

Midwifery Group Practice in Indonesia

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Abstract— insufficient and imbalance amount of midwifery increases the workload and burden of midwives in Indonesia. According to IBI (2016), the philosophy of midwives is to give continuous care to increase the quality of maternal services. However the increase in responsibility for midwives, causes a need of a model with continuity of care maternal health service but which decreases the stress and burden of midwives, increases patients' satisfaction, and supports the midwives life quality. The name of this model is MGP (Midwifery Group Practice). This model consists of 4 midwives who work as a team and replace each other's work if a midwife is on a holiday or day off to provide antenatal services at home, hospital and community. They receive births for 24 hours and serve the postpartum period for up to 6 weeks. The purpose of this systematic literature review is to identify the implementation of MGP and to provide recommendations regarding MGP implementation which can be implemented in Indonesia. **Method:** The researcher filtered 815 literatures which use qualitative methods or mix methods from two databases, Pubmed and Scindirect, to be reviewed. This Systematic Literature Review was adjusted to the Systematic Literature Review with 8 steps. **Result:** There were 15 articles that fit the inclusion and exclusion criteria. The author divided into sub-sections to facilitate the focus of the discussion, namely definition of MGP, satisfaction of the patients, midwives and students with the service of MGP model, and the strengths and weaknesses of the MGP model. **Conclusion:** MGP makes mothers and midwives feel comfortable with the health services, because mothers get receive integrated services with midwives whom they know and midwives can improve their quality of life by being able to replace co-midwife who also knows patients. Thus the quality of service and patient satisfaction will increase, and MGP good to be applied in Indonesia.

Keywords: *group practice, caseload, midwifery*

I. INTRODUCTION

According to WHO, maternal mortality rate in developed countries in 2015 was 12/100,000 births and the maternal mortality rate in developing countries was 239/100,000 births, while the expected outcome of SDGs in 2030 was reducing maternal mortality below 70 / 100,000 births [1]. The Ministry of Health stated that the number of infant death cases in Indonesia decreased from 33,278 in 2015 to 32,007 in 2016, but increased again in 2017 with by 1712 cases. On the other hand the maternal mortality rate decreased from 4,999 in 2015 to 4912 in 2016 and 2017 with 1712 cases [2]. According to WHO in Global Strategy Workforce 2030 (2016) to increase the quality of health status can be achieved by improving the standards of service

quality, availability of health services, availability of childbearing and distribution evenly [3].

Based on the Ministry of Health of Republic Indonesia, the ratio of midwives in 2016 was 63.22/100,000 population and it is still far from the target in 2019 with 120/100,000 live birth rate [4] Insufficient and imbalance amount of midwives in Indonesia cause high workload for midwives, which make decreases the midwives' life quality. According to a study written by Wahyuni in 2013 with the title "Analysis of the Workload of Midwives in Implementing Their Authority in Gladak Pakem Jember in 2015" the average and objective workload level of midwives in rural areas were high [5]. According to the journal "Work load and management in the delivery room: changing the direction of healthcare policy", the high workloads on health care providers are in line with patients' unsatisfactory and errors in providing services [6]. According to Law Number 36 of 2009 concerning Health in Chapter XII about Occupational Health, shows that health efforts are aimed to protect workers to live healthily, free from health problems and adverse effects caused by occupation [7]. The imbalance distribution of midwives causes some regions to have less number of midwives, so a model of health service is needed to maintain the responsibilities and targets of midwives and to decrease their burden. A systematic review is needed to determine whether a MGP (Midwifery Group Practice) model can be applied in Indonesia.

II. METHOD

The author filtered 815 literatures from two databases (Pubmed and Scindirect) to be reviewed. All selected literatures were indexed with Q1 Scopus and were from developed and developing countries. The articles chosen were articles which population of were women, midwifery, and student who got Midwifery Group Practices service. Steps used for scoping literature were as follow: 1) Identifying the problems, 2) Prioritizing problems and questions, 3) Creating frameworks, 4) Literature searching, 5) Selecting articles, 6) Making critical appraisal, 7) Extracting selected paper data, 8) Collecting data and making maps to answer questions.

Identifying the problems: The willingness standard of midwives per individual based on the Decree of the Coordinating Minister for People's Welfare Number 54 of 2013 showed that the target ratio of health workers population in 2019 including the ratio of general physicians to 45 per 100,000 population, ratio of dentist 13 per 100,000 population, nurse ratio 180 per 100,000 population, and the ratio of midwives 120 per 100,000 and it is known that the

