



FIRST TOUCH PROJECT FINAL REPORT

2021



ABOUT FIRST TOUCH

Our vocational education project 2018-1-TR01-KA202-059488 contract number 123.090, prepared by the Kayseri Provincial Directorate of Health and submitted to the Strategic Partnership Projects of the Cooperation for Innovation Development and Good Practice Exchange (KA2) of the EU Project of the National Agency of Turkey in 2018, has been eligible for grant support.

The project has lasted for 36 months and is based on international cooperation based on the development of innovations, the development of training programs for the preparation for childbirth, aimed at training the midwifery profession.

The project partners are the German International Society for Pre and Perinatal Psychology and Medicine (ISPPM), the Greek Doula Association of Greece and the Istanbul Birth Academy.

Among the activities of our project, 1 opening meeting, 6 transnational meetings, 1 closing meeting, 3 transnational workshops, 7 articles dec planned.

The opening meeting, 3 transnational meetings and 2 workshop activities were held face to face. However, due to the cancellation of international flights due to Covid-19, which has increased since March 2020, 3 Transnational meetings could not be held, 1 workshop program was held online, and the closing meeting was organized online.

Projects are quite valuable for correcting a problem or developing another perspective on the problem. We would like to thank the National Agency of Turkey, our project partners Istanbul Academy of Obstetrics, International Society for Pre and Perinatal Psychology and Medicine and Greek Doula Association for their contributions and support to the project.

Maternal and child health is one of the most important health indicators in the whole world and also occupies an important place among sustainable development goals. It is valuable for us that special efforts are being made to improve maternal and infant health all over the world, and that maternal and infant health studies are continuing in the process of an important public health problem affecting normal life, such as the pandemic. We are very happy to contribute to the literature with the trainings and articles included in our activities.

We are continuing to work on participating in new projects.

*Assoc. Dr. Ali Ramazan BENLİ
Kayseri Provincial Health Director*

We are happy to complete your project in a healthy and successful way.

No project can be successful with the efforts of a single person. We are proud to have met and worked with a large number of academicians, experts, mothers and baby lovers on this project.

Thanks to;

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With the hope that the 'First Touch Project', completed with the cooperation and joint purpose of project teams from Turkey, Germany and Greece, will contribute to the scientific literature.

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1. BASIC HEALTH INDICATORS AND MIDWIFERY IN TURKEY, GERMANY AND GREECE

Statistical Indicators

Figure 1. Population Pyramid Of Germany

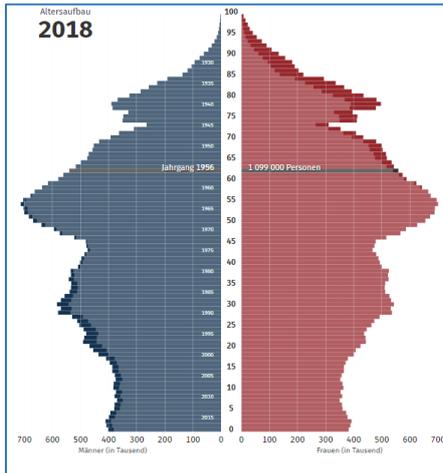


Figure 2. Turkey Population Pyramid, (%), 2018

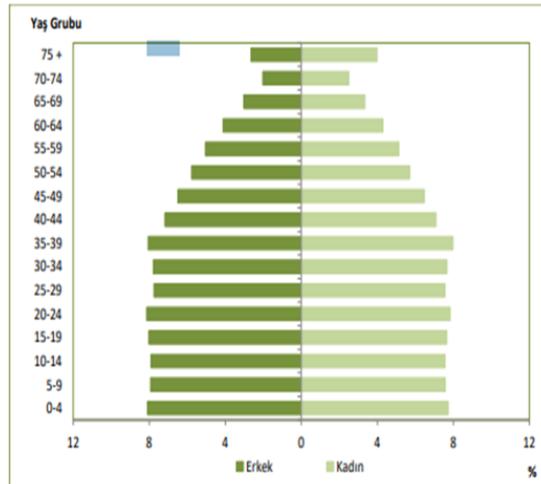
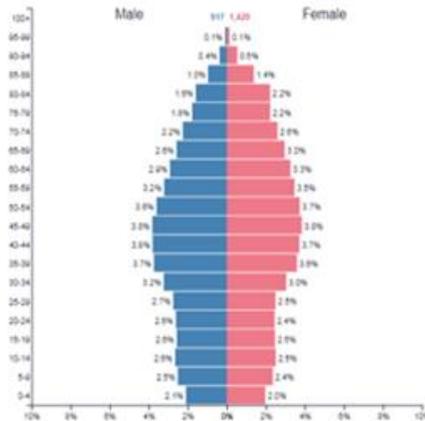


Figure 3. Population pyramid of Greece



Although Germany and Turkey have similarities in terms of population numbers, the population structure is different from each other. The mean age in Germany is higher than in Turkey. In Greece, we can also see that fertility rates are falling, the number of people in the middle age group is higher than others, and the number of young and old is close to each other. (Figure 1-2-3) (Table 1).

Table 1. Basic health indicators

	Turkey	Germany	Greece	Source and data history
Country Population (Year 2020)	83.154.997	83.019.213	10.724.599	2020
Number of women aged 15-49 (2020 data)	21.988.068	16.800.042	2.197.026	Who (2020)*
Proportion of women aged 15-49 to general population %	26,4	20,2	20,4	Who (2020)*
Birth rate (birth rate per 100 people)	16,2	9,4	7,8	2017/ https://population.un.org/wpp/DataQuery/
Mortality rate under 5 (per 1,000 births)	9,97	3,35	4,1	who (2018)*
Neonatal mortality rate (per 1000 births)	5,46	2,18	2,59	who (2018)*
Infant mortality rate (1000 births)	9,1	3,01	3,63	Who (2018)*
Maternal mortality rate (100,000)	17	7	3	Who (2017)* https://greece.greekreporter.com/2018/06/07/greek-c-section-rates-dwarf-international-limit/
C-section birth rate (2018 data) %	54,9	29,6	56,8	Yearbook Of Health Statistics (2018)
Adolescent fertility rate between the ages of 15-19 (at 100 births)	26,56	8,1	7,22	Who (2020)*

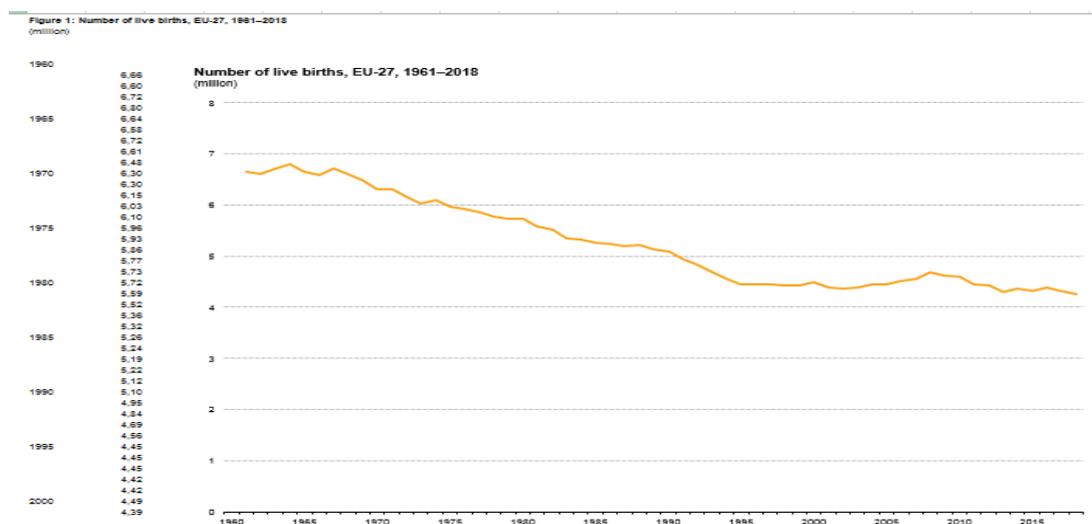
In 2018, the total fertility rate in EU countries was 1.55 live births per woman. (1.56 in 2017). According to Eurostat 2018 data, Turkey has a total fertility rate of 1.99, Germany 1.57, Greece 1.35. But according to a study conducted in Turkey, this figure was reported as 2.3 . Among EU Member States, France had the highest total fertility rate in 2018 with a rate of 1.88, followed by Sweden and Romania with 1.76 live births, and Ireland with 1.75 live births in third place. The lowest total fertility rates in 2018 were reported from Malta (1.23), Spain (1.26), Italy (1.29), Cyprus (1.32), Greece (1.35) and Luxembourg (1.38).

Table 2. Live birth numbers of countries

	2015		2016		2017		2018	
	Number	Rate Of Increase	Number	Rate Of Increase	Number	Rate Of Increase	Number	
Germany	737.575	7,4	792.141	-0,95	784.901	0,33	787.523	
Greece	91.847	1,15	92.898	-4,68	88553	-2,4	86440	
Turkey	1.333.329	-1,6	1.311.895	-1,6	1.291.055	-8,3	1.183.652	

Among the three countries, the country with the highest population of women aged 15-49 is Turkey with a rate of 26.4%, and the number of live births and rough birth rate are also higher than the others with a rate of 16.2%. Looking at the change in the number of births by year, it is seen that the decline in the number of births over the years in Turkey is observed in a certain number range, although there is an increase in Germany in 2016. The number of births in Greece has been falling for the last 2 years (Table 2). In general, it is reported that the number of live births in Europe has fallen over the years (Figure 4).

Figure 4. Change in the number of live births in EU countries



The age of being a mother for the first time in EU countries continues to rise and the average age is 29.3. The average age of being a first mother in Turkey is 23.3, Greece is 31.2, Germany is 29.7. One factor that could explain low levels of fertility in the EU is the increase in the age at which women give birth first. Factors that cause childbirth in later ages: women have higher participation rates in higher education and / or prefer to establish a career before starting a family more; the reduction of a job guarantee (low income levels); child-rearing and increased costs for housing; and a decrease in the number of traditional families (fewer marriages and more divorces), shows.. Due to the impact of the 2007 economic crisis in Greece, it has been reported that women's fertility preferences, especially in metropolitan areas, have changed and there is a trend towards postponing birth.

59% of births in Turkey occur in public hospitals and 40% in private hospitals. Less than 1% of births have been reported to occur at home. According to TUIK 2018 data in Turkey, the cities with the highest total fertility rate were Şanlıurfa with 4.13 children, followed by Şırnak with 3.6 children, Ağrı with 3.26 children and Muş with 3.23 children. In Germany, 2.19% of all births take place outside the hospital. The highest birth rate in Germany was reported from the states of Lower Saxony and Brandenburg with a rate of 1.62. The lowest birth rate is in Berlin, with a rate of 1.45. According to our research, current perinatal Data of Greece was found to be insufficient, and no current data studies were found in the literature review.

