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LESSONS FROM THE INTERNATIONAL EXPERIENCE OF COMMUNITY MIDWIVES

The Challenge: Reducing Maternal Deaths

An estimated 530,000 women die worldwide each year from pregnancy and childbirth complications. 90% of these maternal deaths are in South Asia and Sub-Saharan Africa[1] and another 10% develop chronic complications from poor birthing practices.[2] Although most of these deaths and disabilities can be prevented by skilled birth attendance (SBA) - either by skilled professionals or in health facilities[3], half of all women still give birth without SBA, due to social norms or lack of access[4].

There are 22 countries where maternal and neonatal mortality and morbidity are extremely high: Bangladesh, Bolivia, Burkina Faso, Cambodia, Guatemala, Haiti, India, Indonesia, Jordan, Kenya, Malawi, Mexico, Morocco, Mozambique, Nepal, Niger, **Pakistan**, Sudan, Tanzania, Tunisia, Yemen and Zimbabwe.[5] In order to increase SBA, training and deployment of community midwives in impoverished communities has been proposed as a possible solution. This Policy Brief reviews various international CMW programs in terms of community uptake, reductions in maternal mortality, and factors that predict success.

Historical Background

The World Bank estimates that maternal deaths would decrease by 75% skilled and emergency obstetric care and referral interventions were available to all women[6]. Consistent with this the first ever International Forum on "Midwifery in the Community" held in Tunisia (2006), proposed that all countries with high MMR strengthen and scale up midwifery programs. It stated that strategic decision making in training, deployment and retention of CMWs to provide much needed SBA and quality birthing services in the communities is essential to improving maternal and neonatal health outcomes.

Lessons from Successful CMW Programs

Sri Lanka and **Malaysia** are two countries that have successfully implemented nationwide CMWs program to deliver a wider package of healthcare in the communities.

Lessons learnt from International experience

Countries like Argentina, Chile, Malaysia, Sri Lanka, Thailand, Tunisia, Democratic Republic of Congo and Zimbabwe have successfully reduced their Maternal Mortality Rates by using Midwives. A review of their strategies showed the existence of the following pattern:

1) **High Quality Training** - Training young, inexperienced girls in a poor quality midwifery program, and deploying them into communities without adequate supervision or referral mechanism does not save lives as seen in case studies from Indonesia and Sudan.

2) **Diluting the Effect** – Using CMWs as multi-purpose workers, without sufficient recognition in the communities of their primary responsibility leads to ineffectiveness of their services.

3) **Market Sustained Models –** without good business models of how CMWs can and will sustain themselves in the community, most countries have been unable to expand beyond the initial CMW deployment.

4) **Sustained and successful programs require decades of commitment** by the government – both political and programmatic – leadership.

SALIENT POINTS

- Only 57 percent of births in low income countries and less than 1/3 births in very low-income counties take place with skilled attendants.
- Successful CMW programs can be cost-effective, low-technology, high quality and sustained solutions to achieving safe motherhood and newborn survival.
- Midwives play an important role in addressing the first two of the "three delays" .They also contribute to reducing the third delay by providing high quality midwifery care.
- CMW are a temporary mechanism as communities transition from TBA to CMW to facilities
- Successful public sector programs require sustained political commitment that is maintained despite changes in political or programmatic leadership

SUCCESSFUL STRATEGIES THAT REDUCE IN MATERNAL MORTALITY

Strategy 1: Taking a sustained public health approach	•Countries with low MMR made maternal mortality a national public health issue
Strategy 2: Collaboration between midwives and obstetricians	• A strong collaboration between both led to better results in terms of safer pregnancies
Stratgy 3: Professionalize midwifery and phased movement to institutional births	•Investment in the quality and number of midwives, making midwifery respectable and attractive as a profession by regulating entry and practice. These were all done by Malaysia, Sri Lanka and Thailand
Strategy 4: Political and civil society support	•Support from politicians, the civil soceity, national leaders, opinion makers and the media helps lower MMR
Strategy 5: Working in partnership with traditional birth attendants and refocusing their role	•Reposition the role of TBAs while introducing professional midwives without criminalizing the TBAs

SRI LANKA

- There are two categories of midwives in Sri Lanka: Institutional Midwives (IM) who are specially trained to work in Health Facilities and Public health midwives(PHM) who are trained for different tasks at the community level.
- PHMs conduct home delivery when required and can provide some emergency care. Where additional help is needed, PHMs arrange for the immediate transfer of the mother to the hospital.
- Hospital deliveries are encouraged due to the distances for transfer from home and about 98 percent of deliveries take place in institutions.
- As a result of these policies, which first began to be implemented in the 1930s, traditional birth attendants who were accepted locally because they were available and affordable have been replaced by highly skilled PHMs and IMs and health care is free at the point of delivery. The community has embraced this transition, which has helped to reduce maternal mortality in Sri Lanka.
- Health care at the point of delivery is free and the government ensures that services are available at facilities

MALAYSIA[6]

- Between 1949 and 1995, Skilled Birth Attendance in Malaysia increased from 30% to 90%. This increase occurred in 3 phases.
- During the initial phase, legislation was passed to professionalize midwifery, requiring trained midwives to obtain certification and register. Alongside this the development of a large network of urban Maternal and Child Health (MCH) clinics took place, ensuring employment
- The second phase was characterized by the rapid establishment of rural health services: 1,280 new midwifery clinics were built,
- While encouraging deliveries at midwifery clinics, midwives also attended most rural home births. To facilitate community partnerships and promote the use of midwives' services in rural areas, home deliveries and antenatal care provided by government midwives were free
- Finally, from 1976 to 1989, SBA coverage increased to 90%, with a considerable proportion of women in rural areas giving birth in public sector hospitals.
- By the 1990s, the responsibility of conducting deliveries within rural communities completely shifted from TBAs to trained midwives.
- As a result of these maternal health interventions, Malaysia's maternal mortality fell from approximately 275 per 100,000 live births in 1947 to 41 by the year 2000

References:

1 WHO 2005a

2 WHO 2005

3 FCI, 2002

4 WHO 2006a

5 Investing in Midwives and others with midwifery skills to save the lives of mothers and newborns and improve their health (UNFPA-ICM, 2006)

6 Wagstaff and Claeson, 2004

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