ratio of midwives in Indonesia in 2016 was 63.22 per 100,000 population and it is still far from the 2019 target of 120 per 100,000 population [4]. The high level of achievement that must be achieved by midwives with the reduction in midwives' resources made the midwives themselves stressed with the targets given, that midwives could not achieve these targets perfectly. Prioritizing problems and questions from this systematic literature review were to determine maternal satisfaction, midwife satisfaction, student experience, strengths and weaknesses of MGP model. The research question of this systematic literature review is specifically want to know: 1) how is the satisfaction of implementing the MGP service model (Midwifery Group Practice) and 2) can it be an option for midwifery service models in Indonesia? The authors searched this study through a Comprehensive Literature Search. Searching is carried out using the following steps: 1) Making a framework to determine inclusion and exclusion criteria. 2) determining keywords according to the specified framework. 3) Searching by using keywords in the Pubmed and ScienceDirect databases. 4) Keyword searching is carried out by using filters / filters to get results that are more focused in accordance with the specified framework. 5) Recording the findings, and saving in the Mendley bibliography storage engine. 6) Data that has been stored is then filtered according to the framework. An inappropriate article is issued. 7) recording the findings of the number of articles and compile a prism of flow diagrams. This a framework used for systematic literature review is PEOS (Population, Exposure, Outcome, Study design)

Element	Inclusion	Exclusion
Population	midwifery Pregnant women mother giving birth, childbirth	Maternity with complications
Exposure	experience obstacles satisfaction	
Outcome	Implementation of Midwifery Practice Group	
Study design	Qualitative study and mixed method	

Fig. 1. PEOS table

Searching literature used in this study was obtained through a Comprehensive literature search system. The author used 2 databases for selecting articles and the keyword that used for searching in Pubmed and ScienceDirect were (midwifery OR midwife) AND ("Caseload model" OR "Group practice" OR "Midwifery Group Practice). The papers included if they were published since 2009, were written in English and used qualitative or mixed method. The author got 815 journal articles with 545 articles from science direct and 270 from pubmed. The journal article was duplicated by excluding 21 articles which are the same. After that, 750 irrelevant results were excluded from the database with 15 articles excluded after the reviewing step and the remaining 29 articles were re-screened to obtain only articles that fit the inclusion and exclusion criteria. After this step, 15 articles with qualitative and mixed method design studies were, then the author criticized the appraisal using CASP and has extracted the data. The papers were recorded in a storage machine, Mendley's bibliography. The process of selecting articles to be included in the systematic literature

review was undertaken initially by the primary author and followed that recommended by Prisma flow diagram.

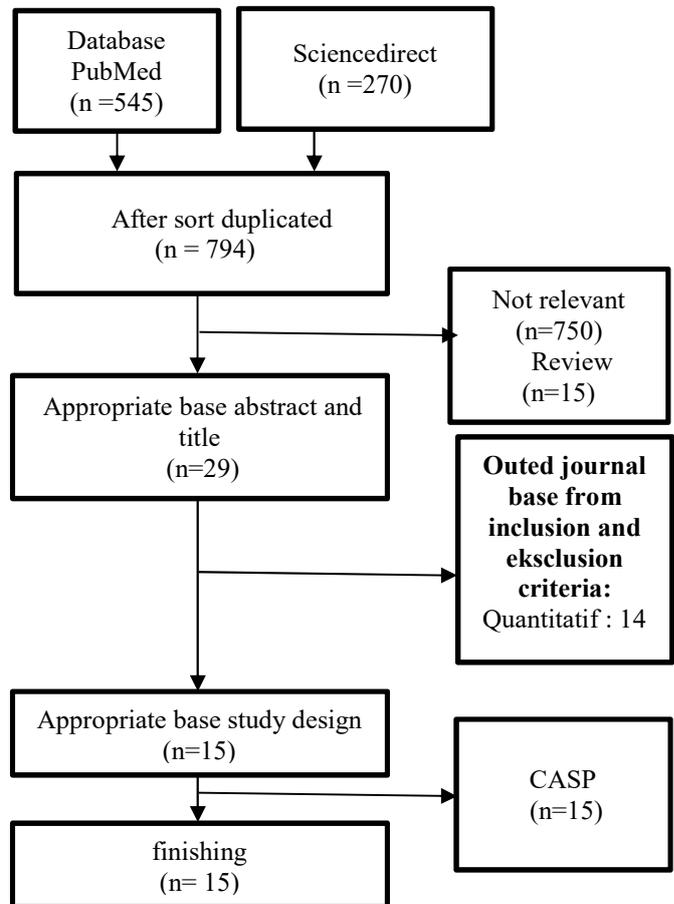


Fig. 2. Framework

Mapping: Based on 15 articles that have been selected and in accordance with good quality and inclusion criteria, we can concluded that 1 journal used semi-qualitative design, 2 journal designs used mixed methods and 12 journal designs used qualitative. In the table below is the location of where this journal articles originated from.

