INVESTING IN MIDWIVES AND OTHERS WITH MIDWIFERY SKILLS TO SAVE THE LIVES OF MOTHERS AND NEWBORNS AND IMPROVE THEIR HEALTH

Policy and programme guidance for countries seeking to scale up midwifery services, especially at the community level

"The world needs midwives now more than ever to save the lives of mothers and babies"

A UNFPA-ICM Joint Initiative to support the call for a Decade of Action for Human Resources for Health made at World Health Assembly 2006

UNFPA

International Confederation of Midwives

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Acronyms

AMDD	Averting Maternal Death and Disability (AMDD) Program, Mailman School of Public Health, Columbia University
EmONC	Emergency obstetric and neonatal care
FCI	Family Care International
JHPIEGO	Affiliate of John Hopkins University
HRH	Human resources for health
ICM	International Confederation of Midwives
IMMPACT	Initiative for Maternal Mortality Programme Assessment, Aberdeen University
MMR	Maternal mortality ratio
PMTCT	Prevention of mother-to-child transmission
TBA	Traditional birth attendant
UNFPA	United Nations Population Fund
WHO	World Health Organization

Glossary of terms adopted at the Forum

Midwifery (French *la pratique de sage-femme*; Spanish *partería*; Arabic *kebela*)	The scope of professional midwives' practice. The art and science of assisting a woman before during and after labour and birth
Midwife (*Sage-femme; Matrona*)	An accredited (qualified) healthcare practitioner who assists women in pregnancy, throughout labour and childbirth and cares for women and babies in postnatal period. She has an important promotive and preventative function in broader reproductive health, health advocacy, empowerment of women and neonatal health. (See International Definition of a Midwife: http://www.internationalmidwives.org)
In the community (*Dans la communauté; En la comunidad*)	Level of health system close to where families live, e.g. government, private or NGO health post or clinic, or the family home (sometimes referred to as primary health care level)
Midwifery workforce (*Les professionnels compétents dans la pratique de sage-femme; Personal calificado de partería*)	Healthcare workers whose primary functions include health care to women in pregnancy and throughout labour and birth, and to mothers and babies in the postnatal period.
Maternity workforce (*Les professionnels compétents dans la pratique de sage-femme; Personal calificado de partería*)	Total workforce needed for maternity care. The category includes midwives and others with midwifery skills; obstetric and surgical staff; paediatric (neonatal physicians and nurses); laboratory technicians, radiologists and other specialists.
Maternity support workers (*Les agents communautaires de santé maternelle; Asistantes de maternidad*)	Healthcare workers, community workers and others, including traditional healers and others, who work and have links with the midwifery workforce. They play an important role in supporting women's and newborns' access to skilled care for safe pregnancy and childbirth, including postnatal and neonatal healthcare.
Emergency obstetric care (EmOC), basic and comprehensive (*Les soins obstétricaux d'urgence (SOU) de base et complets; Cuidados Obstétricos de Emergencia (COEm) basicos y ampliados*)	Consists of eight signal functions: Basic: Parenteral administration of antibiotics,oxytocics and anticonvulsants; manual removal of the placenta; manual vacuum aspiration; vacuum extraction; (plus stabilization of woman for referral), pre-referral care and referral. Comprehensive: all the above plus surgery (caesarean) and safe blood transfusion.

Emergency obstetric and neonatal care (EmONC) (*Les soins obstétricaux et néonatals d'urgence [SONU]; Cuidados obstetricos y neonatologicos de emergencia [CONEm]*)	Consists of ten signal functions: Basic: Parenteral administration of antibiotics, oxytocics and anticonvulsants; manual removal of the placenta; manual vacuum aspiration; vacuum extraction; basic newborn care; (plus stabilization of woman and newborn for referral), pre-referral care and referral. Comprehensive: all the above plus caesarean surgery and safe blood transfusion, neonatal resuscitation.
Skilled care for pregnancy and birth (*Soins obstétricaux qualifiés; Atención calificada durante el embarazo y el parto*)	"Skilled care" denotes a skilled attendant assisting pregnancy and birth in an enabling environment, supported by a functional referral system.
Competency	The knowledge, skills, attitudes and experience required for individuals to perform their jobs correctly and properly.
Skills	Abilities learned through training or acquired by experience to perform specific actions or tasks. Usually associated with individual tasks or techniques, particularly requiring the use of the hands or body.
Core competencies	An area of specialized expertise such as midwifery made up of a combination of complementary skills and knowledge bases (i.e. more than one knowledge base) embedded in that group's, team's or professional cadre's expertise. Descriptions of core competencies are found in the joint ICM/WHO Manual.
MDG-5	The fifth of the Millennium Development Goals adopted by world leaders at the Millennium Summit at the United Nations in the year 2000, with the aim of halving extreme poverty by 2015. The goal is to reduce the maternal mortality ratio by three-quarters between 1990 and 2015.

INVESTING IN MIDWIVES AND OTHERS WITH MIDWIFERY SKILLS TO SAVE THE LIVES OF MOTHERS AND NEWBORNS AND IMPROVE THEIR HEALTH

POLICY AND PROGRAMME GUIDANCE FOR COUNTRIES SEEKING TO SCALE UP MIDWIFERY SERVICES, ESPECIALLY AT THE COMMUNITY LEVEL

INTRODUCTION AND PURPOSE

The Hammamet Forum "Midwifery in the community: lessons learned", 11-15 December 2006, the first international meeting focusing on scaling up of the midwifery workforce at community level drafted a Call to Action for all countries with high MMR to embark on urgent and intensified action to scale up midwifery care at the community level (see Annex 1).

The Forum also decided to issue a document to provide guidance to national programmes for scaling up midwifery services at the community level. The result is the present guidance note, which outlines in more detail the action required by policy-makers and programme managers to effect change at country level and scale up midwifery capacity, specifically for families in poor and hard-to-reach areas.

The guidance note tries to capture and respond to the issues, questions, debates and outcomes of the group work, as well as the many country presentations made during the Forum. It is not intended to take the place of guidelines, which are more of a technical resource. Technical guidelines for operationalizing the guidance note will follow.

Participants in the Forum were drawn from international agencies and organizations such as the International Confederation of Midwives (ICM); the United Nations Population Fund (UNFPA); the World Health Organization (WHO); the Initiative for Maternal Mortality Programme Assessment (IMMPACT) based at Aberdeen University; Family Care International (FCI), and the Averting Maternal Death and Disability (AMDD) Program, Columbia University, along with midwives, nurses, physicians, health policy makers, professional associations, regulatory bodies and researchers from 23 countries where maternal and neonatal mortality and morbidity remain high. The 23 countries were Bangladesh, Bolivia, Burkina Faso, Cambodia, Guatemala, Haiti, India, Indonesia, Jordan, Kenya, Malawi, Mexico, Morocco, Mozambique, Nepal, Niger, Pakistan, Sudan, Tanzania, Tunisia, Yemen and Zimbabwe

DEFINING THE PROBLEM

Forum participants made an urgent request for clear and practical guidance on best-practice options for the rapid scaling-up of midwifery care at the community level. WHO estimates that providing universal access to skilled care and meeting the reproductive needs of all women calls for around 700,000 additional midwives, allowing for attrition. At least half as many more will be needed to meet the MDG-5 target (WHO, 2005a). The question in many countries is how best to go about this with the scarce resources at their disposal.

