Strengthening health systems by focusing on community midwifery

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Dans cet article, Della R. Sherratt explique en quoi le développement de sages-femmes professionnelles intégrées dans les communautés fait sens, notamment dans les pays aux ressources financières et humaines limitées. Selon cette consultante spécialiste de la question, la formation des sages-femmes au niveau communautaire est l’une des voies pour construire un système de santé durable.
Investing in women is critical for sound sustainable development. Further, it is now well acknowledged that socio-economic development must include, take account of and meet the needs of women. Yet despite progress in many areas and the commitments made in various international treaties, conferences and global initiatives, women’s access to a good health, especially women in poor and rural communities, remains no more than an aspiration for far too many countries. As we move closer to the deadlines set for taking stock of the various international commitments to reaching equitable development, it is clear that the needs of women, specifically in relation to their need for healthy reproduction, have not been prioritised sufficiently. The most recent reports on the Millennium Development Goals (MDGs), especially around MDG 5- Improve Maternal Health and the status reports of ICPD (International Conference on Population and Development) Program of Action, emanating from the meeting in Cairo, Egypt in 1994, show that whilst some gains have been made, achieving universal access to Reproductive Health (an aspiration to be achieved under ICPD by 2014 and 2015 for MDG 5) will be missed by many low income countries. Given the rhetoric and promises made at numerous international conferences, plus the impetus provided by targeted initiatives such as “Women Deliver” (the third global conference was held in Malaysia in May 2013), questions must be asked why it is so hard to achieve those targets associated with women’s health? And, what needs to be done to redress this inadequacy of health service delivery for women’s health and development?

It is all too simplistic to say that meeting the reproductive health needs of women, especially as they relate to maternal health, is too difficult, too complex or too sensitive an area for the development community to address adequately. In some aspects there is an element of truth to this - as what women need, especially for safe pregnancy and childbirth, in addition to the general need for safety, food and safe water, is access to good health services including emergency obstetric care, on a 24 hour/7 day a week basis. Family planning information and services are also important, as they give women and their partners’ choice when it is best for them to have a child, also they give women freedom to enter the job market and participate in development initiatives. Moreover, Family Planning services have the potential to avoid, or at least drastically reduce the number of unwanted pregnancies and therefore reduce the estimated one third of maternal deaths that are due to unsafe abortion. However, many women do desire to reproduce, especially in communities where there are no social security nets and dependency on the family
is crucial, therefore health services must be designed and delivered to ensure women and communities can achieve their reproductive health goals.

The ability of families to reproduce and maintain communities is just as important for sustainable development as ensuring sound fiscal policies, good education or long term employment or earning opportunities. The right to reproduce is acknowledged internationally as a fundamental Human Right – yet the right to support and evidence-based services to ensure women can traverse through pregnancy and childbirth safely is still too often left to chance, or the place where a women lives.

What women need for safe pregnancy and childbirth, which includes health of their newborn, has been well known since the very first World Health Organization Technical Meeting on Maternal Mortality, held in 1955. What has been the revolving debate and of much controversy since this first Technical Meeting, has been how best to provide the needed health care and services. The various debates and solutions offered over the years have however failed to prioritize both the needs and wishes of women and, to some extent communities; instead the priority has been what the State can afford, or what makes sense to the health experts and technocrats. As a consequence, many countries, especially but not exclusively low income countries, have often failed to make the necessary investments in building a sustainable health system based on women's needs and their right to and in many cases necessity to bear children safely; in other words to ensure a functioning competent comprehensive midwifery services is available and is connected to hospital services offering quality emergency obstetric care. This is not to say they have not tried – but the solutions and efforts to achieve this have too often been driven by well meaning technocrats with limited experience of working with pregnant and birthing women, who too often lack a holistic view of pregnancy and childbirth and therefore fail to appreciate that neither pregnancy nor childbirth can be treated as an independent medical event, but rather have social, cultural and sometimes spiritual dimensions.