Country	The number of articles
Scotlandia	1
Denmark	1
UK	2
Australia	11

Fig. 3. Mapping

Whereas when viewed from the quality of the journal, all journals have a Q1 index, namely 5 journals from the Women and Birth Elsevier journal and 10 journals from Midwifery Elsevier journal. In this mapping step. The author classifies the things observed from each study, namely

1. Definition of MGP service models

2. Application of MGP
3. Patient satisfaction with the service of the MGP model,
4. Midwife satisfaction in implementing MGP model services
5. Student Perception about MGP and application of MGP to Students
6. 6)The strengths and weaknesses of the MGP service model

III. RESULTS

A. *Understanding Midwifery and MGP*

Caseload midwifery is a midwifery model where mothers get services from health workers whom they know and are trust and is done based on women centered care [8] [9] [10]. The implementation of this midwifery is combined with the MGP model (Midwifery Practice Group) where 4-6 midwives work together in a team to achieve the goal of caseload midwifery, which is to accompany the mother during her life process at home, hospital or community service [11] [12]. In MGP services, midwives are ready 24 hours on call to assist their patients until postpartum services for 6 weeks. Midwifery group practice is a form of professional service model that provides services based on assessment; and peer support. In this MGP service especially in antenatal care midwives meet the mothers biased in clinics and home visits, after meeting and being examined, mothers are invited to attend antenatal classes; where it is a good time for mothers to share experiences with other pregnant women and mothers can meet other midwives of the same team [13].

B. *Mother satisfaction in MGP caseload services*

In antenatal care using the MGP model, there are various first experiences of mothers that they like the existence of this group; According to one participant, her satisfaction with the MGP model was "*knowing that support was always there*", which she referred to the main midwife who accompanied her during the delivery process and provided support to her. The mother was satisfied with MGP services because in the MGP service the midwife built a deep relationship with the mother so that she felt she was given support by a midwife she knew, besides that on call the system applied by MGP made her satisfied [14] [15] [16] [17]. Caseload midwifery care for unassisted vaginal birth cost significantly less than standard maternity care, so this model makes mother satisfied [18]. In caseload model mother said that they was very happy with known midwife; as the midwife could be her partner or even her family to share anything to and to feel comfortable with because the midwife knew her history and gave support to her [19].

C. *Midwife satisfaction in implementing the MGP model service*

The midwife's statement about MGP is felt to be helped by the existence of this model, according to one participant of midwife said "*I think it's all part of it and because you've built up that relationship there isn't really a big need for birth plans because we've discussed it and she told me what she wants and what she knows, that she already knows about woman, so to have somebody else to look after her in labor is didn't cause a strain on that midwife and a strain on the woman*". So it can be concluded that MGP is very helpful for midwives to solve problems because in this team they can meet their manager for general service updates, management of any issues (including conflict resolution), Provide each other with peer support, manage the day-to-day workings of the model, organise back-up and annual leave, referral clinical cases, undertake mandatory education sessions, provide opportunity for clinical supervision. Midwife must be prepared for 24 hours to accompany patient when the patient suddenly contact the midwife for childbirth but MGP facilitated midwives to exchange with another midwife member team if they are on holiday or day off work, when there is a change in work schedule to accompany patient's labor, and the patient knows the midwife who is changing, so the continuity of care goes on optimally [20][21]. Caseload service model is a model to reduce the stress level of midwives, because the caseload model working system is flexible that midwives can still do service in accordance with the authority and responsibility for their work and still have a time together with their family and social time,. It is happened because the midwife can change the schedule with their team.

The caseload model work system (MGP) is a team of midwives consisting of 4-6 people who attend antenatal classes in community programs, where midwives can be contacted via telephone to accompany during childbirth and visit the postpartum period to 6 weeks, or home visits by the main midwife during 45-90 minutes, in this meeting at least 3 people attended, namely midwives, mothers and their partners, this meeting is conducted with antenatal standards that had been determined and carried out by IEC in depth, even midwives are able to make antenatal visits at the patient's workplace [22]. If there are complications with the mothers, midwives can collaborate with specialist doctors and other professional staff [23][24]. To set the schedule in this model, is by spending 3 days prepared for on call and 2 days to develop professionalism such as visit the patient and reporting. Meanwhile the remaining two days are for holidays, but this schedule is flexible, it can be replaced by other member of the midwife's team, so this requires a strong commitment in the team [22].

D. Student Perception of MGP and the application of MGP

Midwifery students who practice clinics use Midwifery group practice service models state that communication that is mandatory to mentors when practice is very important, this will improve the quality of their learning, increase self-confidence, collaboration and students can practice their skills independently and directly, this is because students will meet the same mentor so that communication between students and mentors will continue and improve students' knowledge and skills. The experiences of postgraduate students and MGP midwives were positive [25][26]. Challenges were identified, by addressing these rotation experience that can be improved for future students. In addition, in this model students are also required to provide assistance to the mother of receiving continuity of care which continuity of care is a service of midwives who have high quality, this is according to what one participant said, "I really enjoyed it because I had a good mentor that was very supportive to me. If I had a problem or whatever, it was always no problem we'll go through it, we'll sort it out, we've found out so I'm never worried about going to see somebody. So the mentor support was really, really important" Here it was explained that students were very satisfied when the mentor she had was in one team and still with the same mentor. Caseload midwifery is the right learning practice for students because they can practice their responsibilities to become real midwives [27].