The Lancet's recent series on maternal survival described the need to professionalize and scale up maternity care as a contribution to lower maternal and perinatal mortality and morbidity (see *The Lancet* editorial on maternal survival, September 2006). Scaling-up–increasing numbers and competence of the midwifery workforce–requires investments and capacity-building at all levels of the health system.

The term "capacity-building" is often used incorrectly as a synonym for "training" (Potter, Brough, 2004). In addition to training, capacity-building requires attention to structure, systems, roles, staff and facilities, skills and tools. Because of the complexity of providing quality midwifery care at the community level, capacity-building must also address policies, legal frameworks, infrastructure and logistics within the community and the right to practice life-saving interventions, as well as gender inequalities, women's empowerment, resource mobilization and collaboration between different professional groups.

This guidance note is focused on action to scale up midwifery care at the community level, responding to participants' feeling that the critical shortages and bottlenecks that deny women and their families access to adequate care are to be found in this area. Specifically there is an urgent need to address the needs of underserved people, who are often in rural and poor urban areas. Provision of midwifery care in the community responds to the human right of all women in the world to competent midwifery care, regardless of where they live

Thanks to the excellent work of WHO, UNFPA, AMMD, JHPIEGO and other organizations operating at global, regional and national level, there is an abundance of practice guidelines and guidance on EmONC care and facilities, and on strengthening referral-level care and systems; but not on scaling-up midwifery care at the community level, which leaves a critical gap in the continuum of care needed for safe motherhood.

Quality midwifery care, provided close to where women live, can increase families' capacity to self-care during pregnancy, as well as before, during and after childbirth; it can also increase access to EmONC care by educating and empowering women and their communities. Despite repeated evidence that midwifery care at the community level is inadequate and lacks competent providers with the requisite back-up and support, country plans often fail to address the need.

The facts

- An estimated 530,000 women die each year from complications of pregnancy and childbirth; over ninety per cent in South Asia and sub-Saharan Africa, and less than one per cent in more developed regions (WHO, 2005a).
- An estimated 10 to 20 million women annually suffer severe health problems such as obstetric fistula as the result of pregnancy and childbirth (WHO, 2005a).
- Five major complications, most of which occur during labour, delivery and the postpartum period account for seventy per cent of maternal deaths (WHO, 2005).
- The technology for preventing these deaths already exists: the same five complications also occur in more developed regions, but rarely result in death.
- Approximately 15 per cent of women will experience a complication during pregnancy or childbirth–most of which cannot be predicted, but almost all of which can be managed (WHO, 2005a).
- Most maternal deaths and disabilities could be averted if all births were attended by a skilled health professional with access to a quality referral facility (FCI, 2002).
- Despite evidence of the need for skilled care at birth, almost half of all women still give birth without it (WHO, 2006a).
- Almost all births in high-income countries take place with a skilled attendant, but only 57 per cent of births in low income countries and less than a third in very low-income, war-torn or collapsed-economy countries (WHO, 2006a).

The solutions

Midwives and others with midwifery skills have a pivotal role in addressing the first two of the "three delays" that eventually lead to death from pregnancy-related complications, by working with and empowering women and communities and providing basic EmONC. They also contribute to reducing the third delay by providing prompt, high quality, essential midwifery care, and by giving first-line treatment while waiting for medical practitioners with obstetric and or neonatal skills.

Many reports show that women would use a skilled midwife or other healthcare provider with

midwifery skills, if they were readily available and affordable, and offered culturally acceptable services (MoH Kingdom of Cambodia 2004, Koblinsky, 2003).

The World Bank estimates that maternal deaths would decrease by 75 per cent, if coverage of key interventions rose to 99 per cent (Wagstaff and Claeson, 2004). Equally, WHO has recently concluded that almost half of all perinatal deaths could be prevented with skilled care at birth (WHO, 2006b). Properly trained and supported, midwives at the community level can deliver many of the interventions needed to address maternal health (Campbell, Graham, 2006).

Summary of the evidence

- There is compelling evidence for care by professional trained midwives or others with midwifery skills to reduce maternal death and disability (WHO 2005a, Loudon 2000, FCI, 2002).
- In all countries poverty is strongly associated with less access and use of healthcare, including skilled midwifery care at birth. The World Bank study, Listening to the Voices of the Poor: Crying out for Change, gave a vivid illustration of the importance of health care to poor and vulnerable people, and their hardship in its absence (Deepa et al., 2000). Studies among pregnant women support these findings (Jewkes et al., 1998, Knutsson, 2004, Pettersson et al., 2004, Pettersson et al., 2007).
- Lack of gender sensitivity in healthcare provision, together with lack of women's empowerment, has a direct impact on uptake and access to healthcare (Fonn et al., 2001).
- Midwives and others working at the community level contribute to delivery of essential primary and reproductive healthcare and can deliver many of the needed interventions to save the lives of mothers and babies (Campbell, Graham, 2006, de Bernis et al., 2003).
- One of the main findings of the recent IMMPACT evaluation of their safe motherhood plan in Indonesia shows that midwives who live and work in the community attend births and react appropriately in case of complications, and are more able to make a contribution to safe motherhood.
- Investment in midwifery care in the community has additional benefits: a referral system set up for maternal and newborn care was also used for transferring other seriously ill or injured members of the community (Predhan et al., 2002. Razzak, Kellermann, 2002).
- As respected members of the community, midwives promote health: women and men seek their advice on a wide range of health issues, including pre-conception health; family planning and care of newborns and young children; nutrition; general healthcare, and, increasingly, sexual health (Prathmanathan et al., 2003).

Training for the midwifery workforce has been debated for many decades, long before the early 1990s, when the WHO task force on human resource development for maternal health and safe motherhood met in Geneva (WHO 1993). The task force meeting reached agreement on the minimum level of midwifery skills, including essential skills to save the lives of women and newborns. Recent international consensus confirms that midwives must have the basic EmONC skills (WHO, 2004).

Because their work brings them close to women and families, midwives and others with midwifery skills working in the community also make ideal advocates and actors in HIV/AIDS programmes, especially for PMTC; reducing congenital syphilis; prevention and treatment of malaria, and adolescent and youth health.

Deep and pervasive poverty, coupled with the impact of the HIV/AIDS pandemic, civil unrest and exposure to extreme natural disasters such as severe droughts, floods, earthquakes and typhoons, make midwifery in many African and some South Asian countries the most complex in the world.

