HEALTH DIVISION DOCUMENT 1998:2

Issue Paper on

Supporting Midwifery

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Sida

SWEDISH INTERNATIONAL DEVELOPMENT
COOPERATION AGENCY

Department for Democracy and
Social Development
Health Division

Sida's Health Division has during the period 1996–97 elaborated three policy documents.
These include;
– A Position Paper on Population, Development and Cooperation
– A Policy for The Health Sector
– A Strategy for Sexual and Reproductive Health and Rights

It was during this process that Sida commissioned a series of Swedish experts to formulate Issue Papers on specific areas as a basis for policy discussions. Considering that these papers are of interest to a wider audience the Health Division has now decided to publish some of them.

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Health Division Document 1998:2
Commissioned by Sida, Department for Democracy and Social Development, Health Division

Written in 1997
Printed in Stockholm, Sweden, 1998
ISSN 1403-5545

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Objectives

This document aims to describe the role of the nurse-midwife in reproductive health care, especially in less developed countries, as a basis for further development of Swedish health care co-operation in the area of reproductive health.

Reproductive health care and the role of professionals

Traditional birth attendants

Few women give birth totally alone. When a trained midwife is not at hand, some other person - usually another woman - helps during childbirth. In many cultures, this help is given by certain experienced women. These women, who bear a tradition as old as humanity, are internationally labelled "traditional birth attendants" or TBAs. Commonly illiterate, often with many previous births of their own, and sometimes belonging to a family line of TBAs, these women share the values of the local community and may have a certain social prestige. Prescribing certain treatment or behaviour during pregnancy and giving emotional support during childbirth are inherent parts of the work of many TBAs.

In many impoverished countries, training programs directed at TBAs have been carried out, aiming to make home births safer. Such programs vary greatly in content and outcome, but must be built on dialogue rather than formal teaching the - TBA is, after all, a person of prestige and social experience. TBAs also have a large potential in the area of health promotion. The health care system could often get inspiration from some of the attitudes of TBAs, considering the alienation, isolation and division frequently seen in institutionalised birthing care today.

Well organised, culturally acceptable TBA training programs have positive effects mainly on the survival and health of the new-borns. Maternal deaths are not easily reduced by such programs. For this purpose, TBA training programs are much less cost-effective than training midwives, organising birthing care in health centres, or small hospitals.

In summary, even though TBAs have an important role, maternal death rates can only be reduced if more births take place with the help of medically trained staff. The question is how to attain positive birth-help traditions in institutions, avoiding unnecessary medicalisation of childbirth.

Midwives

Definition of midwife

"Midwife" has been defined by the International Confederation of Midwifery and the Federation of Obstetricians and Gyneologists (FIGO)."A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired

the requisite qualifications to be registered and/or legally licensed to practice midwifery.

"She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility, and to care for the new-born and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the women, but also within the family and the community. The work should involve ante natal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She may practice in hospitals, clinics, health units, domiciliary conditions or in any other service."

This definition has been endorsed by the World Health Organisation (WHO).

Role of midwives

Trained midwives are the backbone of modern ante natal and birthing care. Some countries recognised the need to train midwives quite late, but today practically all countries of the world have midwifery education.

It has been shown in developed countries that the development of national midwifery coverage has often been the single most important measure in reducing maternal mortality. This is true for Sweden, for example. After a few centuries of slow development of midwifery programs, the active coverage of the whole country with midwifery services in 1850-1890 reduced maternal mortality more than any other factor in Swedish history (1).

Many studies in both poor and rich countries have provided clear scientific evidence of the important role of the midwife in the prevention of maternal and neonatal deaths as well as health benefits of having professional midwives as care-givers during childbirth (2). Having a person especially trained to assist and support birth makes the birth process safer and more satisfactory, all over the world. Simple basic equipment and minimum resources are evidently also necessary to achieve this result.

Key concepts describing the role of the midwife are appropriateness and coverage. Appropriateness can be said to mean having the correct background in education and training and being oriented toward the right goals. The classical task of the midwife is to protect the normal process of birth, avoiding harmful interventions but being prepared to intervene when necessary. Interestingly, the word "obstetric" is derived from the Greek "obstetros" which means waiting, standing aside. The word was used for midwives already in ancient Greece.