In the application of MGP in clinical practice, students are implementing this model for 18 months and maximally accompanying 18 mothers. During the service the students are committed to being willing to be on call since 37 weeks of pregnancy, while in holistic services to mothers, the schedule of students can be negotiated by shift. Students can prioritize the delivery of their patients when visited by lecturers from their universities, but if it is not urgent, students can choose to meet their lecturers, as long as student services are accompanied by tutors who are responsible [28].

E. MGP Strengths

Midwifery care standards in developed countries such as Australia, UK, USA and Canada often use LED medically model where mothers get services by different health workers at each visit and even postpartum visits are sometimes carried out by health workers who are unknown to the patient. The standard underlying MGP is continuity of care, namely when the same midwife caring for the mother starting from antenatal visits until childbirth, causing a sense of comfort to the patient and creating trust because the midwife knows the mother's problem since the beginning of pregnancy, but continuity of care in lead midwifery, in reality, many midwives cannot follow the continuity of care process so that the patient will meet with midwives who have never met her, so MGP facilitates the continuity of care service model to keep running according to the rules. MGP is a model of professional health services where services are carried out in a comprehensive, personalized, family centered care. The advantages of MGP compared to other service models are increasing interpersonal relationships between mothers and midwives by making home visits with

less intervention at delivery, patients tend to spontaneously deliver vaginally, and low preterm birth. For the level of satisfaction patients tend to be satisfied with this model compared to other service models. Midwives working in this model have higher professionalism and they also have lower stress levels. But this MGP requires leaders to develop service resilience [23].

F. MGP Weakness

MGP service model is a comprehensive service carried out by midwives, so midwives who implement this model must be truly qualified midwives in providing care, both in science, communication, empathy, etc. Therefore this model cannot be applied if the midwife has a poor quality. If the MGP service model is applied to students or new midwives, they have to come along in the MGP implementation because it may increase student's stress if the student is incompetent during this care, but this model is very useful for students because they can train empathy and have valuable experience to become a mother companion [27]. MGP (Midwifery Group Practice) is a group of midwives who carry out their tasks together which help each other to achieve goals, here it is seen that MGP is a service model that requires leadership in each midwife, to achieve optimal service quality. The following will explain what attributes a midwife needs to become a manager in Midwifery Practice Group

1. Holding the Ground for midwifery
2. The meaning of Holding the Ground for midwifery is that midwives must have a basic midwifery to be able to do service to women,
3. Someone with their hand on the steering wheel
4. The meaning of this theme is to protect midwives in the team, ensuring that all team members are in good condition. According to Jane and Julie "Jane", described by another participant: "Midwifing the midwife in the best possible way, so we are midwives are with the woman". And the third is a supporting relationship, namely midwives facilitate each other in service, to improve service resilience and solve problems together by conducting meetings and apperception.
5. Having it
6. Having it is that the midwife will know the patient deeply including the attitude and personality, which of these will build the trust of the patient to the midwife, besides that a midwife must have a risk-taking character and be emotionally intelligent [23].

IV. DISCUSSION

According to WHO in Global Strategy Workforce 2013 (2016) improving the quality of health status can be achieved by increasing service quality standards, availability of health services, availability of labor and even distribution of health services [3]. The number and quality of health care workers are very important to improve the quality of health status of a country which according to Presidential Regulation Number 72 of 2012 Concerning National Health Systems, health human resources are health workers

(including strategic health workers) and supporting / health support personnel involved and working and devoting themselves to efforts and health management. The implementation of the health human resources subsystem consists of planning, procuring, utilizing, fostering, and overseeing the quality of health human resources and this is one of the problems that occur in Indonesia, as Indonesia has insufficient number of health human resources which further leads to the lacks in the distribution of the health workers

Human Resources for Health (HRH) is one of the subsystems in the National Health System which has an important role in achieving health development goals as implementers of health efforts and services [2].

According to the central statistics agency, the results of the estimated population of Indonesia in 2016 amounted to 258,704,986 people, consisting of 129,988,690 male inhabitants and 128,716,296 female inhabitants. It can be estimated by calculating at the data by excluding young woman aged 0-14 years that the ratio of midwives in Indonesia in 2016 was 63.22 per 100,000 population. this number was still far from the 2019 target of based on the Decree of the Coordinating Minister for People's Welfare Number 54 of 2013 concerning Health Workforce Development Plans for 2011 - 2025, which stated that 120 midwives are needed per 100,000 population. There are four provinces that have met the 2019 target, namely Aceh, Bengkulu, North Maluku and Jambi. The province with the lowest ratio is West Java at 37.21 per 100,000 population. This proves that the distribution and number of midwives in Indonesia is still far from the target of 2019[2]. The insufficient and imbalance amount of midwives increases the workload and burden of midwives in Indonesia, so midwives do not have free time to rest and do not have enough quality of life which causes midwives to tend to experience a high level of stress; To restore the role of midwives in accordance with midwifery philosophy as a holistic primary care provider, a service model that includes service according to standards but still paying attention quality of life of service providers is needed. According to Law Number 36 of 2009 concerning Health in Chapter XII Occupational Health, Article 164-166 states that occupational health efforts are aimed at protecting workers to live healthily and freely from health problems and the bad effects caused by work [2]. With the MGP midwifery service model helping midwives to carry out their duties, including to know the mother and to accompany the mother during her life cycle, so the mother will be more deeply, the mother will feel the midwife is her life partner. The following will be discussed in depth about MGP.