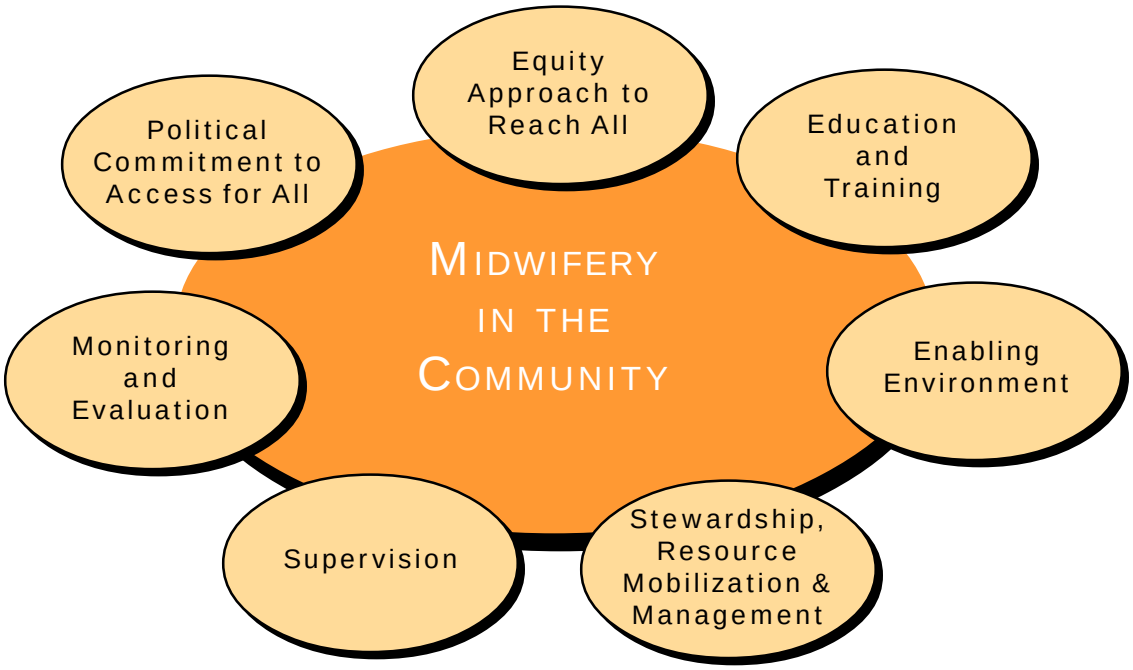
However, the production of skilled midwifery providers is an important component of the Africa Road Map for reducing maternal and neonatal mortality, to which the UN agencies and their partners are committed. Many middle and low-income countries with high MMR are now making skilled care at birth a priority in their national health and development plans.

Issues for policymakers and programme managers

Based on a preliminary review of available evidence, the issues to be considered when planning scaling-up human resources for health, including building the capacity of the midwifery workforce are:

- Policy, legal and regulatory frameworks–based on human rights for clients and providers;
- Equity approach–to reach all in need of access to a competent midwifery provider, especially the urban poor and rural communities;
- Competency-based education and training–both pre- and in-service, employing evidence-based standards;
- Supervision and support for setting up and maintaining standards and quality improvements–including links, support and backup from the local EmONC facility;
- An enabling environment–including safe practice sites; safe living conditions; fair recompense (a living wage); access to basic amenities including schooling and childcare; an adequate supply of essential drugs and equipment, and reliable transportation to an EmONC facility;
- Monitoring and evaluation–to identify gaps as well as progress;
- Stewardship, resource mobilization and management–to enable all of the above.

Figure 1. Framework for addressing issues of scaling-up midwifery at the community level



1. Policy, legal and regulatory frameworks

Political priority for safe motherhood has been shown to be crucial for reducing maternal mortality (Pathmanathan et al., 2003, Shiffman et al., 2004).

The World Heath Report 2005–*Make Every Mother and Child Count* called for access to professional midwifery care to begin ideally before pregnancy; if not, it should start as soon as pregnancy is known and continue until successful breastfeeding has been established. WHO focuses on the period during and immediately after childbirth, when most maternal and neonatal deaths occur. The Report further recommends that care should be provided as close as possible to where women live and that providers should be backed by ready access to a functioning facility, able at all times to provide proper emergency management and care for women and newborns with complications (WHO, 2005a).

Policies to achieve the above are crucial but insufficient. Implementation plans and regulatory frameworks are needed to make policies workable. Above all, there is a need for legal and regulatory frameworks which protect the right to practise of midwives and others with midwifery skills, including basic EmONC.

Key Issues

- Policies should make explicit that all women, wherever they live, have the basic right to access to professional midwifery care.
- The international consensus is that all healthcare providers who care for women and newborns during childbirth should be empowered to provide, at a minimum, basic EmONC.
- Legal and regulatory frameworks that protect midwives and ensure that their scope of practice covers provision of essential life-saving interventions, such as basic EmONC are essential, but are too often inadequate.

Key Action Points

Because of the complexity of scaling-up midwifery, consensus across all stakeholder groups is essential, including especially the other key professional group, obstetricians. While governments hold the ultimate responsibility for ensuring access to skilled care, partners including civil society organizations are essential to consensus-building and political action (WHO, 2005b).

Communities are major stakeholders in such partnerships. Studies on partnership in community health also point to the need for collaborative leadership. To be effective leadership must be built on shared vision, power sharing, systems thinking and process building (Alexander et al., 2001).

Summary

Policy makers and programme managers should:

- Create a coalition of interested stakeholders, ideally through conducting a rapid stakeholder analysis.
- Create partnerships and ensure community participation from the start.
- Develop a few but distinct messages to address the priority for access to midwifery care at the community level.
- Develop and implement an advocacy plan for consensus-building and political commitment, including strategies for execution.
- Develop a consensus on the need for scaling up midwifery services at the community level.

- Identify and gain the support of champions to ensure affirmative action to promote midwifery across society and in the health sector through a variety of media
- Review and revise where necessary current legal and regulatory frameworks, to ensure they protect the right of midwives and others with midwifery skills to practise to the full extent of their role, including providing basic EmONC. For this it is essential to include consultation with other key stakeholders such as obstetricians, who often have the most difficulty with midwives performing some interventions.

Success Story from Cambodia

A group of stakeholders including the Cambodia Midwifery Association and the National Reproductive Health Programme, with support from UNFPA and other agencies, successfully advocated for a High-level Midwifery Forum.

The High-level Midwifery Forum

The first national Forum with high-level support included support by UNFPA, and was led by the Office of the Council of Ministers – specifically by the Deputy Prime Minister and MoH, with involvement of:

- the Ministry of Education, Youth and Sport;
- the Council for Administrative Reform;
- the Secretariat of Public Function;
- the Ministry of Economics and Finance;
- multilateral and bilateral agencies.

The Forum considered the many challenges facing the provision of midwifery care, which included:

- low enrolment of students in the midwifery course;
- low motivation to work in rural and remote areas;
- uneven distribution of midwives;
- low salaries;
- limited resources for retention of midwives in the public sector;
- poor social services infrastructure in rural areas;
- lack of places for clinical practice.

Main Outcomes of the Forum

- Increased salaries and scales.
- Statute for establishing a Midwifery Council.
- Consensus on the need for a full assessment of midwifery capacity and agreeing terms of reference for a comprehensive review of midwifery, June – September 2006.
- Strong commitment from the Royal Government of Cambodia to midwifery issues.
- Midwifery review report to be submitted as part of the mid-term review of the current health sector strategic plan so that actions can be incorporated into the next strategy plan.

2. Ensuring equity in access

In all countries poverty is strongly associated with less access and use of healthcare, including skilled midwifery care at birth (Gwatkin et al., 2004). The World Bank study, *Listening to the Voices of the Poor: Crying out for Change*, gave a vivid illustration of the hardship faced by poor and vulnerable individuals in meeting their health care needs (Deepa et al., 2000). These findings are supported by various studies conducted among pregnant women (Jewkes et al., 1998, Knutsson, 2004, Pettersson et al 2004, Pettersson et al 2007) and in the World Bank Development Report 2004 (WDR, 2004). At the heart of women's access to maternal care lies women's autonomy. Evidence shows that even in relatively low-income groups, women with higher levels of autonomy find it easier to access maternal health services (Mathews et al., 2005).