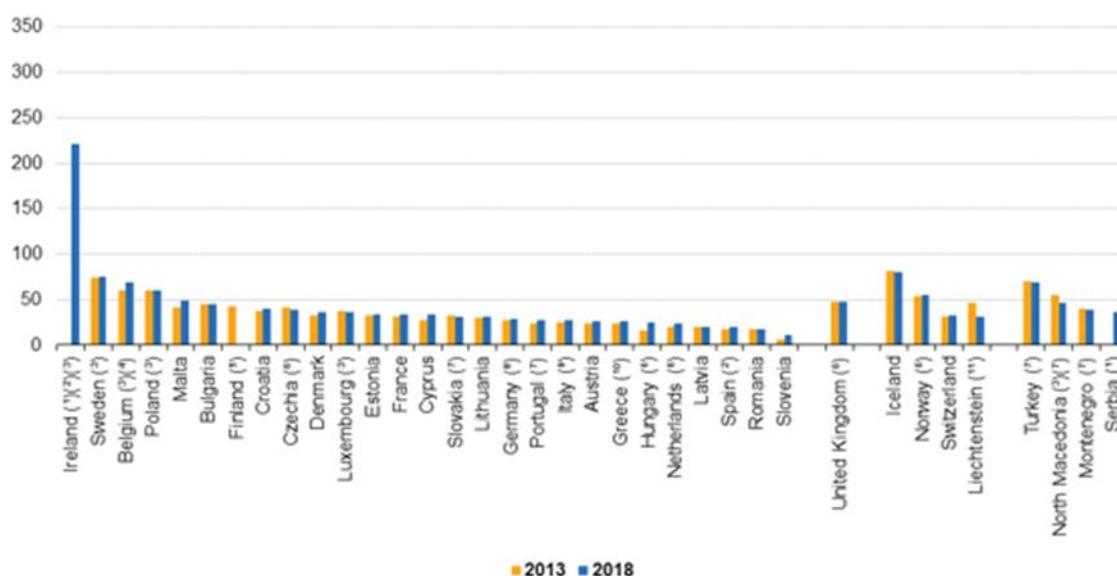
C-section birth rates are highest among OECD countries, with Turkey at 54.9%, and Israel at least 1.49%. According to the OECD, the 2018 cesarean section birth rate is 29.6% in Germany. According to the Kathimerini newspaper, the rate of caesarean sections in Greece has increased from 50% to 70% (between 2007 and 2016). According to the same source, most caesareans are performed in a private hospital. (Table 1).

In recent years, one of the indicators that can be considered important in terms of women's and children's health is the number of immigrants and refugees. Migrants/ refugees and health problems caused primarily by the Syrian crisis are important for midwives in Turkey, Germany and Greece. Turkey and Greece are on the refugee transit route, with Turkey and Germany hosting the most refugees and migrants in Europe. According to the EU, the number of migrants per mean 1,000 is 5.4, with Germany 10.8, Greece 11.1 and Turkey 45.

1.2. Midwife numbers

According to data from Eurostat, the highest number of Midwives among EU member states in 2018 was reported to be 24,000 in Germany, 23,000 in France and 23,000 in Poland (2017 data). Ireland had the highest proportion of midwives by population size in 2017 (221 per 100,000 people), Sweden, Belgium and Poland were the other member states that recorded a rate of more than 50 midwives per 100,000 people.

Figure 7. Numbers of midwives in OECD countries (per 100,000 people) between 2013 and 2018)



The lowest proportion of midwives by a clear margin compared to the population is Slovenia, where in 2018 there were an average of only 11 Midwives per 100,000 people. Romania, Spain and Latvia each reported numbers of Midwives between 17 and 21 per 100,000 people. There was an overall increase in the number of midwives working according to population size in all EU Member States (out of 6) between 2013 and 2018. The largest increases in midwives were reported for Belgium, Hungary and Malta (Figure 7).

Table 4. The number of Midwives of countries (2018) data is taken from the OECD on 24 September 2020 at 12:22 UTC (GMT).

	Midwife Number	Number Of Midwives Per 100,000 People	Of Per 1,000 Live Births	Number of Gynaecologists Per 100,000 (WHO-2013)
Turkey	56.351	69	45,12	9,03
Germany	25.000	30	31,75	20,49
Greece	2.834	26	32,79	25,89

2. General status of midwifery in countries

2.1. Midwifery in Turkey

Duties and responsibilities

According to the Ministry of Health;

1. In sexual health and reproductive health services, midwife provides preparation and execution of pregnancy preparation training and parenting and birth preparation programs in the pre-pregnancy period. Midwife monitors the reproductive health of women within the borders of fertility.
2. Midwife makes a diagnosis of pregnancy, conducts normal monitoring of pregnant women and necessary examinations, determines risky situations at an early stage, and directs them by taking the necessary precautions.
3. Midwife manages the birth process; monitors the health of the mother and baby during travay, performs normal births and emergency breech births in the absence of a doctor, performs an episiotomy when necessary. During the birth process, it determines deviations from normal, takes emergency measures and notifies the doctor, makes emergency intervention in accordance with the doctor's instructions.
4. In the postpartum period, midwife performs the first care and examination of the newborn, performs emergency resuscitation when necessary, gives breastfeeding training to the mother, makes care and monitoring of the mother, detects deviations from normal and sends them.
5. Applies drugs defined in accordance with the protocols organized by the Ministry in emergency obstetric cases.
6. Midwife provides the necessary training and counseling services to maintain and improve the health of the mother and baby during pregnancy, childbirth and postpartum period.
7. Midwife works in family planning services, screening programs for women and newborns.
8. 0-6 years of age monitors child care and development, takes part in infectious disease control programs and immunization services, especially pregnant and 0-6 years of age children vaccines.

Problems With Midwifery

A large proportion of midwives in Turkey (90%) work in the public sector. Midwives working in the ministry have been made to do whatever work is to be done in non-midwifery work lines. With the transition to the family medicine system, midwives providing primary care services, nurses and emergency medical technicians began to work as family health workers and move away from field services. The fact that half of the births are performed by caesarean section medicalized the birth. In fact, according to a study conducted by ICM and who, There is medical pressure on maternal care in Turkey and the public considers midwives as carers or nursing assistants.

Income level of Midwives

A newly appointed midwife in Turkey receives an average salary of £ 4800 (520 euros) (October 2020). There is a salary increase every 6 months at the rates set by the government. In Turkey, the fee of midwives working in the family medicine system is made according to the population registered with the family doctor. Freelance work is not very common, and no sources have been reached on their earnings.

2.2. Midwifery in Germany

Duties and responsibilities

The German midwifery law has been in place since 1985, when a midwife was identified as having medical staff trained to provide care and counselling to women in the normal pregnancy, childbirth and postpartum period. Midwives are legally entitled to provide independent medical care under normal circumstances. With this authority, it is imperative that a midwife is available for each birth, both at home and in the hospital. Doctors can make births accompanied by a midwife. Doctors can make births accompanied by a midwife. But cases of pregnancy, childbirth, and postpartum with complications

should be referred to a doctor. Midwives can also be referred to as "family midwives". Family midwives can provide health care to those with special needs (immigrants, women with disabilities, adolescent pregnancies, or families with low socio-economic levels). The government pays for these studies.

1. Antenatal examination and pregnant monitoring,
2. Prenatal education classes and counseling,
3. Providing monitoring and treatment of chronic diseases during pregnancy under the supervision of a doctor
4. Manage normal labor, perform an episiotomy,
5. Follow-up of mother and baby for at least 10 days after birth (including feeding and breastfeeding).

Problems with midwifery

In Germany, midwives' problems are similar to those of other countries. Because of the overlapping competencies of gynaecologists and midwives, the work responsibilities of midwives are under threat. Doctors do more prenatal care than midwives, and 98% of pregnancies followed by gynaecologists give birth in hospital. Most midwives, especially freelance midwives who work based on performance, are not happy with their income.

Income level of Midwives

The mean monthly gross income of a full-time midwife in Germany is about € 3,400. This also depends on the active working time. A freelance midwife contracted to the hospital can earn more or less depending on the number of consultants and their services according to the official pay scale.

2.3. Midwifery in Greece

Duties and responsibilities

The law on midwifery in Greece has been updated, taking into account directive 2005/36 / EC of the European Parliament and Council. According to this law, the professional responsibilities of midwives are defined as follows.

1. Providing information and counseling about family planning,
2. To make pregnancy detection, to follow normal pregnancies; to make the necessary examinations to maintain normal pregnancy,
3. Detecting risky pregnancies at the earliest, ensuring and recommending the necessary screenings,
4. Prepare a parenting preparation program and complete this program along with recommendations on hygiene and nutrition, including preparation for childbirth,
5. To assist and care for the mother during childbirth, to observe the condition of the fetus with appropriate clinical and technical methods,
6. Notice the warning indicators that may be in the mother and child, call a doctor when necessary, and then help. taking the necessary precautions if there is no doctor, especially removing the placenta and then controlling the uterus,
7. Examine and care for the newborn baby; perform the necessary procedures to revive the baby if necessary,
8. Observing and caring for the mother after birth, giving advice necessary for the mother to take care of her new child,
9. Continuing the treatment determined by the doctor,
10. Keep all necessary documents under record.

Midwives' problems

Although there is a midwifery law that clearly explains that the midwifery profession has an autonomous status, midwives in Greece are often subjected to the opposite practices, the situation of performing tasks below the level of Education. It has been reported that almost all births are conducted under the leadership

of Obstetricians, while midwives act only in accordance with their current policy. Midwives are often unable to fulfill their responsibilities and only provide counselling. (28). ICM and WHO's publication stated that obstetricians took over the birth process in Greece, midwives gave them obstetric nursing, and they did not have the courage to express their views.

Income level of Midwives

In Greece, health professionals working in the public sector are civil servants and receive the salary set by the government as a salary. Freelance midwives receive money based on their own set health service delivery fee. In general, midwives in the public sector receive a salary of about 650 euros (an increase of 10% every 3 years (last source 2012), while midwives working in the private sector earn an average of 540 euros per month.

2. TRADITIONAL MIDWIFERY IN TURKEY, GERMANY AND GREECE

Traditional folk medicine consists of unified practices that have been used for centuries and beliefs that have been developed around them and passed on from one generation to the next. In addition to the new developments in modern medicine, a variety of traditional folk medicine practices that have positive or adverse health effects such as delayed diagnosis and treatment are still being used in different regions of Turkey¹. Apart from seeking remedies with herbal remedies and resorting to healers, cupping performers, those who try to treat bruises and hemorrhoids with leeches, bonesetters, people who give injections, indigenous midwives, those who extract teeth, treat calluses, circumcisers, talismanists, etc. are among the people whom people apply for being healed². Traditional midwifery has taken an important place in every society and has acquired social tasks besides helping women in the process of pregnancy and childbirth. Midwifery education has taken place as a holistic profession centered on women on top of traditional midwifery teachings, has worked hard for this purpose, and has followed medical developments to create its professional roles.

In this review study, the educational development of traditional midwifery and midwifery in Turkey, Germany and Greece and basic traditional midwifery practices were examined.

2.1. TRADITIONAL TURKISH MIDWIVES

In traditional culture, there have always been special people who have played an active role at the times specified as the turning point of life. "Birth, which is one of the most beautiful stages of life, and midwives accompanying the birth have become an indispensable part of Anatolian folk culture".