It must be recognised that medical doctors have a different perspective in their basic education: diagnosis and treatment of disease. Birthing care systems with few midwives but many doctors tend to have high surgical intervention rates (3). Also, medical doctors are much more expensive to educate and employ than midwives, and therefore are not cost effective for normal birthing care, especially in poor countries. Appropriate also may mean culturally appropriate. Many midwives have a cultural background that is similar to what the average citizen has (4), and many midwifery curricula include social issues.

Achieving health service coverage throughout a country, particularly in rural areas, is easier to achieve if people from the periphery are given access to education in health. Urban origin and advanced medical education predisposes to city dwelling.

Midwifery education

Substantial differences are seen in midwifery training in different countries, both as regards minimum entry requirements and as regards the duration, objectives and quality of the contents (5).

The educational entry requirements to midwifery training may vary between 4 years of primary school and full secondary school, and even university level education. Typical requirements are 8-9 years of schooling. The quality of the primary education will also determine the attainable objectives of the midwifery education.

In principle there are two different types of midwifery education. Either the student studies general nursing - and qualifies as a registered nurse - or she is solely qualified as a midwife. Many developed countries have a combination of these systems, i.e. midwifery education is not preceded by qualification as a nurse but actually has such a demanding curriculum that the qualified midwife has good training in nursing anyway.

The duration of midwifery education/training varies from one to three years, depending on entry requirements, objectives and quality of education. A fundamental component is theoretical education in obstetrics/birthing care, as well as practical training in this area. Some countries have several levels of midwifery education, and sometimes it is combined with education in child health/paediatrics ("maternal and child health nurse"). Similarly, the curriculum may contain varying amounts of education in contraception, sexually transmitted diseases, immunisation, health education, communication skills, administration, etc. In general, the focus is on pregnancy and birthing care, and contraceptive and gynaecological components are given less priority. In a few countries like India, however, the opposite occurs, and family planning programs drain birthing care of midwives.

As for other exclusive health care training, midwifery training does not work well when organised in cities. Invariably the students' attitudes will be influenced by the health care perspectives of the city, and of their urban-based teachers. It is quite difficult to demonstrate in practice how a certain complication is handled at rural health center level, since the routines of the big urban hospital are totally different. Examples are incubator care versus the "kangaroo method," Caesarean versus symphysiotomy, and in manual abdominal examination versus ultrasound. Schools where some of the teachers and students themselves come from rural areas can bridge this dilemma, and a proper period of field training in the periphery is also helpful. However, in most parts of the world, students of urban origin will have difficulty in adapting to and remaining in the countryside.

The quality of midwifery education depends largely on local pedagogic traditions, on the economic resources allocated to midwifery education, and on the professional role of the midwives of that country. Pedagogic technique varies widely from the participatory/interactive/liberating kind to theoretical "stuffing," that is, uncritical memorising of irrelevant detail. The degree of linkage

between theory and practice also varies greatly. At its worst, the education of midwives can consist of a meaningless theoretical component without training in how to independently assist at delivery. At its best, the newly qualified midwife is well prepared to solve practical problems in reproductive health care independently, as well as being culturally competent.

The education of midwives is often given low priority compared to other, more prestigious, types of medical education, particularly the much more expensive education of doctors. Because of this, midwifery education is at times supported directly by international organisations.

The actual professional responsibility of midwives in a country influences the contents of local midwifery training curricula, both in teaching and in practice, i.e. what the student sees qualified midwives perform. Examples of skills that may or may not be taught are vaginal examinations, suturing of vaginal lesions after delivery, and insertion of intrauterine devices. Only doctors are allowed to do such things in many countries. Even such simple responsibilities as following the normal progress of labour by use of a graph (partogram) is sometimes a task unnecessarily reserved for doctors, dangerously depriving midwives of access to such fundamental and simple technology. Again the dilemma mentioned above is encountered: the midwife in the periphery may require experience in procedures that are never performed by midwives at an urban training center.

Several countries, like Uganda, Ghana and Nigeria, have emphasised training of midwives in obstetric "life-saving skills," including them in both basic midwifery education and continuing education of trained midwives. This gives midwives both the competence and authorisation to perform such tasks in obstetric emergency situations, and markedly improves the quality of their practice.

Professional responsibilities of midwives

The tasks that a qualified midwife may perform vary greatly. One could say that midwives work more independently the more peripherally they are located. When there is no doctor available to perform a certain procedure, the midwife is often the natural choice. Practical experience gathered in this way has gradually resulted in wise and knowledgeable midwives in many parts of the world, and such midwives prove not only that certain "doctors only" procedures - such as vacuum extraction, and management of eclampsia or asphyxia - can be performed by other staff, but also that new qualities of care may develop.