Over the years there has been two consistent and opposing hypothesis purported for how best to provide pregnancy and childbirth services; on the one hand, an assumption that all women desire or can be motivated to make what is sometimes a long and difficult journey to access modern medical facility-based services. An alternate view is centred on an assumption that it is impossible to get the competent health services to all
women, especially those in rural areas, so reliance has to be on an intermediary solution - local and or traditional helpers or generic/non-specialist, or lay community workers with limited competencies and linked to medical services in some way. In the latter case, the assumption is most women would continue to give birth on their own or with family or traditional/community assistance and only those with a problem will need specialist assistance and therefore the role of the worker is to identify those cases needing referral and help make such transfers. This view however ignores the research that shows that all pregnancies have a potential risk and often complications around pregnancy and childbirth occur with great rapidity and little or no forewarning. Moreover, such views also ignore the fact that, a properly trained midwife who is posted and supported for community practice offers more than the capacity to assist women during pregnancy and childbirth.

There is ample historical evidence from countries with limited resources at the time of initiating action, that investing in the production, deployment and support of well trained midwives working at the community level, results in reduced maternal and newborn deaths\textsuperscript{1,2}. The point that many policy, programme and planning specialists miss is, such practitioners need to be well trained and require a supportive supervisory system to assist them as they practice after graduation. Too often investments have been in provision of short trainings, often mainly theory-based, assuming that if the trainees already have some health training or community practice experience it is a simple task to bolt-on the knowledge and or skills required for safe pregnancy, childbirth and postnatal care. What is so often missing is real or adequate practical, hands-on experience. Mastery of the competencies (an accumulation of knowledge, skills, attitude and experience) required for assisting a woman during pregnancy and childbirth, can only be obtained through adequate amount of experience in the clinical area, working under the supervision and alongside an experienced practitioner. Each woman and each pregnancy and birth is individual, therefore practitioners need experience of caring for many women and assisting at many births to be able to determine the range of normality. Once mastered, the competencies require regular practice and ongoing refreshment; it cannot be assumed that once trained competence remains for life. It is also the case that the specific competencies required to save lives of mothers and newborns, as defined by research and outlined in Lancet article\textsuperscript{3}, require administration of interventions that are only permitted under policy or even in some instances statute, by regulated

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practitioners – and therefore are beyond the scope of unregulated, lay or community worker.

Theory and classroom teaching to ensure safe practice of midwifery competencies is needed to support the clinical experience; but to be successful such teaching must be delivered within an appropriate context, preferably one that promotes problem-solving and self-confidence, such as would be gained when applying participatory education/learning principles, or what is sometimes referred to as “Adult learning”. Although such principles and trainings are being introduced in many countries and not just for midwifery, there remains too many MNH training programmes that are highly didactic and therefore do not produce the practitioners with all the necessary competencies for quality community based midwifery practice –thus adding to the belief that provision of community midwifery practice is not feasible.

Equally, once trained it is too often assumed these new graduates will be willing and able to be posted, or go back to their work place and begin to function, often with no or limited equipment and or supplies, and frequently to function on a 24/7 basis, adding these new competencies to an already full workload. Frequently these new health workers/community volunteers are given no or limited assistance with travel, to allow them to make home visits, even if such was expected from them; so often the new community workers end up sitting in a facility with few clients and therefore limited opportunities to practice and maintain their newly acquired competencies for safe childbirth, as women continue to stay in the community and give birth in their homes.

What protagonists against provision of accredited and regulated midwifery services at the community level often argue is that investing in provision of regulated midwifery practitioners for community-based work, as eluded to above, is not possible, is too costly and or is not cost-effective. In some countries it is true training efforts to implement well developed curricular for community-based midwifery has been thwarted due to lack of investment in providing or developing teachers with the necessary theory and practice. Additionally, in some cases, existing policies and regulations are restrictive and do not allow midwives working at the community level to practice to the fullest. It is also the case that budgets for training of all health professionals are inadequate and have been a driving force for developing minimal non specialist curricular, under the umbrella
of core curricula and shared learning. However experience shows that when such investment are made to ensure competent specialist midwives with capacity to function at community level, the results can be significant, not just in saving lives of pregnant women and newborns, but also in developing confidence in the health sector and willingness of the whole community to seek help for a wider range of health interventions. This latter point is frequently overlooked in the literature.