Anatolia has various cultural resources. Historically, it has been the center of many ancient civilizations combining different cultures whose traces are still evident today. These traditions emerge as a product of the colorful and rich cultural synthesis of civilizations that existed in the region. Like the Umai – Goddess of fertility (Umai Mother) who helps the woman giving birth in Central Asian Turks. Living traditions related to health and methods of helping women before, during and after pregnancy have important places in this rich cultural structure.

For long periods, childbirth has been considered as a physiological event, and it has been believed that women can give birth without assistance or professional help. During the medicine in the classical period, those who performed the birth aid were folk midwives who obtained their knowledge and skills through experience.

In Turkish communities, women who deal with childbirth, who are not health professionals, who have not received health education and obtained their knowledge and skills through experience have been called "midwives". Again, among the people, it is known that "Traditional Midwives", who are believed to have experience and dexterity, are sweet, warm-blooded, well-behaved, sweet-tongued and knowing mothers, aunts and grandmothers⁶.

During the 19th century Ottoman Period, Istanbul was subjected to a different classification of midwifery. "Istanbul midwives were divided into three classes as the midwife of the palace (Saray-ı Hümayun midwives), the midwife of the noble (Kibar midwives), and the midwife of the common people (Ahad-ı Nas/folk midwives). Traditional midwives are also referred to as "Ara (intermediary) Midwives" in Anatolia. When they were all called for birth, they would take their daughter, or daughter in law, or one of their close relatives with them, teach them what they knew by following the master-apprentice tradition, and did not want the profession to pass on to a stranger after her and lose this honor. Generally, these families served as rural health centers.

Although male midwives called "Lavuta" were encountered in the Ottoman, in the midwifery profession, which is known as a women's profession among the people, midwives served houses and villages and shared their practical knowledge with other women and trained each other.

Traditional midwives took the necessary precautions at birth, tried to relieve the woman who gave birth psychologically and made it easy to give birth, while also taking part in the termination of pregnancy, treating infertility or preparing drugs against a relentless disease

The midwives' activities were not limited only to the fertility area. They were also seen to play very active roles in the social sphere. Following up the mother after calculating the pregnancy, calculating the estimated date of birth, helping to prepare the baby's belongings, delivering the baby, showing the mother how to breastfeed her baby and treating infertility and diseases experienced during the postpartum period, advising on birth control, abortion were among the activities of midwives for birth and fertility. In addition to their medical and social roles in childbirth, midwives also played a kind of expertise role between the state and society in cases of sexual offenses such as rape, adultery, or in cases such as determining the age of girls, and miscarriage. The midwives were an important link in inter-women relationship networks thanks to their influence on confidential information of women and confidential space.

2.2.TRADITIONAL GERMAN MIDWIVES

From German HEV (I) *anna* (ancestor / grandmother / holds the newborn) German **HEBAMME** means midwife.

For centuries, midwives have been the most important companion of women during pregnancy, childbirth, and postpartum, and childbirth has been seen as a female-dominated profession. At the time of birth, female family members, girlfriends or neighbors came together to help and support pregnant women. Midwives played a central role in this women's community. From the circle of female relatives and girlfriends who gave birth, often those with the most skills and experience were the first midwives. The skills of these women were based solely on practical experience. Because of the detailed knowledge and practices that midwives pass on to their daughters and grandchildren, midwifery is also often passed on from mother to daughter in Germany.

Midwives are usually elderly, but mostly knowledgeable and educated women, who have acquired their knowledge mainly from tradition and many years of experience. Midwives need to have reliable, medical knowledge and a lot of birth experience.

Midwifery training is built on basically observation and imitation. Professional knowledge has been transferred orally and closed to significant change. It contained information that was mostly imposed by superstition. Due to the lack of a printing press, the low literacy rate among the public and midwives, for a long time the learning of technical knowledge from books could not go beyond practical knowledge.

In German traditional midwifery, experience in her own body (having given birth herself) and life experience (experience of assisting births) have been prerequisites for working as a midwife. In the Middle Ages midwives were considered healing women and were often referred to as herbal healers or wise women. They prescribed analgesic, antispasmodic and pain-relieving herbs.

The Midwife has also performed traditional symbolic actions that are considered necessary to protect the mother and child. For example, amulets and grass mixture amulets were used for this purpose.

Midwifery activities were considered charity work during this period and were not paid for by salary or money, but by food, shelter or gifts. In the following periods, this perception of public Service has turned into a municipal office and midwifery services have started to be provided through municipalities.

16. 17.ve 18th Over the centuries, the idea that midwives should be supervised to ensure their reliability has emerged, and midwives have become much better socially during these periods. Midwives were not subject to any limits other than the rules the church set on them, and were given a number of religious duties by the church. Due to the fact that religious devotees are usually men and are not near the woman at the time of birth, midwives are assigned for emergency baptism. In some areas midwives have been given the power to confess and forgive dying mothers. The church also gave instructions to midwives to help both the poor and the rich, to follow Christian lifestyles, to give up superstitious, magical and abortive means,

not to prevent conception, to report secret pregnancies to the church, and to report fathers of extramarital children. Reasons such as not fully complying with church control, not baptising a stillborn or postpartum baby in time have been shown to lead to midwives being punished. He has been accused of not performing or missing religious duties imposed on midwives, or even accused of witchcraft.

At the end of the Middle Ages, urban midwives were placed under administrative supervision and regulation. The earliest recorded midwife service is recorded in 1452 in the city of Regensburg, where around 12-15 midwives served.

15. and 16. for centuries, the responsibilities of midwives were as follows:

1. The obligation to treat pregnant women at different levels in the same way.
2. Obligation to continue service
3. Obligation to follow the initial call and arrange for the participation or departure of other midwives under appropriate circumstances
4. The midwife's obligation to exist throughout the birth and postpartum period,

First revisions to the task definition on pregnancy and postpartum visits. It can be found at the turn of the century.

In 1552 Ravensburg midwives began to receive a fixed salary and pension from the city, as municipal midwives, they swore to the council to faithfully and conscientiously perform their duties, to serve around the clock and to be loyal to the authorities. Their professional values and earnings remained at the same level as executioners and very low in the social hierarchy. Their actual earnings are known to depend on the number of births. It has also been reported that midwives are exempt from rent and tax in some areas.

From 1555, midwives had to resort to the "doctor of artzney" in cases of complications, caesarean sections, or abnormal situations, rather than a colleague. They were also prohibited from prescribing medicines from 1548 onwards²³. Despite improvements in midwifery services in the city, many midwives are reported to be living at the minimum level of livelihood, as midwifery in the countryside is still considered an act of charity, rewarded not with money, but with free or only food and accommodation. A lack of social recognition of their personalities and activities, as well as a disregard for their vital needs, has led to efforts for trained midwifery. Since the 19th century, trained midwives have been sent to villages. At first, village women rejected an outsider trained foreign midwife, wanting to continue their births with traditional midwives they knew. But over time, trained midwives have replaced traditional midwives, as they have agreed to pay penalties for births performed outside the authorized midwife, pay a fee to the traditional midwife, or pay for any complications that may arise themselves.

2.3. TRADITIONAL GREEK MIDWIVES

Traditional lay midwives or midwife-healers (*mammoyiátrissa*) were women who had helped relatives or friends at their births and had become known as skillful to help birthing women. Some had learnt from their own mothers and were known for the encouragement and the support they provided. Through the rituals they attended (salting of baby, third or seventh-day visit by the Three Fates, visiting the church at 40 days, etc) in many parts of Greece they were also considered mediators with divine forces on behalf of the newborn. In addition to midwifery skills, these women also had knowledge on traditional medicine, some of which was also adopted by the classical doctors of their time.

An interesting example is the reference of Iakovos Pylarinos, M.D., from Istanbul, 1714: he quotes that he learnt the prevention of smallpox from midwife-healers (*mammoyiátrisses*) from Central Greece during a smallpox epidemic. They used to scar the skin and insert infected liquid from the pustules of smallpox patients, like a kind of immunization

3.CURRENT MIDWIFERY EDUCATION IN TURKEY, GERMANY AND GREECE AND COMPARISON WITH THE INTERNATIONAL CONFEDERATION OF MIDWIFERY (ICM) QUALIFICATION

It is recognized globally that investment in the health workforce is the key to achieving the Sustainable Development Goals (SDGs), and the insufficiency of healthcare workers in general and midwives in particular. Midwifery is not a profession that only has a place for childbirth in the field of health. Midwifery includes the process of developing and protecting community health, improving and supporting maternal and child health, helping the mother in normal birth, providing newborn care, and helping the mother for a healthy motherhood in order to maintain a healthy life. Many countries have increased the number of midwife training programs to compensate for the lack of midwives.

However, it is not enough to increase the midwifery workforce numerically. It is also necessary to question the quality of the care they are authorized and provide, otherwise the increasing number may not lead to improved health outcomes. For this purpose, the World Health Organization (WHO) and the ministries of education and health of each country have published legal plans for the minimum training program that midwives should have. European Parliament and Council Regulation 2005/36 (7 September 2005) / EC / EU Official Gazette in the European Union on midwifery education and professional competence/ on the recognition of professional qualifications and the European Credit Transfer and Accumulation system (ECTS), established vocational training standards for the recognition of midwifery as a profession in EU countries.

The International Confederation of Midwives (ICM), which represents midwives at the international level, has also published guidelines on midwifery education and midwifery professional competencies. Training to provide ICM qualified and competent workforce; It has identified three main objectives defending that professional activities should be organized and members should be organized in a strengthened association. ICM emphasizes that a qualified midwifery education should be based on competence and clinical practice rather than an academic degree, and it is important to develop critical thinking, clinical decision-making, and problem-solving skills.

Core Education Program on midwifery education was prepared in Turkey in 2016, with a regulation published in the Official Gazette in 2008; a standard program that refers to the criteria specified by the European Credit Transfer and Accumulation System (ECTS) and ICM has been officially published. ICM criteria, European Credit Transfer and Accumulation System (ECTS), and Hellenic Quality Assurance and Accreditation Agency are taken into consideration in Greek midwifery education . Midwifery education in Germany is still in transition. The law "Hebammenreformgesetz- HebRefG" was published on January 1st, 2020 and, has been harmonized with academic standards in accordance with the midwifery education European Directive 2005/36 EG. Prior to the new law of HebRefG, midwifery education in Germany was carried out in a non-academic format called the three-year midwifery school. This non-academic education program will continue as two types of education system until December 31, 2030 as required by the relevant law. A guide on professional qualifications for midwifery has been published by the midwives association in Germany and recommended for use by undergraduate programs.

In this study, the entry and graduation criteria of midwifery undergraduate schools in Turkey, Greece and Germany, and the status of the teaching staff were questioned, and it was evaluated whether the curriculum programs were in line with the educational qualifications published by the ICM.

FINDINGS

Although 79.2% of midwifery schools in Turkey have shared their curriculum on their websites, no explanatory and introductory data for 7.5% have been reached. 60% of midwifery schools in Greece shared the curriculum on their websites. In Germany, 14.3% of midwifery schools shared the entire curriculum, 42.9% shared general program titles, and 42.8% did not share any curriculum information.