In most countries poor people are not only subjected to inadequate infrastructure and insufficient medical supplies, but also to negative attitudes from health care professionals. It has been recognized for a long time that women in particular are subject to inadequate access and poor quality of care, a great deal of which can be associated with lack of gender sensitivity and women's lack of status and power (Doyal, 1995).

Key Issues

- Evidence shows the poorest quintile in a country often have the least access to skilled care at birth; even when care is available close by, they frequently use services less than wealthier families (WHO, 2005a, Kunst and Houweling, 2001).
- Research shows that introduction of formal user fees and demands for payment "under the table" have a negative influence on utilization of maternal health care services, particularly during childbirth (Borghi, 2006, Pettersson et al., 2004, Pettersson et al., 2007).
- Introduction of free care for childbirth can have a negative impact on quality of care and on staff retention if staffing levels are not kept under constant review and increased to meet increasing workload (IMMPACT Symposium 2007).
- Sometimes lack of female service providers, or someone who speaks the local language and shares–or at least appreciates–local cultural norms stop women accessing care, even when it is available (Knutsson, 2004).
- In some situations, the community's perceptions of quality care and provider performance, especially staff attitudes, can have a greater influence on uptake of services than access and costs (Andaleeb, 2001, Pettersson et al., 2004).
- Ensuring equity in relation to access to midwifery requires gender-sensitive policies and practices for human resources deployment.

Key Action Points

To achieve equitable access to quality midwifery care, the health sector must work in close collaboration with many other sectors, including education; roads and transport; communications; energy and power; finance–specifically the health budget–and in some instances the judiciary system working for women's rights and to improve the status of women.

Recruiting from the local area and ensuring that service provision is culturally cognizant will be easier if education also takes place locally: this will encourage the community's involvement and participation in the programme. This may require radical steps to decentralize schools of midwifery, or at least providing satellite sites close to the community, (see Section 3 on education and training).

Finally, it is crucial to know where the gaps are; a baseline needs assessment that includes assessment of equity in access is essential to identify priority areas. (Reference pitchworth et al.)

Summary

Policy makers and programme managers should:

- Review current human resources policies and plans to ensure they make explicit the need for midwifery services, to be provided by competent midwives or others with midwifery skills.
- Conduct a needs assessment to identify priority areas for increasing recruitment, or implementing special measures to support recruitment for hard-to-recruit areas and ethnic minority groups where relevant.
- As an interim measure, while the number of midwives and others with midwifery skills is being increased, non-midwifery community healthcare providers must be given some additional training and allocated to a team with (or be supervised by) a competent healthcare practitioner with core midwifery competencies.
- Make efforts to decentralise services to the nearest possible community point.
- Actively involve local communities in decision-making on the location of midwifery services, and in monitoring.
- Wherever possible, recruit midwives or others with midwifery skills from the local area. Ideally, the local community should be involved in both selection and support of students through their training programme and in their posting after graduation.

Context-specific Recommendations:

In conflict and post-conflict countries

- Ensuring security of staff, their families, trainees, and training institutions will be paramount – this is especially important for female workers. Simple measures such as providing mobile phones and using solar systems to supply electricity are possible even in low-income countries. Above all, work with the community leaders and get their involvement in supporting and protecting the midwives in the community.
- Maintain cultural congruence and ensure services are provided by local people who families know and accept. Include the community in recruitment and posting decisions.
- Pre-service and in-service training programmes should require as little time as possible away from families. This may call for modular programmes so that clinical practice can be undertaken in the trainees' own community.Ensure that all health staff have minimum midwifery competencies, while at the same time building long-term plans for developing professional midwives.

In medium to large countries

- Regularly undertake a human resources (labour) survey to identify where midwives are working, and how many live and work in a specific area. Some countries require professionals such as midwives to submit an annual or biannual notification of where they are working; whether they are part-time or full-time; what type of practice they provide–private, public or both–and other details.

Mexico finds a local solution for reaching indigenous women

CASA (Centro Para los Adolescentes San Miguel de Allende), an NGO based in San Miguel de Allende aiming at providing sexual and reproductive healthcare to the indigenous population, has demonstrated an impressive reduction of maternal mortality by training indigenous women to become professional midwives. The school was initiated by TBAs who wanted their daughters and women from rural communities to have access to a career in professional midwifery.

In 1997 the Ministry of Health and the Ministry of Education accredited the school and its graduates. After a four-year education programme, the graduates are given a professional licence as an autonomous midwife. Although bound to work with CASA for a specified period of time after graduation, graduates are now obtaining posts in government services.

CASA believes that key to success has been a commitment to ensuring that every new idea and initiative is carefully monitored, evaluated and documented to build a stronger evidence base for what works and what does not work. Building the evidence base also helps to develop confidence in the programme among the local community, and in high levels of authority and the Ministry of Health.

For more information visit their website – http://www.casa.org.mx/midwife.html

3. Education matters: pre-service, in-service and training teachers

Midwifery education needs to be of good quality and include critical thinking and decision-making, as well as community mobilization skills. As the authors of an article on the weakness of referral systems for dealing with obstetric emergencies point out, "The arrival of a woman at a referral facility is the end of a long and often complex decision-making process by both client and provider, of which the providers' skills, including interpersonal skills, are paramount." (Bossyns, Van Lerberghe, 2004).

Both pre-service and in-service education and training programmes should be based on a competency model. The competencies for a midwife or other healthcare worker providing midwifery care in pregnancy, before, during and after birth and for the newborn have been defined by ICM (ICM, 2000). They include family planning and other reproductive health services. These competencies were developed on the basis of a rigorous Delphi study involving clinical midwives, educators, managers and senior midwifery policy makers (Fullerton, Thompson, 2005).

Competence requires skills, knowledge, attitude and experience. Development of competence requires regular, repeated, supervised, hands-on practice in the clinical area and assessment of the competencies acquired. Too often current curricula do not allow for the development or testing of competency, and assume that a level of competency has been reached based on simulations in the classroom or on models, and attendance of a limited number of cases for hands-on-care. One of the major challenges among low-income countries is the gap between the midwifery school, its theoretical teachers and supervisors, and the clinical reality. It is crucial to reduce or eliminate this gap (Lugina, 2003).

Advocacy messages should not leave the issue of competence open to interpretation. Where this has happened there has been a tendency for short, "quick-fix" solutions, which often prove to be neither effective nor sustainable, as many countries are now finding. They can often prove more costly in the longer term (Report of the 1st International Forum on Midwifery in the Community: Lessons Learned, Hammamet, Dec 2006).

The lack of adequate curricula to prepare midwives to address the needs for safe motherhood, including competence in the essential life saving skills and competence to practice in the community, has been and remains a major concern (Kwast and Bentley, 1991, Kwast and Bergström, 2001).

It is also essential that curricula and practice are context-based. Midwives working in low-resource settings might avoid acting in a crisis because of their inadequate knowledge of appropriate techniques and procedures, such as aortic compression for postpartum haemorrhage as in the WHO manual Management of Complications in Pregnancy and Childbirth, (WHO, 2000), or resuscitating the newborn with room air in the absence of oxygen (Saugstad, 2005). It is also important that care be culturally sensitive, to encourage women to seek health care during childbirth (Knutsson, 2004, Pettersson et al., 2004, Leininger 2002).

