International Day of the Midwife 5 May

The global movement to strengthen midwifery services: One Midwife's views

By Jenny Kerrison D.Ed, Registered Midwife and Rotarian from Australia

Introduction

It is every woman's right that she receives quality health care services (United Nations Population Fund, 2011) so that *"…every pregnancy is wanted, every birth is safe and every newborn is healthy."* [italics in original] (Women Deliver Conference, 2010). Today, in developing countries, maternal and child mortalities remain high (Bhutta et al., 2010; United Nations Population Fund, 2011). In most developing countries, the lack of skilled birth attendants is linked to the higher risk for maternal deaths (Carlough & McCall, 2005; United Nations Population Fund, 2011). Within this context, the United Nations Population Fund (2011) and global partners in the document *State of the World's Midwifery. Deliverying Health, Saving Lives* have urged the World to address the need for quality midwifery services for all women. This is one of many strategies to achieve MDGs 4 and 5 by 2015.

The global call for help is a challenge for all Rotarians to save the lives of hundreds of women, unborn children and newborns through for example, supporting the Rotary Action Group for Population Growth and Sustainable Development (RFPD) project on maternal and child health (http://www.maternal-health.org/).

On the International Day of Midwives, as a Midwife since 1980, I wish to share with you my observations of how Midwives contribute toward achieving the Millennium Development Goals (MDGs) 4 and 5. The barriers to effective midwifery practice will also be discussed. The environment within which Midwives function is critical to the Midwives' success or failure in efforts to achieve the MDGs. An enabling environment with a well-functioning health system will ensure that Midwives are indeed, able to save lives. On the other hand, a weak health system can render Midwives ineffective and further violates the rights of women and midwives; and severely compromises the midwifery profession.

Definition of a Midwife

A Midwife is defined

> …as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility, and to provide care for the newborn and infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures. (International Confederation of Midwives, 2011, p.2)

Health surveillance, promotion and treatment are key categories of tasks undertaken by Midwives. Referral of mother and child for medical care that are beyond the Midwives' scope of practice is an equally important task. The International

Confederation of Midwives (ICM) (2011) asserts that counselling and education on health for the woman and her family, including the community are important tasks for the midwife.

Midwives as Skilled Birth Attendants

The World Health Organisation (2004 cited in World Health Organisation, 2008) refers to a skilled health worker as a health professional who is accredited. Examples of a health professional include: a midwife, doctor or nurse with skills proficiency in the management of normal pregnancies, delivery and care of women and child in the immediate postnatal period. In addition, the health professional is required to identify, manage and refer women and newborn with complications. Traditional Birth Attendants (TBAs), including trained TBAs are not considered as skilled birth attendants (Carlough & McCall, 2005).

The universal use of skilled birth attendants is critical to reducing maternal mortality and is a cost-effective approach to reducing newborn mortality (Adam et al. 2005 cited in Darmstadt et al., 2008). As emphasised by World Health Organisation (2008) "…ensuring that all births are attended by a skilled health worker is a key strategy to reduce maternal deaths." By 2015, the global target for births delivered by skilled attendants is 90 percent (United Nations 1999 cited in World Health Organisation, 2008).

Table 1: Key functions for a Skilled Birth Attendant (Carlough & McCall, 2005, p. 201)

A skilled attendant should be able to perform the following signal functions:

1. Safely conduct a normal delivery using aseptic technique
2. Active management of the third stage of labor
3. Provide immediate care of the newborn, including resuscitation
4. Manage most postpartum hemorrhage through use of parenteral oxytocics and abdominal massage
5. Manually remove the placenta
6. Manage eclampsia through provision of parenteral antihypertensives
7. Recognize and manage postpartum infection through use of parenteral antibiotics
8. Perform assisted vaginal delivery through the use of a vacuum extractor[1]
9. Manage incomplete abortions with manual vacuum aspiration (MVA)
10. Know how to refer women to the next level of care and stabilize them for their journey

The list of key functions of a skilled birth attendant (Table 1) is relevant to Midwifery practice. Midwives provide normal delivery care and care of the newborn. Also, during emergencies, midwives can undertake early identification and referral of women with obstetric emergencies. Midwives can also undertake obstetric first aid such as commencement of intravenous fluids; manual removal of placenta; administration of antibiotics; and cardio-pulmonary resuscitation (CPR) if needed. I worked in Indonesia, a developing country, for eight years between 1996 and 2008 and have observed how Midwives are able to provide obstetric first aid at the village and sub-district levels. Delays in identifying and referring women to appropriate health care facilities have been noted to contribute to maternal deaths in Indonesia (IDHS 2007). This management is important, prior to transporting women to tertiary level facilities for basic and comprehensive emergency obstetric care (EmOC) for interventions such as vacuum extraction and Caesarean Section.

Midwives and the MDGs 4 and 5

The MDG 4 is to reduce child mortality by two-thirds of under-five year olds between 1990 and 2015. The three indicators are: under-five mortality rate; infant mortality rate; and proportion of one year-old children immunized against measles (World Health Organisation, 2012). In Indonesia, midwives have the extended role that includes child health surveillance, health promotion and treatment for newborns to children under five years of age. In Indonesia, it is recognised that the newborn (in the first 28 days following birth) and maternal mortalities are high in the immediate postpartum period (IDHS, 2007). The initiation of breastfeeding and supporting women to exclusively breastfeed for six months and more, are important responsibilities for the Midwife. Logistically, in developing countries such as Indonesia, Midwives can and do play a vital role in helping achieve MDG 4.