The number of midwifery graduate academicians working in the midwifery department in Turkey is 36.4% of the total academicians. In Turkey, 15 midwifery graduates, 24 nursing undergraduate graduates, five biologists, three medical faculty graduates, and one veterinary faculty graduate work as department head in midwifery departments. There was not enough information about the five department heads (Table 1). In Germany, the number of midwifery graduate graduates is 81.8% of all academics. In Greece, the number of midwifery graduate graduates is 62.5% of all academics.

According to the data published on the websites of universities, the number of academic staff per midwifery undergraduate program in Turkey is 8.2%, in Germany 8.25%, and in Greece 10.6%.

In order to enter midwifery schools in Turkey, after 12 years of high school education, students are accepted through the central placement exam applied nationally. In Greece, the placement process is carried out according to the university entrance exams (National health sciences) for the graduates of 12 years of education. In previous years, the oral exam has an effect on passing or failing the students' academic abilities and academic qualifications as well as their personality traits. Private universities that offer midwifery education accept students with any 12-year high school diploma without an examination.

In Germany, midwifery education and admission requirements are in transition, as the Midwifery Reform Act (HebRefG) and the Study and Examination Regulations for Midwives (HebStPrV) came into effect on 1 January 2020. As of January 1, 2020, undergraduate programs are planned to provide education in the 2020-2021 academic year in accordance with the relevant law. The condition for admission to the midwifery undergraduate program is to qualify for higher education and to be a high school graduate. Academic and non-academic midwifery education program application requirements are also different from each other. For non-academic; application is also possible with ten years of school education (high school), vocational training, and several years of professional experience (for nurses). It does not seem possible for those completing the non-academic education program to be internationally recognized.

Those who want to get undergraduate midwifery education should meet these requirements:

- Hebammenreformgesetz - a university entrance qualification recognized as general higher education entry qualification, technical college entry qualification or equivalent,
- Basic health suitability for vocational education,
- An extended legal permit document,
- In addition, a four-week internship (assessment of suitability for the profession) in a pre-admission clinical practice area (delivery room or postnatal service) or non-clinical midwifery institutions or with a self-employed midwife (at the request of the university),
- Language proficiency - B2 level German,

-
- The educational motivation and personal and social responsibility infrastructure of the applicants in related fields are also important. To include these factors, applicants can be invited to an interview at the university after checking the formal admission requirements.

While there is no gender discrimination for student preferences for midwifery departments in Germany and Greece, it has been announced that only female students can choose according to the Turkey 2020 YÖK license guide.

It is stated that Turkey and Greece have a standardized curriculum, but Germany is updating as of 2020. According to the current curriculum programs, midwifery education in Turkey and Greece is provided in 240 ECTS and eight terms in accordance with EU directives. However, there are differences among the universities providing undergraduate education in Germany. According to the data of eight universities that shared on their website, it was seen that there were two 240 ECTS (8 semesters), four 210 ECTS (three seven semesters, one eight semesters), two 180 ECTS (one 8 semesters, the other 6 semesters).

Comparison of the midwifery curriculum in Turkey, Germany, and Greece according to the standards specified by the ICM, preconception and prenatal care at the basic knowledge and skill level, birth and postnatal care, continuous care of women and newborns are shown in Table 2. It has been observed that ICM knowledge and competencies are largely met according to the published curriculum list of midwifery undergraduate programs of three countries. It is seen that many subject topics are given to students by all country and undergraduate programs under the heading of compulsory and elective courses. In midwifery programs, 29.2% of schools in Turkey, 37.5% in Germany, and 66.7% in Greece give birth preparation training at the undergraduate level. In Turkey, under the title of elective program, 22% of birth preparation education programs are provided. It is seen that the content of the courses on human psychology is generally sufficient, but more content should be provided on maternal psychology. Midwifery programs of all three countries are insufficient in supporting the grief process of the woman as a result of pregnancy resulting in the mother's postpartum and/or baby loss. It has been observed that an undergraduate program of a school in Turkey offers elective courses on pregnancy and maternity psychology. It has been observed that the rates of the course content of the countries differ in terms of delivery for the fetus in different presentations, which is one of the knowledge and skills of the midwifery profession, the appropriate maneuver and position change, and intervention skill in emergency situations. In Turkey, 85.4% compulsory, 7.3% elective; In Germany, 37.5% is compulsory, 37.5% is elective, and in Greece 66.7% are compulsory and 33.3% are elective courses. The training programs of all three countries on neonatal resuscitation and adult advanced resuscitation, which are among the emergency first aid areas, seem to be quite insufficient. In any of the midwifery education programs in Germany and Greece, there is no information about the curriculum on neonatal and adult resuscitation and advanced life support. It has been observed that 19.5% of midwifery programs in Turkey have this program. It was determined that midwifery programs should add more course content in terms of knowing, applying and educating the family about the care of babies in need of special care. (Table 2).

Among the methods and techniques to reduce pain at birth; non-pharmacological techniques, massage, water/water birth, bathing, breathing exercises were found to be quite low in all three countries midwifery programs. While these subjects were included in 4.9% of the programs in Turkey, it was observed that they were not included in the undergraduate education program in Germany and Greece.

In the research, the elective courses in midwifery undergraduate programs in each of the three countries were determined. In Turkey; evidence-based midwifery practices, infertility and assisted reproductive

techniques, sexual health, transcultural midwifery, forensic midwifery, alternative delivery methods and positions, labor pain management, neonatal nutrition and breastfeeding counseling, family and community midwifery, family counseling, birth preparation classes, neonatal resuscitation, adult resuscitation and advanced life, complementary medicine practices in women's health are preferred more in undergraduate programs. In Germany; evidence-based midwifery practices, transcultural midwifery, monitoring and care in special situations, supporting women/families with mental problems, addiction or experience of violence, support of parent-child relationship / first attachment, midwifery research, midwifery care for families in special cases, case conferences and salutogenesis courses have appeared as elective courses. In Greece; Elective courses were given on pelvic floor malfunctions, electronic fetal monitoring, alternative treatment methods, women in menopause, advocacy and empowerment in midwifery, autonomous midwifery practice and interprofessional training: providing integrated care.

The midwifery graduation criteria of all three countries were arranged in accordance with the vocational training standards for the recognition of midwifery as a profession in EU countries, published in the European Parliament and Council Regulation 2005/36 / Ec / EU Official Gazette on the Recognition of Professional Qualifications. Accordingly, a midwifery student is capable of;

- Counseling to pregnant women, including at least 100 prenatal examinations,
- Surveillance and care of at least 40 pregnant women,
- Carrying out at least 40 normal deliveries (If this number cannot be reached due to the absence of women at birth, it can be reduced to a minimum of 30, provided that the student helps to deliver 20 more deliveries)
- Active participation in breech deliveries (In cases where this is not possible due to the absence of breech deliveries, the application may be in a simulated state).
- Episiotomy performance and starting suturing (Initiation will include theoretical training and clinical practice. The practice of suturing involves suturing the wound after an episiotomy and a simple perineal laceration. This can be in a simulated situation if absolutely necessary)
- Supervision and care of 40 women at risk during pregnancy or childbirth or postpartum,
- Surveillance and care (including examination) of at least 100 postpartum women and healthy newborns.
- Observation and care of newborns in need of special care, including those who are premature, post-term, underweight, or sick,
- Care of women with pathological conditions in gynecology and obstetrics,
- Care in the field of medicine and surgery. Initiation will include theoretical training and clinical practice.

PROFESSIONAL SELF-ASSESSMENT OF MIDWIVES

A profession is an effort that requires a certain education and knowledge in order for its people to get the profits that can continue their lives. Midwifery is a well-established professional group that serves women who give birth in every period when humanity exists, and is respected and respected in every culture. Midwifery is a profession that combines science, art and ethical values at the most critical moments of one's life. Midwives care about the holistic health of mothers and apply their knowledge, abilities and skills to create positive experiences for them. Midwives are an important element of the health workforce; there is a large number of new and high-quality evidence showing the impact and effectiveness of Midwifery in improving maternal and child health / reproductive health data. The 2014 World State of Midwifery report concluded that when midwives are trained and regulated to international standards, they can meet 87% of the global need for basic health care. There is also evidence that investment in Midwives is a cost-effective approach to reducing maternal and newborn deaths and stillbirths, and that midwife-led care models result in excellent mother and newborn. Midwives ' working areas should be places where they can use their professional knowledge and skills, and should be supported legally and institutionally.

Midwifery has been a profession that has passed from mother to daughter for many years. But with developments in the field of Health, the history of Midwifery Education has also adapted to change and has been transformed in the health and education policies of countries. Authorities such as the World Health Organization (WHO), the International Federation of Midwives (ICM) and the Ministries of Health have also published competence standards and duty definitions for midwives. The European Union (EU) has introduced minimum standards for midwifery education for mutual recognition of professional qualifications in member states.

Competence is defined as the level of performance associated with observable skills, while competence is defined as the behavioral and functional skills that allow exceptional performance to occur. "Professional competence is the measurable human ability focused on the ultimate goal and required for job performance". The components that make up competence are knowledge, skills, experience, ability, relationship style and motivation. To increase satisfaction with the work done, McClelland proposed testing the concept of competence and mentioned the value of measuring competence. As for midwifery competence, WHO mentions knowledge, attitudes and psychomotor elements in midwifery practice, while ICM mentions the safe and effective application of knowledge, skills and attitudes. According to the National Core education program of midwifery before graduation prepared in Turkey, it is expressed as 'skills and practices that should be related to the profession".

The purpose of this study;

- * Midwives to question their professional self-assessment within the framework of their professional competence,
- * Determine the factors affecting the choice of profession of midwives working in different countries and under different conditions.
- * Thoughts and expectations about the profession,

Table 1. Survey language completed by participants

Survey Language	Number	%
Turkish	1023	78,7
English	126	9,7
Greek	87	6,7
German	64	4,9
Total	1300	100

FINDINGS

1023 person responded to the Turkish survey form of this study. The mean age of the participants was 35.11 ± 13.45 (min:20 max:65) and they were all women. All those who completed the Turkish survey live in Turkey and have been practicing midwifery for a mean of 13.45 ± 9.3 (min:0-max:44) years. Midwives work of %35,5 in public hospitals and 25.3% family health centers. 28.3% of midwives work in clinics linked to obstetrics and gynecology and midwives working in other clinics are 26.2%. Information about the demographic data of participants is shown in Table1. 277 people participated in survey forms in other languages. Participants from other languages are all female, and male midwives did not participate in the study. We have no idea why they didn't participate in our survey or why we couldn't reach them. The mean age of the participants is 40.70 ± 10.9 (min:22, max:68) and they have been in the midwifery profession for mean of 13.4 ± 10 (min:1 max:45) years. The research group of 32,9% work as freelance midwives. Midwives of 54,2% work in obstetrics and gynecology.