Finally, there is need for research at an institutional level, to provide information on what is working and what is not. There must be more and better collaboration between the training institution and the clinical areas, as well as collaboration between institutions at the national and district level. Lack of this collaboration can delay implementation of changes and introduction of new procedures. Improving quality of care depends on new graduates having these new skills rather than outdated and discarded procedures.

Evidence on types of training

There are basically four types of pre-service training to prepare professional midwives: a) the apprentice model, where the trainee works with and learns under direct supervision from a professional midwife; b) vocational training, where training takes place in a specific training institution, with clinical experience

under supervision of a qualified tutor, midwifery practitioner, nurse or doctor; c) academic programmes, based in universities or other institutions of higher education and d) pre-service or in-service preparation for those already trained as nurses. (Benoit, et al., 2001)

All types of programmes have been shown to produce competent midwives, with varying degrees of success. There is very little evidence to show that one type of programme has advantages over another. Programmes for those without nursing training (direct entry) usually last between 18 months and five years, with a mean of three years. Those for entrants already qualified as nurses last from one to two years, with a mean of 18 months. Most programmes of all types usually require a minimum of 10 years schooling as an entry requirement. One or two countries have tried to produce professional midwives with less than 10 years schooling, but with little success (Sherratt, 2006).

Key Issues

- Many evaluations and reports for low-income countries show a lack of competency-based curricula for teaching midwifery, whether pre-service or in-service.
- Community exposure and experience should be an important part of midwifery curricula, but often is not.
- Teachers of midwifery should be competent and experienced midwives; such teachers are in short supply in many middle- and low-income countries.
- Midwife teachers should have received competency-based education and training in modern education and training technologies, but in many countries have not.
- It is important to have national updated standards for education programmes and institutions; it is also important to have accreditation systems which permit external verification that practitioners completing training programmes have the requisite competencies.
- National standards are needed for clinical midwifery practice, based on best available evidence and tailored to the specific context; they often do not exist or are outdated and ignored by clinical practitioners.
- People are willing to make use of public healthcare services if they perceive pre-service education programmes to be of adequate quality. More work is needed in many countries to build confidence in public services.

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Key Action Points

Rectifying shortfalls in pre-service training can be costly in organization, human resources and funding, and may take many years, to say nothing of the hardship to health providers and their patients, as well as the community at large (MoH Indonesia, WHO, UNFPA, UNICEF, 2004).

Early exposure to community-based learning experiences throughout the curriculum, accompanied by vertical sequencing of community-based learning experiences – starting from primary health care settings and going on to secondary and tertiary levels – are of great value in developing the competencies required for nursing, according to evaluations in South Africa (Ntshali, 2005); there is every reason to believe that midwifery training programmes would derive similar benefits from such approaches. Mobilizing senior midwives to be tutors on equal par with obstetricians could help empowering the profession where needed.

Summary

Policy makers and programme managers should:

- Establish or review national standards for midwifery education and practice, including standards for pre-service and in-service programmes; qualifications entering training, and preparation of midwife teachers and institutions, dialogue with obstetricians and professors to empower midwives in partnership.
- Review all relevant training programmes to ensure they comply with new standards, in particular that they are adapted to the local context and include sufficient exposure to midwifery practice in the community.

- Establish quotas for ethnic minority candidates, to ensure that there will be sufficient recruits to meet demand.
- Ensure that quality assurance systems for education and training are in place, including strengthening or establishing robust accreditation systems, to ensure that all midwives and others with midwifery skills working at the community level have the essential competencies, including basic EmONC skills.
- Review and revise, or if necessary establish, midwife teacher programmes that ensure midwife teachers are both competent in clinical skills and have the requisite modern education and training competencies.
- Ensure that midwifery teachers are collaborating with clinical midwives, to promote coherence between theory and practice.
- Ensure that midwives participate in setting standards of care before being accountable for their adherence
- Consider decentralising training, so that it can take place close to where recruits live; but maintain national accreditation.
- Consider modular programmes as a new option, with variable exit points that allow a phased development of skills. Modular training would allow trainees to leave the course when they reach their personal level of attainment, with a certificate that would qualify them as support workers, but without the competencies of professional midwives. The model is Canada's programme for training aboriginal midwives (NAHO, 2004).
- Ensure that training materials are available in local languages including in ethnic minority languages where feasible.
- Establish incentive schemes to support recruitment into midwifery, in particular support for daughters of current TBAs, so they can continue with the family tradition on a professional basis.

Context-specific Recommendations

In countries where there is difficulty in recruiting into midwifery, or in very weak or complex situations:

The Zimbabwe experience

Between 1980 and 1990 Zimbabwe needed to accelerate the production of providers to offer maternal and neonatal health care in the community because of the rapid movement of the population soon after the liberation struggle.

The country embarked on a six-month programme to upgrade cadres who were medics. After two years it was clear that this programme was too short to give providers the competencies which would make a difference in the community. The upgrading course was therefore extended to 12 months, adding more competencies.

After brief experience, decision-makers in the community demanded that the cadres have still more competencies, so midwifery training was extended again from 12 months to 18 months. The 18-month programme produced midwives able to make decisions, offer life-saving procedures, manage some complications and refer others appropriately and timely.

This programme was then used to upgrade all care providers working in the community as nurse-midwife technicians and to rationalise the different types of care providers, so that the country ended up with only one level of midwife. Once all the people trained at the lower grade were upgraded, all subsequent cadres trained as general nurses first and underwent a one-year midwifery programme. This is currently in use and serving the nation well.

4. Supervision is the key to maintaining quality and motivation

The problem of getting staff to act on evidence is widely recognized (Grimshaw et al 2001). As acknowledged by Penny and Murray in their review of training initiatives for essential obstetric care, community staff, particularly midwives, are required to apply knowledge to solve problems (Penny & Sheen, 2006). Problems are varied and may arise only occasionally. Indeed, many midwives working at the community level may never have experienced in their initial training some of the problems and complication that they may meet during their professional career. With this in mind and because quality control and improvements need to be continuous, providing midwives with capacity-building supervision is essential, especially for those working in the community. However, supportive supervision has been neglected until recently, and there is limited evidence from which to draw models of best practice.

For supervision to build capacity it must go further than assessing records and reviewing case registers. It needs to be supportive; undertaken by clinically competent midwives; allow free and open discussion of clinical practices, and give an opportunity for providers to acknowledge their weaknesses and need for further support or training. Supervision should empower midwives to work to the full extent of their role. It should offer a framework for scrutiny of professional standard practice, through a non-confrontational, confidential, midwife-led review of knowledge, understanding and competence (ENB, 1999, Stapleton et al., 1998).

Providing peer support by competent midwives and networking of staff, especially those working in isolated areas where there is little professional support can be advantageous and improve quality of care.

Key Issues

- Supervision is more than filling in a checklist from provincial or national health offices and should be undertaken by someone who possesses the requisite knowledge and experience of midwifery.
- Lack of supervision is strongly associated in many countries with lack of funds, for example Burkina Faso (country presentation made during the 1st International Forum on Midwifery in the Community: Lessons Learned. Hammamet, Tunisia, 2006).