In some countries qualified midwives are not allowed to perform vaginal examinations, assist at childbirth, insert IUDs or independently handle ante natal visits. In such countries midwives function primarily as doctor's assistants. International experience shows that this results in making poor use of the midwife. Countries of all types benefit from independent midwives (6,7).

What a midwife may do as a professional is also linked to the social status of midwives in that particular society. In some regions the profession is of low social standing and even despised. This may be related to the social position of women in that region. For instance, if women are not allowed to express themselves in public meetings or to appear in public, a female birth assistant may also be of low social standing.

Today the role of the midwife is threatened in some parts of the world. In a few countries midwifery is not even legal. The trend towards privatisation of medicine, with less money going to subsidised public health care networks, often steers resources away from midwives and towards private practitioners in obstetrics and gynaecology (that is, doctors) (8). Privatisation also leads to urban concentration of health care, making access to ante natal and delivery care in rural areas more difficult. Low wages for midwives is a problem in many regions, at times contributing to gradual loss of midwives, especially in rural areas. Despite these low wages, midwives do have a clear and indisputable role in many countries. Most African countries, Sri Lanka, the Philippines and Malaysia belong to this group. Midwifery education, further development of the professional role of midwives, and continuing education are ensured in such countries.

Globally, the role of the midwife must be considered as undervalued, considering her large potential for improving reproductive health. The key question then is why do we need midwives, and not only doctors? Is it really important to support midwifery services? While the need for doctors is beyond dispute, the role of the midwife is not self-evident to all decision-makers. Poor countries still get new doctors while no midwives are available. Poor countries still ask support for new academic chairs in obstetrics and gynaecology while midwifery schools are being closed. It is therefore essential to clearly define the reasons for supporting the existence and development of midwifery services. These are summarised below.

Why midwives and not only doctors?

- the midwife is trained for normal pregnancy and birth, and managing life threatening complications, to defend normal life processes, and has a health-promoting basic training
- midwifery systems can achieve better national coverage easier than doctors (who tend to concentrate in urban centres)
- usually, being a woman, it is often easier for a midwife to empathetically identify with the birthing woman
- the midwife has a training that is less costly than a long medical education. Midwives and nurses are better at performing commonplace, unsophisticated and unglamorous routine work..

The midwife and the chain of perinatal care

In the areas of ante natal care, birthing care, and care of new-borns, positive health effects are determined by co-operation in the chain from population - TBA - health post - district hospital - referral hospital. The confidence of the population in this chain will determine the usage of ante natal care and birthing care.

If for instance a woman with prolonged, complicated labour is assisted by the local TBA to reach the local midwife who in turn refers her to the closest hospital, and a Caesarean section is successfully carried out, this will increase the confidence of the population in TBAs, midwives and hospital care. (This may even be the main advantage of obstetric referral centres from a public health point of view: to increase people's confidence in peripheral health care). As communication problems are so great in many developing countries, this referral chain will be very vulnerable as will the co-operation within the chain. The woman may not reach hospital because of transport problems or she may not be operated on be-

cause of mismanagement. Or, even if the operation is performed, the local midwife may not get feed-back about the result and any follow up care required. Similar "care chains" - even though not always so life-threatening - also exist in contraceptive care and in the handling of sexually transmitted diseases.

The challenge of maintaining a continuous dialogue between the different levels of medical care is decisive for the final outcome as regards saved lives and prevented illness. Unhappily, this dialogue is often lacking, and the levels of care remain isolated from each other. Midwives are very important links in this chain, and physicians have a great responsibility in maintaining the function of the chain. Supervision as well as continuous education are therefore prerequisites for a well functioning obstetric chain. Many of the world's midwives lack such support, and the quality of care decreases due to years of professional isolation.

Teamwork between midwives and doctors
Good results in reproductive health care demand teamwork. Without physicians, the system does not function. Maternal health care will be of lower quality, as referral institutions will be lacking and continuous education of staff difficult, and thus credibility will be lost.

In strengthening the role of the midwife globally, attention must be given to the potential professional conflict or competition between midwives and doctors. Only with teamwork and co-operation can this conflict can be counteracted, to the benefit of reproductive health in the world. Swedish efforts in this field may set an example.