Table 2. Demographic data of the participants

	Turkish Survey		Other survey language		Görev Yeri	Turkish Survey		Other survey language	
	Number	%	Number	%		Number	%	Number	%
Cinsiyet									
Woman	1023	100	277	100	Public Hospital	363	35,5	62	22,4
Age					Family Health Center	259	25,3	10	3,6
20-29	288	28,2	39	14,1	Private Health Center	121	11,8	34	12,4
30-39	400	39,1	105	37,9	Public Health Center	116	11,3	23	8
40-49	300	29,3	68	24,5	Provincial Directorate of Health	48	4,7	0	0
50-59	32	3,1	48	17,3	University Hospital	40	3,9	2	0,7
60 ve üzeri	3	0,3	17	6,1	Peripheral society midwifery	23	2,2	0	0
Education Level					Non-working	21	2,1	31	11,3
High school	1	0,1	167	60,4	Freelance midwife	18	1,8	91	32,9
2-year college	54	5,3	0	0	Academician	14	1,4	24	8,7

					Workplaces				
Bachelor	948	92,7	65	23,4	Obstetrics and gynecology clinics	308	30,1	150	54,2
<i>Bachelor (4 Years)</i>	727	76,7	65	100	Family Health Center	268	26,2	10	3,6
<i>Bachelor (2+2)</i>	168	17,7	0	0	Other clinics	165	16,1	18	6,5
<i>Other Bachelor</i>	53	5,6	0	0	Immunization activities	81	7,9	23	8,3
Master's degree / doctorate	20	2	45	16,2	non-working and retired	38	3,71	31	11,2
Total midwifery year					Management Officer	33	3,2	0	0
non-working	21	2,05	0	0	Pregnant Education Class	32	3,1	6	2,2
1-5 Year	213	20,82	72	26	Patient and community education	14	1,4	9	3,2
6-10 Year	196	19,2	67	24,2	Academician	14	1,4	24	8,7
11-15 Year	193	18,9	43	15,5	Migrant health	0	0	4	1,4
16-20 Year	122	11,92	38	13,7	Nursing Home	0	0	2	0,7
21-25 Year	162	15,8	15	5,4	Emergency Service	24	2,3	0	0
26-30 Year	81	7,91	24	8,7	Peripheral society midwifery	23	2,2	0	0
31 and up	35	3,4	18	6,5	Cancer early diagnosis and screening center	16	1,6	0	0
					Operating room	7	0,7	0	0

Table 3. Factors affecting choosing midwifery profession

Factors affecting choosing midwifery profession	Turkish survey participants		Others language's surveys participants		Statistics	
	Number	%	Number	%	Chi-Square	P
A lot of opportunities to find a job	407	39,8	10	3,6	0,001	P<0,05
Family request / referral	280	27,4	7	2,5	0,001	P<0,05
Coincidentally, unplanned	225	22	42	15,2	0,001	P<0,05
Ideal profession	201	19,6	180	65	0,001	P<0,05
Medical staff family members to be role models	133	13	25	9	0,001	P<0,05

35.9% of respondents in Turkish and 3.6% of respondents in other languages stated that they chose the midwifery profession due to the high job opportunities. According to the survey results in Turkish and other languages, the rates indicating that midwifery is the ideal profession are 15.2% and 63.9% (Table 3).

Table 4. Midwives ' thoughts about the profession

Thoughts about the profession	Turkish survey participants		Others language's surveys participants		Statistics	
	Number	%	Number	%	Chi-Square	P
I do midwifery willingly and lovingly	809	79,1	244	87	0,001	P<0,05
I think my profession suits my personality	776	75,9	234	84,5	0,001	P<0,05
I think the status of my profession is high	317	31	110	39,7	0,001	P<0,05
I think my profession is exhausting	609	59,5	245	88,4	0,001	P<0,05
I'm getting enough financial satisfaction from my profession	117	11,4	57	20,6	0,001	P<0,05
I think the future of my profession is negative	252	24,6	27	9,4	0,001	P<0,05
I think midwives who will join the profession will be more knowledgeable than current midwives	293	28,6	55	19,9	0,001	P<0,05
I think the status of the profession will be better in the future	483	47,2	111	40,1	0,19	P>0,05
I think our economic conditions will improve in the future	285	27,9	79	28,5	0,922	P>0,05
I plan to do higher education that will allow me to progress in the profession (Master's degree-doctorate)	507	49,6	78	28,2	0,001	P<0,05
I have no expectations for the future. I plan to retire when my time is up	251	24,5	25	9	0,001	P<0,05
I think I'll be promoted at work	265	25,9	77	27,8	0,2	P>0,05

Turkish respondents of 24.6% think negatively about the future of midwifery and 28.6% believe that midwives who are new to the profession will be more knowledgeable than current midwives. Midwives of 47,2% believe profession status will be better in future and 27.9% believe that economic conditions will be better in the future. Midwives 9,7% of participating in the language survey form have a negative view of the future of the profession and 19.9% believe that new midwives will be more knowledgeable than current midwives. 40.1% believe that the status of the profession will be better in the future, and 28.5% believe that economic conditions will improve in the future. 49.6% of midwives who completed the Turkish survey said they wanted to continue higher education, while 24.5% said they planned to retire after the end of their working period. The proportion of those who think they will be promoted in their profession is 25.9%. Midwives who responded to the survey in other languages, 28.2% said they wanted to continue higher education, while 9% said they planned to retire after the deadline. The proportion of participants who think they will be promoted in their profession is 27.8% (Table 4).

Table 5. Comparison of the mean professional self-assessment score of all participants

	Turkish survey participants (N:1023)	Others language's surveys participants (N:277)	interquartile range	p
	Ortalama _SD*	Ortalama _SD*	r Değeri	P
Public Health Activities and skills	712,87	423,28	0,32	0,001
Family planning activities and skills	691,08	502,68	0,2	0,001
Pelvic exam and skills	696,12	484,31	0,23	0,001
Pregnancy Monitoring Evaluation skills	649,41	654,47	0,005	0,838
Monitoring and Managing birth action skills	637,28	698,67	0,06	0,15
Postpartum care and counseling skills	669,03	583	0,09	0,001
Newborn care, monitoring and examination skills	624,85	743,94	0,13	0,001
Professional development	611,93	791,01	0,19	0,001
Total Score Of Professional Self-Assessment Scale	657,63	624,53	0,03	0,191

* Mann-Whitney U Testi

r = 0.10 (small effect). In this case, the effect explains 1% of the total variance.

r = 0.30 (medium effect). In this case, the effect explains 9% of the total variance.

r = 0.50 (large effect). In this case, the effect explains 25% of the total variance.

The mean score in the professional self-assessment survey of Midwives participating in this study was 3.42 ± 0.36 (min:1.22-max:3.95). The mean score of midwives who completed the Turkish survey from the professional self-assessment survey was 3.51 ± 0.38 , while the mean score of midwives who participated in surveys in non-Turkish languages was 3.46 ± 0.31 . From the subheadings; Turkish survey form public health activities score rank mean is 3.33 ± 0.6 , while other languages survey form score rank mean is 2.75 ± 0.7 . A statistically significant difference was found between the mean score of public health activities in both groups ($p < 0.05$). the effect size of the difference between the two groups is $r = 0.32$, indicating that it has a moderate effect and 9% of the total variance is explained by the independent variable (difference between countries). The ability to conduct immunization studies under public health activities has the highest score among participants in the Turkish questionnaire, while the ability to know the principles and indicators of epidemiology and community recognition has the lowest score. In contrast to those who responded to survey forms in other languages, those who participated in the Turkish survey form had the highest ability to know the principles and indicators of Epidemiology and community recognition, while the ability to conduct immunization studies was the lowest score.

The mean score for family planning activities of the respondents in the Turkish survey is $3.38 \pm 0,5$, and the mean score for the respondents in other surveys is $3.09 \pm 0,5$. A statistically significant difference was found between the mean score of both groups of family planning activities ($p < 0.05$). But the difference was that the effect size was $r = 0.20$ and had a small effect. The IUD (intrauterine device) and infertile couples counseling substances under this heading are the lowest rated application in both Turkish and other languages. Among all participants, the rate of those who stated that they had never been able to practice IUDs was 31,5%. The practice with the highest score according to the Turkish survey form under this skill activity is 'I can provide adequate counseling for couples in choosing the most appropriate family planning

method'. According to surveys in other languages, the article "I am qualified to describe reproductive anatomy and physiology' received the highest score.

The mean pelvic exam score among those who participated in this study and responded to the Turkish questionnaire was 3.44 ± 0.6 , and 3.05 ± 0.7 in those who responded to other questionnaires. The difference between the two groups is significant according to the pelvic examination score rank mean ($p<0.05$)(Table 5). In both groups, the ability to 'determine the position of the Uterus by bimanual examination' had the lowest score and was accepted by 42.1% of the total participants. According to the Turkish survey, the ability to 'I can get a sample for cervical screening' and the ability to "I can do cervical examination" in others had the highest score.

The skill score for female follow-up during pregnancy was 3.72 ± 0.3 in those who responded to the Turkish questionnaire, while the mean rank was 3.74 ± 0.2 in other language questionnaire. 'I can calculate the expected date of birth and measure the fetal heart rate' had the highest score in both groups. 'I can provide advice on medical and non-drug methods in the face of abnormal conditions that may occur during pregnancy " was the lowest rated item for both groups.

The mean score for birth action management is 3.36 ± 0.5 for those who fill out the Turkish questionnaire and 3.48 ± 0.4 for those who fill out the questionnaire in other languages. In both groups, 'I can perform an enema if necessary and apply a urinary catheter to empty the bladder if necessary' has the highest mean score but the ability to' manage breech delivery and multiple pregnancy delivery in emergency situations " has the lowest mean score.

The average score of skills including postpartum care and counseling skills was 3.75 ± 0.3 in those who responded to the Turkish questionnaire, while 3.71 ± 0.2 in the other survey group. The difference between postpartum care and counseling score mean is statistically significant ($p<0.05$), but the effect value is quite low. Breast milk was the highest rated practice by all participants in both groups. The ability to provide support for victims of adolescent and sexual violence, which requires special attention, and to provide support to a mother whose child died at birth, was also the area of skill that midwives in both groups gave them the least points for.

The mean score for newborn care and examination was 3.50 ± 0.5 in Turkish survey respondents and 3.67 ± 0.2 in other language survey respondents. The difference between both groups is significant ($p<0.05$). The ability of the mother or father to provide postpartum skin contact with their children if the conditions are appropriate has the highest score for both groups. Those who responded to the Turkish questionnaire have the lowest score; the ability to perform newborn resuscitation in emergency situations, the ability to provide special care for the needs of the newborn in other survey respondents. 47.2% of all participants stated that they could perform newborn resuscitation, and 30.2% said that they could provide special care for the needs of the newborn who needed care.

The mean score for professional development activities is 3.07 ± 0.5 in those who responded to the Turkish questionnaire, and 3.34 ± 0.4 in those who applied the questionnaire in other languages. Membership in Professional Associations, participation in Congresses and symposiums had the lowest score in those who responded to the Turkish survey form, while the same substances had the highest score in those who responded to the survey in other languages. The score between both groups is statistically significant ($p<0.05$). 'I do research for the development of my profession " was the lowest rated item in non-Turkish languages.

According to the results of professional self-assessment in this study, it was found that the area with the lowest average score according to the Turkish questionnaire was professional development, the area with the highest score was postpartum care and counseling activities. According to survey results in other languages, the lowest average score is public health activities, while pregnancy monitoring activities are the most rated section.