Strengthening supervision is the key

Since 2001, Bangladesh has been developing a tailor-made training programme for a special type of community midwife called a community-based skilled birth attendant (CSBA), based on existing community health workers, the family welfare assistant and the female health assistant. The training programme for CSBAs has been designed in the light of the special circumstances in Bangladesh, where 90 per cent of all births still take place in the home and only 13 per cent with a skilled birth attendant. Training is in three modules: an initial six-month training is followed by a nine-month (or longer) supervised period with practical work in the field. After completing set targets for work practice, a further three-month course completes the programme.

Supervisors of the CSBAs – a cadre known as family welfare visitors – receive special training in midwifery, focused on life-saving skills, as well as a separate training on supportive supervision. The CSBA is required to keep a logbook and reflect on practice during supervised practical work. The logbook forms an important part of supportive supervision: the supervisor goes through the logbook to discuss issues of clinical practice, and provides on-the job training for areas of perceived weakness.

The supportive supervision of CSBAs is not a stand-alone activity, but only one component of a comprehensive supervision mechanism currently under development, which will eventually encompass all levels of maternal healthcare provision.

- Supervision is a separate function from the management of the midwifery service, although linked to it. In some areas supervisors may have responsibility for both. Supervision, and therefore those who supervise midwives, play an important role in protecting the public.

Key Action Points

Supervision is a critical component of "clinical governance", which has been defined as "A framework through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish." (DoH, 1998)

Professional self-regulation and life-long learning (continuous professional updating and development) are the other key elements of clinical governance. Supportive supervision, aimed at helping staff reflect purposefully on their practice, lies at the heart of clinical governance and therefore the safeguarding of standards. (DoH, 1998)

Summary

Policy makers and programme managers should:

- Establish systems built on models of clinical governance, aimed at maintaining and improving the quality of midwifery care in the community;
- Require each district to appoint an experienced senior midwifery supervisor, to oversee and support supervision of midwifery within the district; offer technical advice to the district planning and management teams on quality of midwifery and related issues, and commission in-service training as required;
- Develop criteria for supervisors of midwives working at the community level, which should include the requirement that all who supervise midwifery care are themselves competent in midwifery and receive training in supervising midwifery practice.

5. Enabling factors, including provision of safe practice environments

An effective health system is the cornerstone of successful efforts to reduce maternal and newborn mortality. According to Koblinsky, (2003, p.6) "Assistance at birth by a skilled birth attendant in the home or any health facility, supported by a functioning referral system, can reduce the MMR to around 50 or below."

An effective health system is also the cornerstone of many other priority health issues such as rolling back malaria; STI and HIV/AIDS programmes; efforts to address neglected diseases; health education and promotion, and even immediate first aid referral for accidents and emergencies. Strengthening health systems is therefore an absolute necessity for all countries.

Reducing maternal mortality does not call for sophisticated equipment or technologies. It requires a regular and adequate supply of safe, inexpensive drugs; basic equipment such as supplies for maintaining universal precautions against infections (HIV/AIDS and other blood-borne diseases); effective, supportive supervision; transportation, and links to a functioning EmONC facility.

Active involvement by the community is crucial, including support for midwives working at the community level to function as integral and key members of the total maternity workforce. Further, the community needs to encourage and support women to seek available services and avoid women from giving birth at home without skilled care. The community plays an important part in creating an enabling environment and must be supported in the role.

Key Issues

- Some countries find women's empowerment a major challenge in their efforts to increase provision and access to midwifery care. Women must be empowered to demand access to midwifery care, as well as to participate in establishing services and monitoring quality improvements to ensure that maternity care is acceptable, accessible and culturally appropriate (Portela, Santarelli, 2003).
- Support from the local community and community leaders, and the active participation of men, are vital, despite the barriers to male participation (Mullay, 2006).
- Gender inequality also affects the status of midwives and makes it more complex to give midwives the support they need to function effectively (Sherratt, 2006). Gender perceptions also affect issues of recruitment, mobility, career development, and remuneration.
- Evidence from many maternal mortality studies reveal that continuing high rates of MMR are linked to failure of the health system to respond with the right care, at the right time, in the right ways (Geelhoed et al., 2003 [Ghana], Castro et al., 2000 [Latin America], Massawe et al., 1997 [Tanzania]).
- Clinical protocols must be adequate, regularly updated, and deal with both facility-and community based care.
- The essential drugs for EmONC should be included in the national drugs list. Safe and continuous supply of essential drugs down to the community level must be assured.
- Lack of basic equipment and supplies, and maintenance of equipment, are major issues in most high-burden countries.
- National efforts are needed to prioritise the need for emergency referral and primary health care, strengthening referral networks and emergency transportation systems (Razzak, Kellerman, 2002, De Brower, Van Leberghe, 2004)
- Midwives or others with midwifery skills who work at the community level are an integral part

of the maternity care team, and must be given due respect and appreciation, including in terms of status and commensurate remuneration.

- Staff morale and motivation, feelings of security etc., will all contribute to the sense of working in an enabling environment (Vlassoff, Fonn 2001) and should be given high priority. Additional research is needed in that area
- Career opportunities for personal advancement affect staff motivation and are part of an enabling environment.
- All workers, including midwifery practitioners who work in the community, have rights to protection under various international conventions, not least ILO - C155 Occupational Safety and Health Convention, 1981.

Key Action Points

In order to strengthen health systems, priority actions need to be identified and focused. Quality improvement systems, such as continuing total quality care improvements, quality circles, even having basic monitoring systems in place, as well as use of needs assessments, clinical audits, community surveys, confidential enquiry into maternal death, investigations of near-miss cases can all be used as means of identification of priority areas. They can pinpoint priority action so that midwives working at the community level can function in a positive practice environment. By addressing priority actions over time, improvements will take place.

In a positive practice environment, health care practitioners can carry out all their tasks and function effectively according to national standards, without concern for their health or damage to the health of patients or clients. Patients' and clients' rights do not supersede the rights of health practitioners in terms of safety, protection from harassment and physical or mental harm. (ICN, 2006)

While both employers and staff have a responsibility for ensuring a positive practice environment, governments must hold ultimate responsibility for prioritising legislation and frameworks on safety at work. They do this by establishing national standards for practice, and safety frameworks for all employed personnel, as well as rights for patients and clients, all of which must apply to both the public and private sectors.

Tanzania improves midwifery care close to where women live

In early 2001, Family Care International (FCI) and the Tanzania Ministry of Health conducted an assessment of the availability and quality of maternity care in Igunga District, in Tabora Region in central-western Tanzania. The assessment revealed serious problems in Igunga's health facilities, including chronic shortages of supplies and medicines, as well as gaps in providers' knowledge and skills, a non-functioning referral system, and lack of clean water. The assessment also showed that lower-level health facilities, where the majority of births take place, were the worst off and least able to provide good quality care to prevent and manage obstetric and neonatal emergencies.

With assistance from FCI, the district health officials began to address these gaps. Specifically, interventions were introduced to strengthen logistics systems and improve the availability of essential medicines and supplies. In addition, FCI supported the purchase a new ambulance and the installation of a radio call system linking the hospital to rural health centres so that patients requiring advanced care could be quickly transferred. Maternity care providers at all levels of the health system were trained in life-saving obstetric care skills and in routine maternal health care, including high-quality antenatal, delivery, and postpartum care. Many of these healthcare providers had not had any refresher training in midwifery or obstetrics since their basic training – and pre-training assessments of their skills revealed serious gaps in their knowledge and ability to recognize and respond to complications. A recent evaluation of the work has shown increases in rates of skilled attendance at birth, and maternity staff all various levels of the health system are better able to recognize and respond to complications.