A. Understanding and implementing MGP in midwifery services

This MGP is a midwifery model where mothers get services from health workers they know and are trusted and based on women center care [29]. The implementation of caseload midwifery is combined with the MGP model (Midwifery Practice Group) where 4-6 midwives work together in a team to achieve the goal of caseload midwifery, which is to accompany the mother during her life process both in the home, hospital or community service [30] In MGP services,

midwives are ready 24 hours on call to assist their patients until postpartum services for 6 weeks. The results of the journal interview also stated that all the informants said they were satisfied with the MGP model because they felt comfortable and trusted with the main midwife, who knew the mother and the problem deeply, the mother felt cared for, supported and the mother got the right to decide against herself [17]. This is also supported by journal results that show the satisfaction of mothers and midwives in using MGP services. According to Beckmann's Midwifery Group Practice and Mode of Birth in 2011, the MGP service model reduced the rate of cesarean delivery, reduced intervention, and gave birth without epidural analgesics.

Midwifery care standards in developed countries such as Australia, UK, USA and Canada often use LED medically where mothers get services by health workers who are different at each visit and even the postpartum visits are sometimes carried out by health workers who are unknown to the patient. The standard underlying MGP is continuity of care, but in reality many midwives could not follow the continuity of care process. As a consequence the patient will meet with midwives they never meet., MGP should facilitate the continuity of care service model to keep running according to the rules.

Whereas in Indonesia the MGP service model has not been implemented because midwives have their respective regions in carrying out their duties,—the distribution of midwives in Indonesia is still uneven; due to many factors, for example most midwives do not want to be placed in remote areas, resulting in a shortage of midwives in some regions in Indonesia. This enables the achievement of holistic midwifery service targets, to obtain maximum service, maximum results and still consider the quality of midwives, MGP (Midwifery Group Practice) can be used as an option in lightening the work of midwives in the area that has a shortage of midwives.

B. Midwives Perception in MGP Services

The presence of MGP has made midwives' work feel easier because they can discuss the needs of patients with colleagues who understand the basic philosophy of midwifery and midwives believe that midwives are the primary health care professionals who know what is needed by mothers. Midwives accompany mothers in every process of life so that midwives must be prepared for 24 hours a day to guard whenever the patient suddenly contacts the midwife, but with this MGP midwives can exchange schedules to other midwives in the team who is still known to the patient, so continuity of care can run optimally. In addition, midwives working in this model have higher professionalism and they also have lower stress levels. Midwives believed they provided an excellent service to socially disadvantaged and vulnerable childbearing women. Midwives gained satisfaction from working in partnership with women, working across their full scope of practice, and making a difference to the women [31]. If it is associated with the situation in Indonesia, MGP is very appropriate. A research conducted by Wayuni in 2013 entitled "Bi Workload Analysis and the Village in Implementing Its

Authority in the Work Area of Gladak Pakem Health Center, Kabupaten Jember” concluded that the duties and functions of village midwives were increasing and from the results of the study showed that the level of subjective workload of village midwives was moderate, and the objective workload of village midwives was high [5] accordingly this MGP can be an option to ease the work of midwives. In this MGP service the midwife felt proud of her work because it can help patients who undergo the process of pregnancy, birth, and childbirth and is happy that mothers can make decisions for their own lives [32] This is in accordance with the midwifery philosophy of belief about ~~women~~ women empowerment and decision making. Women must be empowered to make decisions regarding their own health and their families through communication, information and education (IEC) and counseling. Decision making is a shared responsibility between women, families and caregivers.

C. *Mother's Perception in MGP Services*

Maternal perceptions in MGP services have been investigated that mothers are satisfied with MGP services because in MGP services midwives build deep relationships with mothers so that mothers feel supported by midwives they know. On the other hand the call systems that MGP uses make mothers satisfied [33]. It is very important in a health service to prioritize the satisfaction of the patients it serves, thus it proves that midwifery services are truly high quality. This is in accordance with the midwifery philosophy that midwives believe that each individual has the right to obtain safe and satisfying health services in accordance with the needs and differences in culture. Every individual has the right to self-determine and obtain sufficient information and to play a role in all aspects of health care [34]. In this MGP service midwife feels proud of his work because they can help patients to undergo the process of pregnancy, birth, and childbirth and is happy that mothers can make decisions for their own lives [35].