In general, it is observed that all midwives participating in the study find their knowledge and skills sufficient in their professional self-assessment.

FIELD OF STUDY AND FUTURE PERSPECTIVES OF MIDWIFE ASSISTANT STUDENTS

An assistant midwife is a healthcare technician who graduated from the midwife assistant program of vocational high schools for healthcare and works as an assistant under the supervision of midwives thereby helping and accompanying patients in carrying out their daily activities, implementing nutrition programs, with their personal care and cleaning and access to healthcare services. Carrying out maternal and child healthcare services, providing prenatal, birth and postnatal services, providing nutrition and vaccinations for children between ages 0-6 and information on family planning, personal hygiene, first aid, protection from and combating against infectious and social diseases to the individual, family and society; the assistant is an exemplary member of the profession with his humane and moral behaviors and provides the necessary cooperation with public institutions educating on healthcare and collecting and evaluating birth and death statistics.

The World Health Organization (WHO) aims to optimize the roles of healthcare workers in regions with problems towards the access to healthcare professionals and help address critical healthcare workforce shortages that are slowing the progress towards the Millennium Development Goals. It is planned that a more rational distribution of duties and responsibilities among the healthcare workforce can significantly increase both access and cost effectiveness. In this context, it has been stated that assistant midwives can help in providing maternal and newborn healthcare services, not only during birth but also in the prenatal and postnatal terms. It has been stated that these people will have some competencies in midwifery, but they will not be fully qualified as midwives. According to the WHO definition, assistant midwives have some level of healthcare education at middle school level and may sometimes have received some training at a formally authorized institution. The most appropriate English term to describe assistant midwifery in Europe has been is the "Maternity Support Worker" (MSW), in other words support staff for mothers. Definitions used globally, such as Assistant Midwife and Auxiliary Midwife also refer to an assistant midwife. On foreign job search sites the profession has been defined as Midwife Support Worker (MSW) . When compared with other countries in the world, it was seen that there is a midwife assistant practice especially in rural areas in Asia, the United Kingdom, the Netherlands and the United States, and that education is realized through paid course programs.

Assistant midwifery is an older practice in the UK and a standard framework for the minimum competencies necessary to safely fulfill the profession has been drafted. 2nd, 3rd And 4th level classifications were made in order to identify and define the differences in knowledge, skills, values and behaviors acquired during the assistant midwife training process. The levels were determined according to the standards specified in the Skills for Health Career Framework (2010).

Level 2 Maternity Housekeeper: Uses basic skills to improve the services provided to women and their families in various aspects of maternity services, often under the close supervision of a licensed professional, who is a midwife, nurse or level 4 practitioner. The professional knows, understands and uses basic healthcare information and has a fundamental awareness of contemporary public health, initiatives, policies, legislation on health promotion and ethical and legal issues related to their roles.

Level 3 Maternity Support Worker: Uses additional skills to improve the services provided to women and their families and can work at all levels of the multidisciplinary team under the guidance of practitioners. The professional has general knowledge of tasks and activities and has a fundamental awareness of contemporary public health, initiatives, policies, legislation on health promotion and ethical and legal issues related to their roles.

Level 4 Maternity Support Worker: Uses advanced skills across the spectrum of maternity services to support multidisciplinary teams. He has cross-professional knowledge that will increase the work of professional teams and has a fundamental awareness of contemporary public health, initiatives, policies, legislation on health promotion and ethical and legal issues related to their roles. The professional can understand broader issues on healthcare and social care and policies that affect services and the presentation thereof.

The lowest level of education is the 2nd level and the transition to the 3rd and 4th levels is made according to progression and accomplishments. Those who have completed the 4th level are given the opportunity to apply for entry to midwifery schools. Those who want to receive education at Level 2 do not need to take any exams, but they are expected to have gained experience in the field of healthcare for a short time and show good professional motivation.

In Turkey, midwifery and nurse education has been revised with legislative changes that came into force on the 8th of November 2014. The high school midwifery department was changed to assistant midwifery and it was stated that graduates could work as assistant midwives, whereas a bachelor's degree was required to be a midwife.

According to official data obtained from the Ministry of National Education, students were admitted to the midwifery assistant high school education program for the first time in 2015 and as of the end of 2018, 6351 people graduated. As of 2019, the number of active students is 8306. It has been observed that employees were recruited as clinical support staff (nurse assistant, midwife assistant and health care technician graduates were included in the same staff) to work in hospitals within the scope of the Ministry of Healthcare. In 2019, 865 permanent workers and in 2020, 1010 permanent workers were recruited through İŞKUR (Turkish employment office). There is insufficient information about the employment data of assistant midwives in the private sector.

Job description of a midwife assistant in Turkey

- a) Helps to keep records of reproductive health of women within the fertility limits.
- b) Assists in the implementation of pregnancy preparation training programs and parenting and birth preparation programs in the pre-pregnancy period.
- c) Prepares the woman for examination, including the pregnancy follow-up process.
- d) Helps to meet the needs of the pregnant woman in daily activities, the implementation of the nutrition program, personal care and hygiene during pregnancy, delivery and the postpartum period.
- e) Helps the pregnant woman to cope with labor pain and fear of childbirth during childbirth.
- f) Helps the mother with baby care and breastfeeding and informs the midwife of the changes in the general health of the mother and baby in the postpartum period.
- g) Assists and accompanies the woman's transfer to another clinic or unit.
- h) Provides information to the service group in order to protect and improve maternal and infant health during pregnancy, birth and the postpartum period.
- i) Assists the midwife in carrying out screening programs for women and newborns in family planning services.
- j) Helps with cleaning, disinfecting and the proper storage of the materials used.
- k) Takes part in keeping the unit he works in ready for use.
- l) Provides the transport of blood, tissue or other samples to the laboratory.

According to the final exam in middle school students are admitted directly to the Assistant Midwife program through the preference and placement system. *Vocational and Technical Anatolian High School Anatolian Vocational Programs* and *Vocational and Technical Anatolian High School Anatolian Technical Programs* are provided within the framework of 2 different school types. There is no difference between schools in terms of post-graduation competence. The training period for both is 4 years. Education consists of theoretical and practical training and the duration of education differs according to the type of school (Figure 1-2). During their education, students take Gynecology and Obstetrics, Maternal and Child Health

Services and Education, Pediatric Health and Diseases, Mental Health, Midwifery Methods, Family Planning, First Aid, Anatomy and Physiology, Histology, Pharmacology, Introduction to Nutrition, Pathology, Public Health and Midwifery classes. These practice-oriented vocational courses are given in hospitals, maternity homes and mother - child health centers.

Figure 1. Vocational and Technical Anatolian High School Anatolian Vocational Program, field of Healthcare Services (Assistant Midwife, Nurse Assistant, Health Care Technician Branches) Weekly Course Schedule

Categories of classes	Classes	9 th grade	10 th grade	11 th grade	12 th grade	
Obligatory classes	Turkish language and literature	5	5	5	5	
	Religious culture and moral knowledge	2	2	2	2	
	History	2	2	2		
	Revolution history and kemalism of the Republic				2	
	Geography	2	2			
	Mathematics	6	5			
	Physics	2	2			
	Chemistry	2	2			
	Biology	2	2			
	Philosophy		2	2		
	Foreign language	5	2	2	2	
	Physical education and sports	2	2	2		
	Visual arts and music	2				
Medical knowledge and traffic culture	1					
Total		33	28	15	11	
Major/ branch classes	Major/ obligatory classes	Professional development	2			
		Professional principles		6		
		Anatomy and physiology		4		
		General nutrition		2		
		Office programs		2		
		Professional rights and obligations			2	
		Personal care of the patient			2	
		First aid			2	
		Communication in medical services				2
	Branch classes	Professional education in businesses				
		Prenatal care and birth				
		Neonatal and pediatric health				
		Gynecology and family planning				
		Aseptic practices				
		Infectious diseases			16	26
		Systemic diseases				
		Medical psychology				
		Special care practices				
		Basic medicine knowledge				
Basic professional practices						
Major/branch classes total hours		2	14	22	28	
Total hours of optional classes		4	1	6	3	
Guidance counseling		1			1	
Total hours of classes		40	43	43	43	

Obligatory classes and branch classes are taught in the 9th and 10th grades and obligatory classes courses and branch specific courses are taught in the 11th and 12th grades. Students start their major in the 10th grade and continue their branch education in the 11th and 12th grades by choosing a specialization at the end of this grade.

Figure 2. Vocational and Technical Anatolian High School Anatolian Vocational Program, field of Healthcare Services (Assistant Midwife, Nurse Assistant, Health Care Technician Branches) Weekly Course Schedule

Categories of classes	Classes	9 th grade	10 th grade	11 th grade	12 th grade	
Obligatory classes	Turkish language and literature	5	5	5	5	
	Religious culture and moral knowledge	2	2	2	2	
	History	2	2	2		
	Revolution history and kemalism of the Republic				2	
	Geography	2	2			
	Mathematics	6	6	6	6	
	Physics	2	2	4	4	
	Chemistry	2	2	4	4	
	Biology	2	2			
	Philosophy		2	2		
	Foreign language	5	2	2	2	
	Physical education and sports	2	2	2		
	Visual arts and music	2				
Medical knowledge and traffic culture	1					
Total		33	29	29	25	
Major/ branch classes	Major/ obligatory classes	Professional development	2			
		Professional principles		6		
		Anatomy and physiology		4		
		General nutrition		2		
		Office programs		2		
		Professional rights and obligations			2	
		Personal care of the patient			2	
		First aid			2	
		Communication in medical services				2
	Branch classes	Prenatal care and birth				
		Neonatal and pediatric health				
		Gynecology and family planning				
		Aseptic practices				
		Infectious diseases				
		Systemic diseases			6	12
		Medical psychology				
		Special care practices				
		Basic medicine knowledge				
		Basic professional practices				
Major/branch classes total hours		2	14	12	14	
Total hours of optional classes		4	1	3	4	
Guidance counseling		1			1	
Total hours of classes		40	44	44	44	

Achievements of Assistant Midwife Graduates

-
- By taking occupational health and safety measures, the assistant helps the midwife in prenatal care, risky situations related to pregnancy and childbirth, birth and postpartum care by distinguishing women's and reproductive health, pregnancy and fetal physiology.
 - Assisting the midwife/nurse in preparing the newborn unit, the evaluation of the newborn, protection and improvement of newborn and pediatric health thereby taking into account occupational health and safety measures.
 - Assists the midwife/nurse with gynecological problems and family planning services thereby taking into account occupational health and safety measures.
 - Helps with sterilization, disinfection and separation of medical waste thereby taking into account occupational health and safety measures.
 - Takes infection control measures by distinguishing the infectious agents and transmission routes in order to be protected from infectious diseases in line with occupational health and safety measures.
 - Distinguishes respiratory, circulatory, digestive, endocrine, nervous, urogenital system, blood, joint and sensory organ diseases.
 - Explains the basic concepts of psychology, personality traits and helps to control emotions in mental disorders.
 - Provides psychological support to patients and their relatives in disasters and traumas.

The 2014 Health Workforce Targets and Health Education Report of the Ministry of Healthcare has stated that there may be a need for 13.000 assistant midwives in 2023.

