (3)	2550(850-12750)	240(90-520)
Postgraduate (4)	2975(900-7650)	240(180-312)
p&	***0.026***	*0.262*
p1-2	***0.039***	
p1-3	***0.021***	
p1-4	***0.039***	
p2-3	*0.156*	
p2-4	*0.575*	
p3-4	*0.132*	
Professional Experience		
1–5 years	900(500-4250)	240(144-450)
5–10 years	1850(900-12750)	228(150-315)
10+ years	2975(850-11050)	240(90-520)
p&	*0.006*	*0.613*
p1-5-5-10	*0.171*	
p1-5-10+	***0.006***	
p5-10,10+	*0.140*	

&: Kruskal–Wallis test; other p-values are from pairwise comparisons conducted using the Mann–Whitney U test, adjusted with the Benjamini–Hochberg correction.(**p_{1-2}**: Comparison between High School and Associate Degree groups, **p_{1-3}**: Comparison between High School and Bachelor's Degree groups, **p_{1-4}**: Comparison between High School and Postgraduate groups, **p_{2-3}**: Comparison between Associate Degree and Bachelor's Degree groups, **p_{2-4}**: Comparison between Associate Degree and Postgraduate groups, **p_{3-4}**: Comparison between Bachelor's Degree and Postgraduate groups)

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