For more information on FCI support see http://www.familycareintl.org

Summary

Policy makers and programme managers should:

- Establish or revise national standards for clinical practice, education and human resource management, including review and revise the regulatory frameworks to ensure midwifery providers' right to practise, including their right to practise basic

EmONC. This may need an autonomous midwifery regulatory body to be set up.

- Review and revise as necessary the essential drug list, to ensure all essential drugs for maternal and newborn care are included.
- Establish minimum criteria for EmONC facilities.
- Develop and implement quality improvements systems to ensure all EmONC facilities meet minimum standards for supply of essential equipment; drugs; staff; technical quality of care; access, and acceptability.
- Actively encourage local communities' participation in management of local services, so that they feel a sense of responsibility for staff safety and protection and can help arrange appropriate and realistic referral systems.
- Establish systems so that staff and their families can have regular medical check-ups and essential immunizations, and access subsidised or free medical care.
- Develop and apply quality improvements systems for community practitioners, including use of community-based satisfaction surveys, follow-up of all maternal deaths and near-miss cases and auditing midwives' practice.
- Establish protocols for health and safety at work, including reporting and investigation of adverse incidents affecting clients or staff.
- Work with professional associations to identify appropriate career pathways for midwives working in the community, including progress into education and management positions. This will help improve motivation, which in turn assists recruitment and retention of staff.

6. Monitoring and evaluation: measuring what, why and how?

Monitoring and evaluation is a very important area of programming, but yet another which has been neglected. Until recently little attention has been paid to the need for permanent monitoring and periodic evaluation of large midwifery in the community programmes. Very few current programmes have built-in evaluation, and there is consequent uncertainty about their health outcomes, and thus their effectiveness.

As mentioned in a presentation at the Forum by Dr Hussein, (IMMPACT), it is not always feasible to use the MMR, nor is it always the right parameter to monitor and evaluate the desired outcome of a programme. She suggests that a stepped wedge study might be more appropriate for programmes aimed at scaling up midwifery in the community, through rolling out a cluster of interventions in a phased way in different districts. The design is also useful where, for logistical, practical or financial reasons, it is impossible to deliver the intervention simultaneously to all participants. Stepped wedge designs offer a number of opportunities for data analysis, particularly for modelling the effect of time on the effectiveness of an intervention. (Brown, Lilford, 2006). The first recognized study to use this design was in the Gambia in 1987 Hepatitis study (Gambia Hepatitis Study Group, 1987).

Most safe motherhood programmes rely on fairly standard process indicators (UNICEF, WHO, UNFPA, 1997; Pathak et al., 2000; Paxton, Bailey, Lobis, 2006). However, they are most often used for measuring the availability, use and quality of obstetric care.

Key Issues

- Safe motherhood programmes should have monitoring and evaluation plans built in from the very beginning, in order to assess their effectiveness.
- Lack of a universal benchmark to define a skilled birth attendant has not only caused confusion and lack of validity around this indicator, but has led to great variations and thus an inability to make comparative judgements on programmes (Stanton, 2006).
- There are currently few reliable and tested tools to measure the midwifery competencies of healthcare providers.
- Standards for calculating the number of midwives or others with midwifery skills needed must take account of the skill mix needed to care for obstetric emergencies. The commonly used basic national standard of 1 midwife to 5,000 population may have to be adapted to reflect different geographical situations; other personal or work demands on the midwife, and differences in fertility. For example, more midwives will be needed in very high fertility countries.

Key Action Points

"A goal cannot be met or missed unless it is measured." Unless regular monitoring and periodic evaluation plans are built in from the beginning, it will be impossible to say how effective a programme is, or how well a new intervention is reaching its objective.

Regular monitoring should be based on routine data collection. Both monitoring and evaluation should involve midwives at the community level, as well as the community members themselves, for both data collection and analysis, so that midwives can use the findings. This is particularly important for evaluating training initiatives, where for pragmatic reasons descriptive, non-experimental designs calling for before, during and after studies are the only option for assessing effectiveness (Campbell, 1999).

Finally, there is a need to ensure data is relevant and useful to those who are asked to collect it. Without this, the reliability of the data will always be in question.

Summary

Policy makers and programme managers should:

- Prepare a monitoring and evaluation plan as a component of the initial implementation plan.
- Define precisely the expected outcome of the programme and ensure routine data is matched to measure these outcomes.
- Use ICM's essential competencies for midwifery practice as a benchmark for measuring the midwifery staff's skills and abilities (available from ICM web-site http://www.internationalmidwives.org).
- Establish baseline indicators through needs assessments. These need not be long or overly ambitious.
- Ensure that the midwives at the community level are involved in designing the monitoring and evaluation plan, as well as collection and use of data
- Involve the community in monitoring and evaluation: their perceptions of quality have a direct bearing on utilization of services.
- Use data from regular monitoring and periodic evaluations to make changes in the programme.
- Monitor midwifery coverage using the midwife-to-birth ratio (UNFPA, 2007) and ensure data is disaggregated to identify underserved areas, and pockets within districts where access is limited.

Senegal – making strategic informed decisions

For countries with limited resources, good data from regular monitoring and periodic evaluations are critical in making informed decisions, as Senegal has discovered. Senegal has been able to show a significant reduction in MMR from 691 in 2000 to 401 in 2005. Good data to track over time not only how many but where maternal deaths were taking place in the country and from what causes, and where healthcare services and personnel were located and utilized, have enabled Senegal to develop and implement strategies to address major priority areas.

Because they have relatively good time bound data, they know that healthcare access is not yet equitable. Recent reports suggest that only 40 per cent of the 11 million population have access to healthcare services. Data on health facilities and personnel show that almost three-quarters of all qualified health professionals are located in two cities, Dakar and Thiès. In 2000, Senegal was able to embark on an ambitious programme based on this data to re-equip a large number of healthcare facilities and ensure they were able to provide EmONC.

A recent evaluation of Senegal's MMR reduction strategies, undertaken with the assistance of UNFPA, IMMPACT and CEFOREP (Centre de Formation et de Recherche en Santé de la Reproduction), has shown the importance of political commitment for development and implementation of MMR reduction strategies. It has also shown the importance for effective decision-making of good data on all aspects of health care services and delivery, as well as comprehensive data on maternal deaths.

Draft Report. *Evaluation Des Strategies De Reduction Des Barrières Économiques, Socioculturelles, Sanitaires Et Institutionnelles À L'accès Aux Soins Obstétricaux Au Sénégal,* March 2007

7. Funding, stewardship and resource mobilization and management

It is a core responsibility of all governments to ensure that basic healthcare–which includes access to skilled care during pregnancy, as well as during and after childbirth–reaches all women and newborns, especially those living in poverty in urban and rural areas. The crucial message from the Lancet's series on maternal survival reminds the global community of the need for professionalisation of maternity care as an absolute priority (Horton, 2006). This is needed more than ever for the maternity workforce at the community level. As Campbell et al., point out in their paper in the Lancet series, "No single intervention can reduce maternal mortality and morbidity, but rather it is a package of interventions that is required. Above all, the package of interventions must be targeted for high coverage" (Campbell et al., 2006).