D. *Student perceptions about MGP*

Midwifery students practicing clinics use the Midwife group practice service model stating that communication is mandatory to mentors when practice is very important, this will improve the quality of their learning, increase self-confidence, collaboration and students can practice their skills independently and directly because students will meet the same mentor so that communication between students and mentors will continue and improve student knowledge and skills. In addition, in this model students are also required to provide assistance to the mother with continuity of care which is a service of midwives who have high quality, this is according to what one participant said, "I really enjoyed it because I had a good mentor that was very supportive towards me. Let's find out 'So I'm never worried about going to somebody. So the mentor supports was really, really important." Here, it was explained that students were very satisfied when the mentor she had in one team and still with the same mentor. Caseload midwifery is the right learning for students because students can practice their responsibilities as real midwives [27].

E. *Service model of Midwifery in Indonesia*

According to Minister of Health Regulation No. 28 of 2017 concerning the practice of midwives explained that midwives are midwives who work in primary health care, and usually have independent midwives practice when midwives give health services, namely women's reproductive services and family planning and Maternal and child health services including handling childbirth independently. Midwives do their duties according to midwifery philosophy which is to follow the entire life process of women in continuity of care and make many reports but it becomes a burden and makes the midwives get overworked. By making midwife team practices (MGP) where the midwife can working with fellow main midwives and complement their duties can ease the work of midwives and reduce stress levels in midwives [36].

There is a regulation supporting the formation of team services (MGP) in Indonesia. According to the Minister of Health of the Republic of Indonesia number 369 / MENKES / SK / III / 2007 which states that there are 3 types of services that can be carried out by midwives, one of which is collaboration and according to Permenkes number 28 of 2017 article 43 stated that midwives can ask another midwives if they cannot do their job. However, in this regulation there is no detailed mention of how the midwife's division of labor is detailed as in the caseload model theory. The caseload theory model explains that each team consisting of 4-6 midwives must provide care for 35 women per month with a target of delivery and the birth of 30 women per month, and midwives work 12 hours in 24 hours. Services at the primary healthcare have also implemented team division in midwifery services, but not in accordance with the caseload theory. Midwife services such as birth are still in accordance with the midwife's shift schedule whereas according to the caseload theory the birth service is still carried out by the patient's main midwife so that the patient reaches satisfaction because it is handled by the midwife who cared for her since pregnancy.

V. CONCLUSION

This Midwifery Group Practice (MGP) service model can be applied to achieve satisfaction of mothers, midwives and students. This service model is based on midwifery standards and philosophy and is able to improve the quality of life of the midwife herself. Given that the number and distribution of midwives in Indonesia is still lacking, an MGP service model is needed, in which the MGP service model can improve the life quality of midwives, reduce the workload of midwives and improve the quality of health services in Indonesia, especially in maternal care services. There are already regulations regarding the making of midwifery teams but have not detailed the rules according to the caseload theory such as how the shifting system is, the maximum number of patients handled by midwives and the rules about incorporating the continuity of care model into the team division. This allows the application of MGP caseload in Indonesia, but further efforts are needed to advocate for policy makers to make regulations on the caseload MGP model. MGP makes mothers and midwives feel comfortable with the health services, because they can

improve their quality of life by being able to replace co midwife who also know the patients. Consequently, the quality of service and patient satisfaction will increase. Thus MGP is good to be applied in Indonesia.