No studies concerning the assistant midwife program in Turkey have been found in the literature and there have been very few studies carried out abroad. In this study, the opinions of midwife assistant students on their choice of profession and the factors affecting it, the education and internship experiences they had and the development of skills in accordance with the job description were investigated.

Whereas the entire research group consisted of female students, the average age was 17.2 ± 0.7 (16 years = 17 people, 17 years = 45 people, 18 years = 32 people). A percentage of 79.8% of the research group stated that they chose their school and program voluntarily (Table 1) and among the reasons for choosing the profession, interest in the profession and job opportunities were marked the most. No significant relationship was found between the economic status of the family and the reasons for choosing the profession ($p > 0.05$).

Table 1. Demographic Data of Assistant Midwife Students

	Number	%
Age		
16	17	18,1
17	45	47,9
18	32	34
Location of school		
Provincial center	44	46,8
District	50	53,2
Family type		
Elementary	84	89,4
Extended	10	10,6
Family income status		
Low	2	2,1
Medium	74	78,7
High	18	19,1
Profession of own choosing		
Yes	75	79,8
No	19	20,2

A percentage of 46.8% of the students were interested in the field of healthcare, 30.9% thought they would have a lot of job opportunities, 27.7% loved babies, 16% had sufficient high school entrance scores, 10.6% stated that they chose the assistant midwife program because of the sanctity of helping others. While 75.5% of the students stated that they did their research before choosing the program, 38.3% described assistant midwifery as a difficult profession. While 35.1% of the students described the midwife assistant program as a good preparation for the job before they started school, this rate increased to 34% at graduation. When asked about their opinion on society's point of view towards the program, 21.3% evaluated it positively. A percentage of 57.4% of the students stated that there should be no male students in the field of assistant midwifery.

Table 2. Professional and self-descriptive statements

Statements describing the midwife assistant profession		Self-descriptive statements	
	%		%
Compassion/empathy	90,4	Understanding	75,5
Patience	84	Patient	67
Understanding	79,8	Sympathetic	57,4
Helpfulness	73,4	Collaborative	56,4
Service	70,2	Assertive	53,2
Communication	67	Calm	48,9
Talent	55,3	Chatty	47,9

Devotion	39,4	Attentive	46,8
Tiredness	35,1	Aggressive	43,6
Continuous development	28,7	Stubborn	34
Excellence	23,4	Playful	33
Normativeness	23,4	Angry	21,3
Creativity	14,9	Creative	20,2
Innovation	14,9	Shy	19,1
Science	13,8	Idealist	19,1
Anger	12,8	Cautious	16

The rate of those who want to continue the profession after their education was 62.8%, while 27.7% stated that they had not yet decided. A percentage of 94.7% of the students stated that they wanted to continue their education and 75.5% of them wanted a career in midwifery.

The students were asked to choose the statement that described them the best from the table prepared by the researcher, which included the descriptive expressions of the job and the student. Among the descriptive professional expressions 90.4% chose compassion and empathy, 84% chose patience and 79.8% chose understanding. Self-defining statements were 75% understanding, 67% patient, 57.4% sympathetic (Table 2).

Assistant midwife senior year students were presented a 4-point likert scale questionnaire in which they were asked about practices that were and were not in accordance with the job description and the curriculum of the assistant midwife program. It has been determined that almost half of the research group has never participated in practices such as admitting the pregnant woman to the delivery room, taking anamneses and filling out the necessary records, preparing the delivery table, taking the pregnant woman to the delivery table, ensuring the privacy of the pregnant woman, putting the mother to bed and providing contact with her baby and helping the breastfeeding process. It was reported that they carried out enemas, provided prenatal training to pregnant women on birth and taught breathing exercises that were not in line with their job description, although in a limited manner (Table 3).

EFFECT OF ONLINE CHILDBIRTH PREPARATION TRAINING ON CHILDBIRTH FEAR AND CHILDBIRTH

Pregnancy and childbirth are important transitional stages and existential processes in the lives of women. Childbirth is unique and special for every woman. Since the pregnancy ends with the act of childbirth, the greatest stress a woman experiences after pregnancy is childbirth.

Childbirth fear is a common health problem for women during pregnancy. It refers to feelings of uncertainty and anxiety arising from the expectations of women from the upcoming childbirth, and their experiences after childbirth. While the prevalence of childbirth fear in pregnant women has been defined as approximately 20-25%, 6-10% of expectant mothers have reported serious degrees of fear, impairing their daily activities as well as their abilities related to childbirth and coping with childbirth.

A positive childbirth experience is supported by a sense of personal satisfaction among new mothers, affecting their well-being as well as their emotional relationship with the newborns. Similarly, it affects their interactions with their partners and their sexual desires, including the desire to have more children in the future.

It has been globally agreed that providing pregnant women with information enables them to access accurate information about childbirth and the process after childbirth, and keeps them distant from risky situations. Childbirth fear is known to be caused by an unknown situation or a negative previous experience. There are many studies in the literature stating that pregnant women, who receive training, experience less childbirth fear. For this purpose, pregnancy training courses and classes have been developed in the public and private sectors. The Republic of Turkey Ministry of Health planned to standardize educators, training topics, educational materials, and physical conditions by publishing a circular on pregnancy school, pregnancy information class, childbirth preparation, and counseling centers. Studies were initiated for these centers to be authorized by the Ministry of Health.

Wijma Delivery Expectancy/Experience Questionnaire (W-DEQ) was developed with the aim of determining and measuring childbirth fear in women and was tested for validity and reliability in Turkish. It is a widely known 33-item scale used for measuring childbirth fear, which has been translated and approved in various countries.

This study evaluated whether there was a difference between the degrees of childbirth fear between women who had no previous experience of pregnancy, who received and who did not receive online preparation training, and who had been pregnant for more than 30 weeks. This is the first study conducted to evaluate the effectiveness of online childbirth preparation. The main purpose of this study was to determine the degree of childbirth fear in pregnant women, who received online childbirth preparation training and who did not receive any training.

MATERIALS AND METHODS

This study is a semi-experimental research, it was carried out with primiparous pregnant women identified in A Family Healthcare Center Kayseri City in Turkey, between February 1, 2021, and April 30, 2021. The trainings were conducted by the researcher, in order to prevent the difference; the difference between the educator, the educational material and pregnant women depending on their online participation time.

Selection of the Participants:

Participants were selected in a family healthcare center in Kayseri, which was known to have a higher number of primiparous childbirths compared to the other regions. The population of the study consisted of primiparous pregnant women registered with family physicians at the family healthcare center.

Concerning the experimental group of the study, the inclusion criteria included primiparous pregnancy, having a single fetus, having no medical history of infertility, being at 16 to 28 weeks of pregnancy, having routine prenatal follow-ups, not having medical problems (chronic disease and physical disability) that would require a cesarean section, not having any psychological problems, not having a medical history of miscarriage, and having consent to participating in the program, which was acknowledged by the researcher on the phone.

Inclusion criteria for the control group of the study included primiparous pregnancy, a single fetus, having no medical history of infertility, being at week 29 or further weeks of pregnancy, having routine prenatal follow-ups, having no medical problems (chronic disease and physical disability) that would require a cesarean section, having no psychological problems, having no medical history of miscarriage, and approving to participate in the program, which was acknowledged by the researcher on the phone.

Exclusion criteria included failure to meet the inclusion criteria, and being multiparous.

Preparation of training groups:

Primiparous pregnant women (N: 99) were grouped as 16-19 weeks (n: 18), 20-24 weeks (n: 15), 25-28 weeks (n: 12), and 29 weeks and above (n: 54) according to the name and contact information obtained from the family healthcare center by the researcher. The primiparous pregnant women were contacted by phone according to the name list. During the phone conversation, the training program was introduced and the purpose and the type of implementation were described. It was also explained that the program was free of charge, Internet access was a requirement, and a questionnaire would be administered at the end of the training. A total of 13 women stated that they did not desire to participate in the study due to reasons such as not having their own phone or Internet access (n: 5), thinking that they did not need education (n: 3), disliking surveys (n: 2), and not trusting links (n: 3). Having agreed to participate in the study and met the inclusion criteria, 38 women constituted the experimental group, and 48 women constituted the control group. WhatsApp groups were created for enabling communication with groups. Before the training, explanations were made in the WhatsApp groups about downloading and installing Zoom software. A meeting link was sent to the groups once a week before the training, and the training classes were created. During the 10-week training program, additional training days were created for the women, who had not been able to attend, and the entire curriculum was delivered to all participants.

Content of Training:

The childbirth preparation training module determined by the Ministry of Health was administered in this study. The training topics included physiology of pregnancy and childbirth, and psychological changes; support of spouses and relatives; family support in pregnancy and childbirth; stages of childbirth; methods of coping with childbirth pain without medication; problems that may occur during pregnancy, childbirth and the postpartum period, and early diagnosis; signs of danger in pregnancy and methods to be followed in emergencies; benefits of natural childbirth for mother and newborn; postpartum period; reproductive health methods that can be used after childbirth; and newborn care.

Additional topics were also integrated upon the request of the participants (pregnancy and breastfeeding during COVID-19, what is the delivery room environment like?), and question-answer activities were also held.

Since none of the participants had given birth at the time of writing this article, the data on childbirth methods were not evaluated.

Administration of the questionnaire and statistical evaluation:

After the training, the Wijma Delivery Expectancy/Experience Questionnaire Version A, which was tested for validity and reliability in Turkish in 2019 (Körükçü, 2009), was sent online to the primiparous pregnant women in the experiment group (n:38), and primiparous pregnant women at week 29 and further weeks of pregnancy in the control group (n:48). In our study, the Cronbach's Alpha value of the questionnaire was 0.93. The compatibility of the data to normal distribution was evaluated using the One-Sample Kolmogorov-Smirnov Test in order to compare the mean scores obtained by the pregnant women, who received and did not receive training, from the Wijma Delivery Expectancy/Experience Questionnaire. The nonparametric test techniques of the Kruskal Wallis Test and Mann Whitney U tests were used in the evaluation of the data, which was determined to be incompatible with a normal distribution ($p < 0.05$) and non-homogeneous ($p < 0.05$).

Research Ethics:

The study was conducted in accordance with the World Medical Association Declaration of Helsinki, upon the permission of the Ethics Committee of Kayseri City Hospital dated 21 January 2021 and numbered 277. Participants were asked to participate in the study by approving an introductory text containing information and informed consent.

RESULTS

A total of 86 pregnant women participated in the study (experiment: 38 - control: 48), and the mean age was 28.04 ± 4.48 (min: 19 - max: 40). The mean age of the spouses of the pregnant women was 30.36 ± 4.24 (min: 22 - max: 43). The mean duration of pregnancy was 33.38 ± 3.28 (min: 27-max: 38). All participants had social security, and other demographic data were presented in Table 1.

