Published in final edited form as:

J Midwifery Womens Health. 2015 July ; 60(4): 343–347. doi:10.1111/jmwh.12341.

Strengthening Midwifery to End Preventable Maternal, Child, and Newborn Health

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INTRODUCTION

During the 50th anniversary of the American College of Nurse-Midwives (ACNM) in 2005, a *Call to Action* was presented to the membership. This call addressed the severe healthcare workforce capacity issues the world was facing at the time and the resulting impact on maternal and child health outcomes in low resource countries.¹ The components of the *Call to Action* revolved around the need for advocacy to improve working conditions for midwives in these low resource settings, specifically in the areas of health and safety, salary and benefits, and professional development. While some improvements have been made over the ensuing decade, many countries still face a profound deficit of healthcare workers. On the 60th anniversary of ACNM, we examine the persistent global shortage of healthcare workers and its impact on maternal, child, and newborn mortality and morbidity, the increased attention on midwives as we approach the post-millennium development goals era, and the work of ACNM in response to the *Call to Action* issued a decade ago.

BACKGROUND

Fifteen years ago, leaders from across the globe came together at the United Nations to craft a bold vision with measureable objectives for improving the health and well-being of the world's poorest citizens. The result was the establishment of eight Millennium Development Goals (MDGs) which were identified as a blueprint for governments, civil society, and other development partners to meet the needs of the world's poorest citizens.² [Table 1] Two key MDGs of relevance to midwifery are MDG 4: to reduce by two-thirds the mortality rate for

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Conflict of Interest: The authors have no conflicts of interest to disclose.

children under 5, and MDG 5: to reduce by three-quarters the maternal mortality ratio by 2015. However, one of the biggest threats to achieving these has been the shortage of providers with midwifery skills in the healthcare workforce.³ In the least developed countries, only 54 percent of women have access to a skilled birth attendant at delivery, with this number dropping to 29 percent for those in the poorest quintile.⁴ In 2006, the World Health Organization (WHO) recommended 2.28 doctors/nurses/midwives per 1,000 people to ensure that 80 percent of births are attended by a skilled birth attendant.⁵ Yet the 73 countries that account for 96 percent of maternal mortality, 91 percent of stillbirths, and 93 percent of neonatal mortality are functioning with less than 42 percent of the world's midwives, nurses, and physicians.⁶

STATE OF THE HEALTHCARE WORKFORCE

The WHO estimated in 2013 that the world lacks 7.2 million healthcare workers, with that number slated to reach 12.9 million by 2035.⁷ An appropriate combination of healthcare workers and skill mix is necessary for a functional and enabling health system. As the recent Ebola crisis in West Africa has highlighted, the global poor suffer disproportionately, and access to health care is severely limited when an acute shortage of healthcare workers exists. Today, Africa carries 25% of the global burden of disease with only 3% of the world's healthcare workers and 1% of the economic resources.⁸

The impact felt by the scarcity of healthcare workers is compounded even further by a maldistribution of the workforce. Rural and remote areas are especially hard hit by this maldistribution. Although the majority of many countries' populations live in rural areas, health workers are often loathe to practice in those areas due to the lack of basic infrastructure and for concern of being left out of continuing education opportunities which their peers in urban areas can easily access.⁹⁻¹¹ In many countries, continuing professional development is the surest way to advance in one's career; healthcare workers in remote and rural areas are often not made aware of these opportunities nor are they able to take part.¹² Healthcare workers away from urban settings are frequently left on their own and have an almost complete isolation from professional peers.

In low resource countries, clinical settings often lack the basic infrastructure and resources needed to practice. Many of these settings are without high quality housing and opportunities for the education of the healthcare worker's children are nonexistent.⁵ For all of these reasons, healthcare workers often refuse postings to rural areas. When they do agree to a rural posting they frequently transfer as soon as possible, leaving major portions of the population without access to basic health service.¹³

Additionally, low resource countries that invest scarce resources in the training of healthcare workers often find these workers recruited away by developed countries such as the United States and the United Kingdom. This brain drain takes the brightest and best from developing countries and leaves many health systems without the needed workforce to care for its own citizens.¹⁴ The United States has done little to influence this trend. Without adequately addressing our own educational issues related to health workforce development,

we continue to recruit healthcare workers from countries that can ill-afford to lose them to the United States.¹⁵

Internal brain drain, from the public to private sector, also contributes to the lack of overall health workforce available to provide care to the majority of the world's population. Private facilities and non-government organizations are able to pay higher wages than the public sector, drawing healthcare workers out of public practice into other settings. Highly funded disease eradication projects are stripping health and public health sectors of their best people, often abandoning maternal, child, and newborn healthcare goals as a consequence. These projects typically deliver vertical programs to treat a specific disease that is the focus of the donor. Very few donors take a global approach to address the overall disease burden affecting a population, exacerbating the numbers of women, children, and newborns who continue to die from preventable causes.¹⁵

STATE OF THE MIDWIFERY WORKFORCE

With increased attention focused on the skillset needed to achieve MDGs 4 and 5, midwives have moved to the forefront as an essential cadre of healthcare providers. Governments are investing heavily into midwifery education and rapidly scaling up programs to produce more midwives. The International Confederation of Midwives (ICM) has taken a leading role in strengthening midwifery globally as a means of securing women's rights to access midwifery care. They are setting the standard for midwifery education and regulation and contribute to the on-going discourse addressing the shortages of healthcare workers while advocating to maintain quality of care through a strong midwifery workforce. In 2010, ICM published the "Global Standards for Midwifery Education" and the "Essential Competencies for Basic Midwifery Practice" providing two core documents to support the essential pillars of ICM's efforts to strengthen midwifery worldwide and improve quality of care.^{16, 17}