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REFERENCES

- [1] WHO. WHO Guidance for Measuring Maternal Mortality from a Census [Internet]. 2013. Available from: (www.who.int/about/licensing/copyright_form/en/index.html).
- [2] Health M of. Profil Kesehatan Indonesia Tahun 2016. 2017; Available from:<https://search.yahoo.com/search?fr=mcafee&type=E211US714G0&p=Profil+Kesehatan+Indon>
- [3] WHO. Global Strategy on Human Resources for Health:Workforce 2030. [Internet]. 2016. Available from: https://www.who.int/hrh/resources/pub_globstrathrh-2030/en/
- [4] Health M of. Rencana Pengembangan Tenaga Kesehatan Tahun 2011-2015 [Internet]. 2011. Available from: https://www.who.int/workforcealliance/countries/inidonesia_hrhplan_2011_2025.pdf
- [5] I. S Wahyuni E. Analisis Beban Kerja Bidan Desa dalam Melaksanakan Kewenangannya di Wilayah Kerja Puskesmas Gladak Pakem Kabupaten Jember. Digit Repos Univ Jember Copyr. 2013;
- [6] K. Sfregola G, Laganà AS, Granese R, Sfregola P, Lopinto A, Triolo O. Work load and management in the delivery room: changing the direction of healthcare policy. J Obstet Gynaecol (Lahore) [Internet]. 2016 Dec 7 [cited 2018 Dec 16];37(2):1–6. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/27924674>
- [7] Sekretariat G. Undang-Undang No.36 Tahun 2009 Tentang Kesehatan [Internet]. Jakarta; 2009. Available from: sireka.pom.go.id/requirement/UU-36-2009-Kesehatan.pdf
- [8] Health NM of. Midwifery Continuity of Carer Model Toolkit. 2012; Available from: www.health.nsw.gov.au
- [9] McAllister S, Coxon K, Murrells T, Sandall J. Healthcare professionals' attitudes, knowledge and self-efficacy levels regarding the use of self-hypnosis in childbirth: A prospective questionnaire survey. Midwifery [Internet]. 2017 Apr [cited 2018 Dec 17];47:8–14. Available from: <https://linkinghub.elsevier.com/retrieve/pii/S0266613817300852>
- [10] Tracy SK, Hartz DL, Tracy MB, Allen J, Forti A, Hall B, et al. Caseload midwifery care versus standard maternity care for women of any risk: M@NGO, a randomised controlled trial. Lancet [Internet]. 2013 Nov [cited 2018 Dec 28];382(9906):1723–32. Available from: <https://linkinghub.elsevier.com/retrieve/pii/S0140673613614063>
- [11] Lewis L, Hauck YL, Crichton C, Pemberton A, Spence M, Kelly G. An overview of the first “no exit” midwifery group practice in a tertiary maternity hospital in Western Australia: Outcomes, satisfaction and perceptions of care. Women and Birth [Internet]. 2016 Dec [cited 2018 Dec 17];29(6):494–502. Available from: <https://linkinghub.elsevier.com/retrieve/pii/S1871519216300208>
- [12] Hartz DL, Foureur M, Tracy SK. Australian caseload midwifery: The exception or the rule. Women and Birth [Internet]. 2012 Mar [cited 2018 Dec 16];25(1):39–46. Available from: <https://linkinghub.elsevier.com/retrieve/pii/S1871519211000035>
- [13] Allen J, Kildea S, Stapleton H. How does group antenatal care function within a caseload midwifery model? A critical ethnographic analysis. Midwifery [Internet]. 2015 May [cited 2018 Dec 16];31(5):489–97. Available from: <https://linkinghub.elsevier.com/retrieve/pii/S0266613815000303>
- [14] Teate A, Leap N, Rising SS, Homer CSE. Women's experiences of group antenatal care in Australia—the CenteringPregnancy Pilot Study. Midwifery [Internet]. 2011 Apr [cited 2018 Dec 17];27(2):138–45. Available from: <http://linkinghub.elsevier.com/retrieve/pii/S026661380900028X>
- [15] Everitt L, Reilly A, Murray N. Providing antenatal care to young mums in groups: Unexpected lessons. Women and Birth [Internet]. 2013 Oct [cited 2018 Dec 27];26:S28. Available from: <https://linkinghub.elsevier.com/retrieve/pii/S1871519213002837>
- [16] Bar-Zeev S, Barclay L, Kruske S, Kildea S. Factors affecting the quality of antenatal care provided to remote dwelling Aboriginal women in northern Australia. Midwifery [Internet]. 2014 Mar [cited 2018 Dec 17];30(3):289–96. Available from: <https://linkinghub.elsevier.com/retrieve/pii/S0266613813001277>
- [17] Williams K, Lago L, Lainchbury A, Eagar K. Mothers' views of caseload midwifery and the value of continuity of care at an Australian regional hospital. Midwifery [Internet]. 2010 Dec [cited 2018 Dec 17];26(6):615–21. Available from: <https://linkinghub.elsevier.com/retrieve/pii/S0266613809000126>
- [18] Tracy SK, Hartz DL, Tracy MB, Allen J, Forti A, Hall B, et al. Caseload midwifery care versus standard maternity care for women of any risk: M@NGO, a randomised controlled trial. Lancet [Internet]. 2013 Nov [cited 2018 Dec 17];382(9906):1723–32. Available from: <https://linkinghub.elsevier.com/retrieve/pii/S0140673613614063>
- [19] Beake S, Acosta L, Cooke P, McCourt C. Caseload midwifery in a multi-ethnic community: The women's experiences. Midwifery [Internet]. 2013 Aug [cited 2018 Dec 28];29(8):996–1002. Available from: <https://linkinghub.elsevier.com/retrieve/pii/S0266613813000119>
- [20] Fereday J, Collins C, Turnbull D, Pincombe J, Oster C. An evaluation of Midwifery Group Practice. Part II: women's satisfaction. Women Birth [Internet]. 2009 Mar [cited 2018 Dec 28];22(1):11–6. Available from: <https://linkinghub.elsevier.com/retrieve/pii/S1871519208000772>
- [21] Stuart J, Barnes J, Spiby H, Elbourne D. Understanding barriers to involving community midwives in identifying research participants; experience of the first steps randomised controlled trial. Midwifery [Internet]. 2015 Aug [cited 2018 Dec 17];31(8):779–86. Available from: <https://linkinghub.elsevier.com/retrieve/pii/S0266613815001266>
- [22] Fereday J, Oster C. Managing a work–life balance: the experiences of midwives working in a group practice setting. Midwifery [Internet]. 2010 Jun [cited 2018 Dec 28];26(3):311–8. Available from: <https://linkinghub.elsevier.com/retrieve/pii/S0266613808000600>
- [23] Hewitt L, Priddis H, Dahlen HG. What attributes do Australian midwifery leaders identify as essential to effectively manage a Midwifery Group Practice? Women and Birth [Internet]. 2018 Aug 24 [cited 2018 Dec 16]; Available from: <https://linkinghub.elsevier.com/retrieve/pii/S1871519218300143>
- [24] Kemp J, Sandall J. Normal birth, magical birth: the role of the 36-week birth talk in caseload midwifery practice. Midwifery [Internet]. 2010 Apr [cited 2018 Dec 17];26(2):211–21. Available from: <http://linkinghub.elsevier.com/retrieve/pii/S0266613808000636>
- [25] Straus L, McEwen A, Hussein FM. Somali women's experience of childbirth in the UK: Perspectives from Somali health workers. Midwifery [Internet]. 2009 Apr [cited 2018 Dec 17];25(2):181–6. Available from: <http://linkinghub.elsevier.com/retrieve/pii/S026661380700040X>