Table 1. Demographic indicators of all participants

	Pre-Birth Training / Experimental Group		Non-Birth Preparation Training / Control Group	
	Number	%	Number	%
Age				
20 and ↓	0	0	3	6,2
21-25	12	31,6	12	25
26-30	19	50	18	37,5
31-35	7	18,4	9	18,8
36-40	0	0	6	12,5
Education Status				
High School	17	44,7	30	62,5
University	21	55,3	18	37,5
Family Type				
She only lives with his partner	31	81,6	42	87,5
She lives with family elders and other family members	7	18,4	6	12,5
Job				
Unemployed	21	55,3	23	47,9
Employee	17	44,7	25	52,1
Partner's support for pregnancy				
Yes	19	50	33	68,7
Partial	19	50	15	31,3
No	0	0	0	0
Total	38	44,2	48	55,8

Table 2. Mean Wijma Delivery Expectancy/Experience Questionnaire Scores of Experimental and Control Groups

Scale Score	Receiving Childbirth Preparation Training (N: 38)		Not Receiving Childbirth Preparation Training (N: 48)		Total	%
	Number	%	Number	%		
Women with a low degree of childbirth fear (W-DEQ Score < 37)	7	18,4	6	12,5	13	15,2
Women with a moderate degree of childbirth fear (W-DEQ Score: 38-65)	18	47,4	9	18,8	27	31,4
Women with a severe degree of childbirth fear (W-DEQ Score: 66-84)	11	28,9	28	58,3	39	45,3
Women with a clinical degree of childbirth fear (W-DEQ Score >85)	2	5,3	5	10,4	7	8,1
Mean Score	63.5 ± 21.28 min: 9 max: 80		69.8 ± 23.57 Min: 23 max: 92		66.33 ± 22.4 min: 9 max: 92	
Total	38	44.2	48	55.8	86	100

Kruskal-Wallis Test: 0.027 Statistically significant (P < 0.05).

In the study group, 8.1% of the study group had a clinical degree of childbirth fear, and 71.4% of this group consisted of women who did not receive childbirth preparation training (Table 2). According to the study, there was a significant difference between the women, who received online childbirth preparation training, and the women, who did not receive online childbirth preparation training.

According to the results of the comparison between mean Wijma Delivery Expectancy/Experience Questionnaire scores of the pregnant women and their demographic characteristics, the degrees of childbirth fear was found to be more severe in women, who had university degrees, who lived in extended families, who partial supported from partner, who had an unplanned pregnancy, who planned to have a cesarean section or had not planned any childbirth methods (Table 3). Among the participants, 84.9% stated that they were prepared for this pregnancy and it was a planned pregnancy, while 15.1% mentioned that they did not feel prepared yet and it was an unplanned pregnancy. Nonetheless, it was determined that all the participants and their spouses were pleased with this pregnancy, and they desired to have their babies. It was observed that 12.8% of the pregnant women had a chronic disease (migraine, 4.7%; skin diseases, 4.6%; asthma, 2.3%; and HT, 1.2%). The proportion of women, who stated that they had medical problems related to their pregnancy, was 5.8%. It was observed that 5.3% of women, who reported health problems experienced nausea and vomiting, 2% had edema problems, and the majority of their medical problems occurred in the first months. The proportion of pregnant women, who stated that they received support from their spouses for their medical problems, was 88.4%.

The question of "Would you like to give birth at home if it was possible?" was responded as "never" by 33.7% of the participants, as "maybe" by 58.1%, and as "yes" by 7%. Of the women, who received childbirth preparation training, 18.4% stated that they could give birth at home if it was possible, and 68.4% stated that they might prefer home birth. No participants in the control group mentioned that they would like to give birth at home ($p < 0.05$).

The mean value for visiting the obstetrician for pregnancy follow-up during pregnancy was 8.2 ± 2.8 , and the mean value for visiting the family physician was 3.9 ± 1.3 . Of the pregnant women, 77.9% mentioned that they planned to give birth in a private hospital, and 12.8% of them planned to give birth by cesarean section.

Table 3. Wijma Delivery Expectancy/Experience Questionnaire Scores of Pregnant Women, Who Received and Did Not Receive Childbirth Preparation Training, According to Their Demographic Characteristics

Demographic Characteristics	Low degree of birth fear (W-DEQ < 37)		Moderate degree of birth fear (W-DEQ 38-65)		Severe degree of birth fear (W-DEQ 66-84)		Clinical degree of birth fear (W-DEQ > 85)		Total	Statistical analysis		
	Study	Control	Study	Control	Study	Control	Study	Control				
Age	N	%	N	%	N	%	N	%	N	%	$\chi^2 = 4,409^*$	P 0,35 3
20 ↓	0	0	0	0	0	0	3	100	0	0		
21-25	4	13,8	0	0	5	17,2	2	6,9	6	20,7		
26-30	3	8,8	6	17,6	7	20,7	4	11,8	3	8,8		
31-35	0	0	0	0	4	30,7	2	15,4	2	15,4		
36-40	0	0	0	0	2	28,6	1	14,3	0	0		
Education Status											$u = 653,50$	P 0,00 2
High School	7	16,7	6	14,2	7	16,7	4	9,5	4	9,5		
University	0	0	0	0	1	25	5	11,4	7	15,9		
Family Type											$u = 180,00$	P 0,00 1
She only lives with his partner	7	9,2	6	7,9	1	23,8	8	10,6	9	11,8		
She lives with family elders and other family members	0	0	0	0	0	0	1	10	2	20		
Income level											$\chi^2 = 0,141$	P 0,70 7
Adequate	0	0	0	0	5	33,4	2	13,3	2	13,3		
Middle	7	11,9	6	10,2	1	16,9	5	8,5	6	10,2		
Inadequate	0	0	0	0	3	25	2	16,7	3	25		
Pregnancy planning											$u = 180,000$	P 0,00 1
Planned pregnancy	7	8,9	6	7,6	1	22,8	8	10,1	1	12,8		
Unplanned pregnancy	0	0	0	0	0	0	1	14,3	1	14,3		
Partner's support for pregnancy											$u = 709,500$	P 0,03 7
Yes	3	5,3	6	10,5	6	10,5	2	3,5	0	0		
Partial	4	13,8	0	0	1	41,2	7	24,2	1	3,4		
Choosing how to give birth											$u = 709,500$	P 0,03 7
If all goes well, vaginal birth	7	14	6	12	1	28	4	8	4	8		

Cesarean	0	0	0	0	0	0	2	18,2	3	27,3	4	36,4	0	0	2	18,2	1	12,8	x ² =21,426	0,001
Unplanned	0	0	0	0	4	14,4	3	11,5	4	15,4	1	42,3	1	3,8	2	7,7	2	30,2		
Total	7	8,1	6	7	1	20,8	9	10,5	1	12,1	2	32,8	2	2,3	5	5,8	8	100,6		

x²=Kruskal-Wallis, u= Mann-Whitney Test, Statistically significant (P < 0.05).

This is the first study conducted to evaluate the effect of online childbirth preparation training on childbirth fear. Wijma Delivery Expectancy/Experience Questionnaire was administered to 86 women, who were pregnant for the first time, who had mean 33 weeks of pregnancy, who received childbirth preparation training (n: 38), and who did not receive childbirth preparation training (n: 48). Mean Wijma Delivery Expectancy/Experience Questionnaire scores of the participants was 66.33 ± 22.4 (Experimental Group: 63.5 ± 21.28 & Control group: 69.8 ± 23.57 $p < 0.05$). The prevalence of severe childbirth fear (W-DEQ 66-84) was 45.3% (Experimental: 28.9% & Control: 58.3%), and the prevalence of clinical degree of childbirth fear (W-DEQ ≥ 85) was 8.1 (Experimental: 5.3% & Control: 10.4%).

It has been observed that childbirth preparation training has positive effects on childbirth and childbirth preferences. It has been determined to reduce the fear of birth, affect childbirth preference, and prepare the women for the postpartum period. In cases where childbirth preparation training programs cannot be performed face-to-face or pregnant women have a problem of participating (situations requiring isolation such as the COVID-19 pandemic, women living in rural areas or abroad with problems of access to training, women who cannot participate in regular training programs due to working life, women with a second baby, who have problems with caregivers), continuing the training online is important and beneficial in terms of continuity of health services.

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PROJECT RECOMMENDATIONS

1. Although the basic health indicators differ in Turkey, Germany and Greece, the problems of midwives are similar. The current health care system, health workforce, updated education programs and the change of health care groups should be taken into account. The midwife training policy and authority need to be updated. There is a need to conduct further studies on the health indicators and health economics that will arise with the effective use of the midwifery system.
2. The curriculum content of the midwifery undergraduate programs of all three countries is at the level that meets the competencies specified by the ICM. It may be advisable to increase the number of courses and/or the content of the courses on the subjects of preparing for delivery, supporting the mother's post-pregnancy mourning process that results in abortion, postpartum and/or infant loss, delivery techniques for the fetus in different presentations, the ability to intervene with appropriate maneuver and position change in emergency situations, newborn resuscitation and adult advanced resuscitation theory and application, methods and techniques to reduce pain at birth, knowing the care of babies requiring special care, application and education of the family. It is necessary to increase the number of academicians in the field of midwifery in order to create educational staff that can give these courses and have the quality recommended by the WHO. In order to train students with advanced practical skills, while opening midwifery programs, internship opportunities should be taken into consideration. Academic research directed at the field should increase.
3. According to our study, midwives need to increase their ability to work and communicate with cases of traumatic pregnancy and childbirth, intervention skills for risky births, and IUD application, as they do not see a significant lack of their professional competence.
4. Midwives are required to be aware of and participate in lifelong learning opportunities for their professional development.
5. Feedback from midwives working in the field will contribute to the development of educational programs.
6. In countries where there is no midwifery law, the implementation of it as soon as possible will increase professional belonging and quality.
7. When the working areas of midwives of each country were examined, it was seen that midwives in Turkey were more involved in primary care. There is a need to conduct further studies on the

primary care midwifery model, to add programs related to the concept of community health midwifery, family midwifery to the educational program, and to regulate personal rights in this regard.

8. The fact that midwives are members of professional organizations and contribute to professional policies will have important consequences for the future of the profession.
9. In particular, it was observed that midwives who joined from Turkey preferred midwifery because there were more job opportunities. People who are going to choose midwifery need to really want to do the profession and be willing to provide the skills required by the profession.
10. Women's health, including pregnancy preparation, is an issue that requires a multidisciplinary approach. Therefore, gynecologists-obstetricians, family doctors, midwives, nurses and other health professionals should provide care to the patient in team collaboration. According to the data obtained from our research, it is estimated that students who are trained as assistant midwives will have a confusion of concepts about what exactly they should or should not do and will experience.
11. There is a need for studies that also question the opinions of current midwives about midwifery in our country.
12. It has been observed that childbirth preparation training has positive effects on childbirth and childbirth preferences. It has been determined to reduce the fear of birth, affect childbirth preference, and prepare the women for the postpartum period. In cases where childbirth preparation training programs cannot be performed face-to-face or pregnant women have a problem of participating (situations requiring isolation such as the COVID-19 pandemic, women living in rural areas or abroad with problems of access to training, women who cannot participate in regular training programs due to working life, women with a second baby, who have problems with caregivers), continuing the training online is important and beneficial in terms of continuity of health services.
13. There are regions all over the world where traditional midwifery practices are still continuing. In order not to adversely affect the health of the mother and baby, the number of evidence-based studies should be increased in cooperation with traditional techniques and traditional midwives.

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