Maternal health is the focus of the MDG 5. The World is challenged to improve maternal health by reducing maternal mortality ratios by three-quarters between 1990 and 2015. There are six indicators for this MDG and these are: maternal mortality ratio; births by skilled health personnel; contraceptive prevalence rate; antenatal care coverage; and unmet need for family planning (World Health Organisation, 2012). Midwives can be trained to develop competencies that include: commencement of intravenous therapy; vacuum extraction delivery; manual removal of placenta and perineal repairs for episiotomy and vaginal tears. These additional lifesaving skills are performed by midwives in circumstances to improve outcomes for mothers and babies (International Confederation of Midwives, 2011). As observed in West Timor, Indonesia, Midwives based at the sub-district Health Centres do undertake these lifesaving skills and many are performed successfully. Family planning is another important task for Midwives in developing countries, as noted in the Indonesian health system. Midwives in Indonesia are trained to provide education on family planning and importantly, they also provide clinical services such as insertions of Implanon and Intrauterine Devices (IUD).

An important role relegated to Midwives is the task of tracking the MDGs indicators, as noted in Indonesia. This administrative role may be important but it does compete with other important tasks that the Midwives need to undertake.

Barriers to Midwifery practice

Without more competent Midwives; women, newborns and children under five years of age will continue to die from preventable causes. In reference to Maternal and Child Health Workers (MCHWs) in Nepal and relevant to the Midwifery profession, Carlough & McCall (2005) assert that "…competency alone will not necessarily improve the situation. To affect maternal mortality in Nepal, MCHWs must be widely available, they must be allowed to do what they are trained to do, and they must have logistical and policy support."

In developing countries, poverty, lack of education for women, gender inequality, lack of health human resources, and lack of quality health services systems are major contributing factors to the high, preventable deaths of mothers and newborns. Distance to health services and costs of medical care are reasons for the delays to seeking health care (IDHS 2007). In addition, as observed in parts of Indonesia, the Midwifery profession experiences the following barriers: lack quality education and training; lack of continuing professional education; and lack of supervision in the workplace. In Indonesia, Midwives is the most abundant and cost-effective option to

providing surveillance and clinical services; and are in a position to support achievement of the MDGs 4 and 5. Some of the key barriers for skilled birth attendants that are also experienced by Midwives (as observed in Indonesia) are displayed in Table 2 below.

Table 2: Key barriers to effective practice by Skilled Birth Attendants (Carlough & McCall, 2005, p. 205)

- Little support for skilled birth attendants at the family/community level
- Lack of transportation resources, emergency funds and unclear referral systems at the community level
- Cultural and financial barriers to seeking obstetric services at all levels
- Lack of quantity and quality of facilities providing basic and comprehensive EmOC
- Supervisors or managers who obstruct in various ways, including controlling access to essential medications and equipment
- National policies which preclude health workers at all levels from performing tasks they are qualified and expected to perform.

NB: EmOC = basic and comprehensive emergency obstetric care

Conclusion

Whilst the Midwifery profession takes centre stage in the global emphasis to achieve the MDGs 4 and 5, care needs to be taken to ensure that barriers within a resource-poor environment that prevent Midwives from functioning effectively are addressed. It is important that the midwifery profession is not compromised and midwives placed under unreasonable stress, to bear the tyranny of professional obligations. It is simply not appropriate. Midwives cannot function effectively without an enabling environment provided by a well-functioning health system.

Jenny's brief CV

I graduated as a Midwife in England, in 1979 and remained a practising Midwife today. In 2001 I completed a Doctor of Education degree and completed a research thesis in the field of program evaluation. Currently, I am undertaking a PhD study on pregnant teenagers and their needs from socio-ecological determinants of health framework. My love for midwifery began when working in international development projects in maternal and child health in West Timor. I worked there for eight years between 1996 and 2008. Since 2010, I spent four weeks each year as a volunteer in a part-charity hospital in rural Bangladesh. Over the years, I have seen how Midwives can save lives in Indonesia and Bangladesh. In Australia where I live, we often underestimate the important role of Midwives and erode the profession through replacing midwives with Enrolled Nurses and Nursing Assistants.

References:

Bhutta, Z. A., Chopra, M., Axelson, H., Berman, P., Boerma, T., Bryce, J., . . . Wardlaw, T. (2010). Countdown to 2015 decade report (2000–10): taking stock of maternal, newborn, and child survival. *The Lancet*, *375*, 13.

Carlough, M., & McCall, T., M. (2005). Skilled birth attendance: What does it mean and how can it be measured? A clinical skills assessment of maternal and child health workers in Nepal. *International Journal of Gynecology and Obstetrics, 89*, 9.

Darmstadt, G. L., Walker, N., Lawn, J. E., Bhutta, Z. A., Haws, R. A., & Cousens, S. (2008). Saving newborn lives in Asia and Africa: cost and impact of phased scale-up of interventions within the continuum of care. *Health Policy and Planning 23*, 101–117. doi: 10.1093/heapol/czn001

IDHS. (2007). *Indonesia Demographic and Health Survey*. Jakarta: The Government of Indonesia.

United Nations Population Fund. (2011). The State of the World's Midwifery. Deliverying Health, Saving Lives. New York: UNFPA.

Women Deliver Conference. (2010). *A global call to action: strengthen midwifery to save lives and promote health of women and newborns*. Paper presented at the Women Deliver Conference in Washington DC, Washington DC.

World Health Organisation. (2008). Proportion of births attended by a skilled health worker 2008 updates. In W. H. Organisation (Ed.), *Factsheet*. Geneva: Department of Reproductive Health and Research.

World Health Organisation. (2012). The Partnership for Maternal, Newborn and Child Health Retrieved 4 May, 2012, from http://www.who.int/pmnch/about/about_mdgs/en/index.html