Experience of many working in the field, include the author, has shown that taking student into the community for midwifery practice does allow the building up of trust with the community that leads to request for assistance from the wider the community for assistance well beyond maternal and newborn care. Most community members and leaders value and appreciate services provided for their most vulnerable - their pregnant and childbearing women and young children. When they see these services being provided in a respectful way, with the regularity and frequency needed to ensure coverage of all pregnant women over the pregnancy, birth and postnatal continuum, the community will then ask these same practitioners for assistance and or advice on a wider range of health issues. As such, provision of competent midwives armed with skills in community practice can be an entry gate for building links between communities and the formal health system as well as provision of the wider Primary Health care (PHC) services, as countries such as Myanmar, Cambodia and the People's Democratic Republic of Laos to name but a few are finding. This will come as no surprise to those experienced in providing midwifery education and training programmes. If one considers the full range of competencies required by midwives working at the community level, it is easy to see that adding on other skills and competencies for delivery of non-Maternal Newborn health (MNH) interventions for a basic package of PHC services is possible. Adding these additional skills to those trained as a midwife is easier than trying to add midwifery competencies to generic workers, as these non MNH skills often require the midwife to transfer knowledge and skills to a different scenario and not the development of new specialist competencies, as would be required if adding specialist midwifery competencies to non-midwife health practitioner.

In addition, what those who argue that provision of community-based midwives services with accredited midwives is not possible should remember is, that supportive supervision of some kind and the same supplies and equipment is always
needed, even if investing in community/lay workers or volunteers, if they are to be expected to provide evidence-based MNH services. Provision of an adequate supportive supervision system, based on accreditation of the midwifery graduates and regulation of practice is particularly helpful for strengthening the health system, as it will help provide ongoing data for evidence-based planning and programme monitoring and evaluation purposes.

Finally, protagonists should recall that training specific workers for community-based midwifery practice, if done properly, is more cost effective than training generic or lay workers and hoping they can add on a few midwifery skills, as it is more likely that those who apply or agree to be trained as a midwife will be more willing to provide 24/7 services and work with local communities. Too often programme or pilots for training generic health workers for MNH fail, as those trained then fail to deliver the services on posting, due to lack of interest of even lack of confidence in their own abilities. Whereas, the new midwifery graduates enter service knowing that midwifery is not a clinic hours only service, therefore will be more motivated to provide out-of-hours and out-of-facility services; those that do not wish/not willing to provide such services are easy to identify and can be weeded out during training. In addition, when working with the family, especially during home visits, the community-based midwife is in a prime position to observe behaviours as well as the health status of other members of the family, as due to the often nature of the work where they develop close relationships with women, they are often more able to enter into conversations and offer wider health education and counselling to meet the individual needs of families, rather than providing a scatter-gun approach to health education.

In conclusion, investing in professional midwives to work at the community level make sense for many reason, especially for countries with limited resources, both financial and or human resources. Training and supporting midwives at the community level can help countries build a sustainable Human Resource for Health workforce and thereby a sustainable and strong health system. As testified to during a fact finding conference on how best to provide midwives at the community level in Tunisia in 2007 with joint support from ICM, WHO and UNFPA, many of the activities needed to provide competent midwives at the community level are needed for building and delivery an appropriate basic or essential package of health services to the community. Given the focus on women and children, midwifery

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practitioners can often find it easier to gain acceptance by the community and therefore permit the health system to deliver a wider package of health services. Finally, investing in a cadre of accredited midwives for community practice is more likely to ensure that the interventions are not only delivered and delivered at an early stage to avert complications becoming life-threatening, but because they are regulated it is easier to reward good practice and amend poor practice or when this proves not possible, to remove the right to practice – not possible when the workforce is volunteers or made of traditional workers. Moreover investing in midwives work at community level, rather than just in facilities will assure that those cases that require more sophisticated and facility-based services are readily recognized and steps taken to ensure that fist line management/resuscitative measures are applied, therefore making it more likely that the women and or her baby does not succumb to their complication on the way to the facility, as can too often happen.

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