- [26] Papalia L, Atkinson J, Viljoen O, Butt J. Experiences of an extended midwifery group practice rotation for paid postgraduate midwifery students in a WA Tertiary Hospital. *Women and Birth* [Internet]. 2018 Oct [cited 2018 Dec 27];31:S42. Available from: <https://linkinghub.elsevier.com/retrieve/pii/S1871519218305584>
- [27] Rawnsdon S. A qualitative study exploring student midwives' experiences of carrying a caseload as part of their midwifery education in England. *Midwifery* [Internet]. 2011 Dec [cited 2018 Dec 17];27(6):786–92. Available from: <https://linkinghub.elsevier.com/retrieve/pii/S026661381000118X>
- [28] West R, Gamble J, Kelly J, Milne T, Duffy E, Sidebotham M. Culturally capable and culturally safe: Caseload care for Indigenous women by Indigenous midwifery students. *Women and Birth* [Internet]. 2016 Dec [cited 2018 Dec 17];29(6):524–30. Available from: <https://linkinghub.elsevier.com/retrieve/pii/S1871519216300257>
- [29] Brintworth K, Sandall J. What makes a successful home birth service: An examination of the influential elements by review of one service. *Midwifery* [Internet]. 2013 Jun [cited 2018 Dec 17];29(6):713–21. Available from: <https://linkinghub.elsevier.com/retrieve/pii/S0266613812001167>
- [30] Hartz DL, Foureur M, Tracy SK. Australian caseload midwifery: The exception or the rule. *Women and Birth* [Internet]. 2012 Mar [cited 2018 Dec 28];25(1):39–46. Available from: <https://linkinghub.elsevier.com/retrieve/pii/S1871519211000035>
- [31] Menke J, Fenwick J, Gamble J, Brittain H, Creedy DK. Midwives' perceptions of organisational structures and processes influencing their ability to provide caseload care to socially disadvantaged and vulnerable women. *Midwifery* [Internet]. 2014 Oct [cited 2018 Dec 28];30(10):1096–103. Available from: <https://linkinghub.elsevier.com/retrieve/pii/S0266613813003628>
- [32] Jepsen I, Mark E, Nøhr EA, Foureur M, Sørensen EE. A qualitative study of how caseload midwifery is constituted and experienced by Danish midwives. *Midwifery* [Internet]. 2016 May [cited 2018 Dec 16];36:61–9. Available from: <https://linkinghub.elsevier.com/retrieve/pii/S0266613816300043>
- [33] Fereday J, Collins C, Turnbull D, Pincombe J, Oster C. An evaluation of Midwifery Group Practice. *Women and Birth* [Internet]. 2009 Mar [cited 2018 Dec 27];22(1):11–6. Available from: <https://linkinghub.elsevier.com/retrieve/pii/S1871519208000772>
- [34] IBI. *Filosofi Kami*. 2016;
- [35] Jepsen I, Juul S, Foureur M, Sørensen EE, Nøhr EA. Is caseload midwifery a healthy work-form? – A survey of burnout among midwives in Denmark. *Sex Reprod Healthc* [Internet]. 2017 Mar [cited 2018 Dec 16];11:102–6. Available from: <https://linkinghub.elsevier.com/retrieve/pii/S1877575616301318>
- [36] Ministry of health. *Nomor 28 Tahun 2017 Tentang Izin dan Penyelenggaraan Praktik Bidan*. 2017;
- [37] Ministry of Health. *Nomor 369/MENKES/SK/II/2007. Tentang Standar Profesi Bidan*. 2007; Available from: www.pdpersi.co.id/peraturan/kepmenkes/kmk3692007.pdf