The graphic in the Campbell et al. paper clearly demonstrates the contribution that midwives working at the community level can make to maternal outcomes. If they are properly trained and supported, midwives can deliver almost all of the required elements of the package of interventions. They cannot do life-saving surgery, but they can increase access to surgical interventions when necessary by helping families make realistic birth and emergency plans, by applying the partograph correctly, and by following a management protocol. Midwives can also deliver most of the essential interventions to save the lives of newborns. Midwives working at the community level are a cost-effective investment.

Only good governance – which includes access to reliable data sets and a focus on reaching the poor – can make it possible for governments to demonstrate that they are meeting the internationally-accepted obligation of reducing poverty, as stated in MDG-5. Ensuring equitable midwifery care requires intensified actions and substantial investments, all of which call for increased funds (Borghi et al., 2006). This calls for greater attention to resource mobilization and to strengthening managements systems, as well as establishing realistic health budgets that recognise the need for additional funds.

Financing healthcare and worker incentives are of particular concern, given the global shortage of human resources. Further, it is acknowledged that human resources are likely to be the key to success of any wide-ranging efforts to scale up health-related priority areas, including maternal and newborn health (JLI, 2004, Wyass, 2003). However, evidence suggests that financing for health services in general, and for maternal and newborn health in particular, has not reached required levels, and in many areas has not been sufficient to meet even basic care for the majority (Ensor, Ronoh, 2005). Studies show poor women are especially vulnerable during pregnancy, more particularly at the time of birth, and especially if the birth becomes complicated (Ranson, 2002).

Key Issues

- Financing for midwifery services in the community has until recently received little attention and in most cases remains inadequate.
- In many countries parliamentarians and senior policy makers are not fully aware of the issues around access to midwifery care at the community level and often fail to understand the complexities involved.
- User-fees for maternity care have been introduced without sufficient evidence that they benefit the poorest, while evidence suggests that user fees harm the poorest of the poor (Borghi, 2006).
- In many countries midwifery care at community level is too often left to volunteer workers or semi-skilled, poorly supervised multi-purpose workers.
- Even where safe motherhood programmes are

built on increasing access to childbirth in institutions such as health centres, clinics or hospitals, women and newborns need access to community-based midwifery care.

- Women who access skilled care in the community during pregnancy are more likely to seek skilled care for the actual birth (FCI, 2002).
- Provider performance can increase productivity and therefore reduce demands for human resources for health (Wyss, 2003); yet most efforts to improve provider performance have focused on training rather than capacity-building and worker motivation.
- Decentralization efforts have focused mainly on financial and structural reforms and have not taken sufficient account of the human resource dimension (Kolechmainen-Aitken, 2004).

Key Action Points

The recent Lancet series on maternal survival suggests, "The next 12-18 months will be critical for safe motherhood advocacy, offering an unprecedented chance to redress errors of the past and take advantage of new opportunities." (Starrs, 2006)

The paper in the Lancet series by Koblinsky et al., "Going to scale with professional skilled care" suggests that the main obstacles to the expansion of care are the dire scarcity of skilled providers and health systems infrastructures; substandard quality of care, and women's reluctance to use maternity services where costs are high and poorly attuned to services. The paper goes on to call for strategic decision-making in three principal areas – training, deployment and retention of healthcare workers (Koblinsky et al., 2006). All three areas are equally important and all three areas ultimately require action at senior policy and programme level, and adequate funding.

Summary

Policy makers and programme managers should:

- Identify economic factors that most crucially influence motivation of the midwifery workforce at the community level, especially in rural and urban poor areas, and develop policies, procedures and systems to address them.
- Ensure that realistic budgets at national, sub-national and district level are set for maternal and newborn health services, for training of healthcare personnel at all levels, for formalizing accreditation, and advocate for full funding of the budget.
- Establish national levels of production for midwifery providers, based on realistic demands for equitable services and where necessary negotiate with other sectors, including education and finance, to meet national production targets.
- Leverage the influence of stakeholder groups, including NGOs, civil society including professional associations and influential men's groups, to advocate for increased investments in providing midwifery care at the community as a human-rights issue.
- Ensure financing schemes for maternal health without relying on payment for services, giving the poorest access to maternal and newborn health services.

Call to Action

Hammamet Call to Action On Scaling-up "Midwifery in the Community"
Resulting from the 1st International Forum on Midwifery in the Community
11 – 15 December, 2006, Hammamet, Tunisia

Every minute a woman dies somewhere in the world from pregnancy-related complications, and many more are left disabled, because they lack access to skilled midwifery care. Evidence shows that a midwife or other healthcare provider with midwifery skills offers the most cost-effective, low-technology but high-quality solution to achieving safe motherhood, a central component of reproductive health. In addition, midwives are crucial to help ensure newborn survival, improve maternal and newborn health and reduce the estimated 7 million perinatal deaths each year.

The 1st International Forum in Hammamet, Tunisia, on "Midwifery in the Community" concluded its week-long deliberations with a Call to Action for the strengthening and scaling up of midwifery in the community–to contribute to the prevention of the avoidable death and disability of mothers and their newborns, as well as promoting the health of mothers and babies.

The Forum gathered international agencies and organizations, along with midwives, nurses, physicians, health policy makers, professional associations, regulatory bodies and researchers from 23 countries around the world where maternal and neonatal mortality and morbidity remain unacceptably high. The objective was to consider how to make midwifery care more accessible, especially to women living in hard to reach and underserved areas. Having reviewed progress and constraints over these last twenty years, since the launch of the Global Safe Motherhood Initiative, participants concluded that intensified action is needed at global, regional and national levels to achieve the additional midwives needed to work in contact with communities. Midwives working in close proximity to where women live will help prevent 530,000 avoidable maternal deaths a year. In addition it will prevent many post-delivery problems such as obstetric fistula, and help to reduce the alarming rate of neonatal morbidity and mortality. In 2005 the World Health Organization estimated that 334,000 more midwives and others with midwifery skills are needed around the world. If well supported by effective health systems, midwives will help governments to achieve their fourth and fifth Millennium Development Goals by 2015.

The Call to Action says:

We, the participants of the 1st International Forum on Midwifery in the Community, call on governments, regulatory bodies, professional health care organizations, educators, and communities worldwide to ensure the provision of midwifery services in the community by establishing or improving the following key areas:

- Policies to ensure equitable access to midwifery services;
- Policies and regulatory systems to improve the number, deployment, status and conditions of work of midwives and others with midwifery skills;
- Competency-based education and training in midwifery skills;
- Peer and supportive supervision of providers in the field;
- An enabling environment to support effective healthcare delivery, including infrastructure, communication, emergency transportation, adequate funding, equipment and supplies;
- Permanent monitoring and periodic evaluation.

We believe that these actions will strengthen midwifery as an integrated part of the healthcare in the community. In addition they will improve the continuum of care needed to protect the health of women and babies, and save their lives by increasing access to emergency obstetric and neonatal care (EmONC).

We also believe that it is the collective obligation of all stakeholders to guarantee mothers and their newborns their human rights to safe pregnancy, childbirth, and a safe postpartum recovery wherever they may live.

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