Co-operation between midwife and TBA
While the midwife regularly co-operates "upward" in the hierarchy of health care, i.e., with doctors and hospitals, there is also a co-operation "downwards" with TBAs. Practical experience from many countries shows that a continuous dialogue with local TBAs leads to safer routines for home births. The health care staff that should maintain this dialogue are midwives. Support to these local midwives is important if they are to be able to handle outreach activity in addition to their usual tasks in their own area of work.

Co-operation between the midwife and the community
Maintaining links with the local community is important in many ways for a midwife in the periphery. A dialogue with women's groups, local decision makers, teachers and adolescents is important in the local health promotion work. The local midwife can directly observe the health of women, babies and adolescents, and reproductive health in general, and communicate about this to the community's decision makers.

Swedish support to midwifery in other countries

Sweden has for many years supported midwifery internationally. This support has been channelled to Swedish bilateral co-operating countries through NGOs, international organisations, and Swedish academic institutions, International Child Health Unit, ICH, at Akademiska Hospital in Uppsala and Division of In-

ternational Health Care Research, IHCAR, at Karolinska Institutet, in Stockholm. No recent overview of this support is available. Some examples may be mentioned however:

Sida has supported midwifery education in Zambia for many years. This support ended about 10 years ago but SAREC-supported research in this field in Zambia continues. Sida continues its long-term commitment to midwifery education in Ethiopia, both directly and through UNFPA. Sida support to midwifery training and maternal health care development in Angola is both direct and channelled through Swedish NGOs, including Rädda Barnen, the Red Cross, the Africa Groups and many religious organisations.

SIDA has been the single largest donor in this area to UNICEF, and also supports several special WHO programs (Human Reproduction Program, Special Program on AIDS, Expanded Program of Immunisation, Reproductive Health Technical Support), UNFPA, International Planned Parenthood Federation, and the World Bank. All these programs contain present or potential aspects of sexual and reproductive health where the role of midwives is important.

In summary, even though there is no complete picture, Sweden has many important and broad international contacts in which the role of the midwife can be promoted, to improve sexual and reproductive health globally.

Giving emphasis to midwifery – international experiences

Globally, a very varied situation exists as regards midwifery, from rich and poor countries where midwives have a well-defined and important professional role, to rich and poor countries where midwives hardly exist. The USA and Canada belong to the latter group. The USA has around 5000 certified midwives, and in Canada midwives were until recently illegal. In such countries, contraceptive care, ante natal care, and birthing care are handled mainly by doctors. Similar patterns are seen in large parts of Latin America, for instance in Cuba and in Nicaragua. It appears that the midwife is even losing ground in Latin America through doctor-oriented privatisation, causing unemployment to increase among midwives.

The international professional association, International Confederation of Midwives, ICM, has for many years worked to strengthen the role of midwives. Until the 1980s, very little was been done outside ICM to improve midwifery care globally. In 1983, the World Health Assembly pronounced the need for stronger national and international support to midwifery (9). In 1987, The Nairobi conference on Safe Motherhood appears to have been a turning point (10). Since then, WHO and UNICEF have taken a more active role in supporting midwifery (11). All organisations involved in the Safe Motherhood Initiative and the Baby Friendly Hospital Initiative support the development of midwifery care, and ICM takes part in all discussions on this issue. A series of concrete initiatives have also been taken during recent years, but progress is still slow. In 1989, WHO expressed its concern over the slow rate of strengthening of nursing/midwifery in many countries of the world, pronouncing that this is an important obstacle to Health for All. There is simply too little attention being given to this question by many governments (12), (13).

Conclusions

In reproductive health care, midwives are necessary. In the less developed world their work is often directly life-saving. Unhappily, the role of the midwife in many parts of the world is not officially promoted, or is even threatened, and this has serious implications for the health of mothers and children.

Sweden has important practical experiences in the field of reproductive health. Among these experiences is a high degree of teamwork between well-trained nurse-midwives and obstetricians. In this teamwork, midwives have an independent professional role. The midwife has proven not only to be well qualified to perform many tasks that in other countries are reserved for physicians, but also to add new, health-promoting qualities.

Activities for promoting the role of the midwife:

- strengthen midwifery education, in service training and upgrading, the supervision of midwives and midwives' collaboration with doctors
- support midwifery education curriculum development and teachers education
- support the development of adequate legislation regulations for midwives
- support international collaboration and education of midwives
- stress the importance of involving midwives in STD/HIV/AIDS prevention programs, sexuality and gender education and contraception
- stress the need to give priority to the gradual development of midwifery education programs nationally, and regionally
- influence multilateral organisations to explicitly include midwives in development programs whenever applicable.
- support midwifery research

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