In 2011, the first *State of the World's Midwifery*¹⁸ report was issued as a collaborative effort between 30 agencies and numerous individuals led by the United Nations Population Fund (UNFPA). This report was the first systematic examination of the midwifery workforce focused on the 58 countries with the highest global burden of maternal, fetal and newborn mortality.⁴ It provided the much needed data to engage midwifery in national policy dialogue and to support the incorporation of the need for a strong midwifery workforce within global health strategies.¹⁶ The report highlighted the need to increase women's access to a high quality midwifery workforce and examined midwifery in each country under the framework of education, regulation, and professional associations as the three pillars of a quality workforce.¹⁶

The second *State of the World's Midwifery* (2014) report identified developments in the midwifery workforce since 2011 and again provided an evidence base to support policy dialogue, accelerate progress on the MDGs, and inform discussions of the post-2015 development agenda.⁶ It expanded on the work from 2011 to focus on 73 of the 75 countries representing more than 95% of the global burden of maternal, child, and newborn deaths. These statistics come from a report titled *Countdown to 2015*;¹⁹ the countdown reports have been released every 2 to 3 years since 2005 through a multidisciplinary, multi-institutional

collaboration that includes WHO, UNFPA, The United Nations International Children's Emergency Fund, The Lancet, and the World Bank. The Countdown reports generate a country profile, with key health and survival statistics, coverage levels, and policy, financial, and equity indicators for all high burden countries.¹⁹ Highlights from the 2014 *State of the World's Midwifery* report include: 45% of the 73 countries have actively attempted to improve workforce retention in remote areas; 28% have initiated programs to increase recruitment and deployment of midwives; 25% report an increase in the production of health care workers such as midwives; 16% have opened new midwifery schools; 18% have plans to establish regulatory bodies for midwifery; and 20% have adopted a new code of practice and/or regulatory framework.⁶

Many aspects of pre-service midwifery education have been evaluated to identify bottlenecks that inhibit the numbers of midwives needed to provide adequate services to women, infants and families. According to the *State of the World's Midwifery* (2014)⁶ report, pathways from education to clinical placement are often a challenge. Graduates in more than half the countries reported it took longer than a year to become an active member of the healthcare workforce, allowing for deterioration of clinical skills prior to a graduate's first employment.⁶

Clinical education is time-consuming, costly, and labor intensive. While recommendations vary, the number of tutors (faculty) required to provide both adequate instruction and supervision for students is often stated to be ideally a ratio of 1:10.²⁰ By contrast, in many midwifery programs throughout the world, a tutor lecturing 150 students or a preceptor providing clinical instruction and supervision to twenty students on the maternity unit is a common occurrence. The workforce crisis for midwifery tutors is significant enough that promising new graduates are often hired immediately after graduation to become tutors, thereby limiting their effectiveness through lack of experience in the clinical setting and lack of professional maturity. The number of students is often so great it becomes virtually impossible for tutors to track and provide reliable or comprehensive mentorship and supervision. Opportunities for tutors to access professional development are restricted by location and the overwhelming workload. Lastly, resources often constrain the ability to establish and fully utilize simulation to learn evidence-based processes of care and achieve learning outcomes.²¹

RESPONDING TO THE CALL TO ACTION

In response to these challenges, the ACNM Department of Global Outreach (DGO) has been extensively involved in supporting pre-service midwifery education and in-service midwifery training for over 30 years. The DGO has been responsive to the realities of the acute human resource shortage throughout the world and works to promote the acquisition of midwifery skills within multiple health cadres while advocating for improved working conditions for midwives. With this depth of experience, DGO has developed a number of approaches to educate and train maternal, child, and newborn healthcare providers to promote competency and sustainability.

In response to a nationwide shortage of midwives, the government of Ghana had mandated a large increase in admissions to midwifery schools; tutors were overwhelmed with the volume of students and morale was low. The students' learning experiences were confined to didactic lectures; there was no functional simulation center; and clinical practice experiences consisted of up to several dozen students being posted to a clinic or hospital where they were not permitted to participate in patient care but stood against the wall and observed. Using a multi-pronged approach, the DGO developed programs to methodically address the components of infrastructure, tutor development, simulation approaches integrated with didactic learning, and clinical practice systems to support preceptors. To support the clinical practice system, preceptors were provided clinical updates and training designed to help them understand and more fully participate in their roles as preceptors and mentors. Because students had the opportunity to practice clinical skills in the simulation lab prior to their arrival at sites, they were then permitted to participate in patient care and thus acquire the needed experience to gain competency. When well-educated, motivated, and supported licensed midwives are introduced to a healthcare system as part of an integrated team, maternal, child, and newborn health gains have been repeatedly shown.²²

Following the lead of ICM, the DGO and members of the volunteer Division of Global Health (DGH) are taking an active role in working with professional associations across the globe through both funded and unfunded initiatives. The DGH has taken the lead in a twinning relationship, supported by ICM, with the Midwives' Association of Zambia. In late 2014, members of the division returned from a week-long workshop in Zambia where a 4-year work plan was mapped out for ACNM members to develop collaborative relationships with midwives there. These relationships hold potential for opening the window of professional development for both US- and Zambia-based midwives.

The DGO has also been working closely with the DGH to provide the ACNM members with opportunities to engage with midwives around the world. Collaborating with multiple partners including the American Congress of Obstetricians and Gynecologists and the American Academy of Pediatrics, ACNM, through the DGO and DGH has entered into a public-private partnership in 2012 entitled Survive and Thrive Global Development Alliance. The primary objective of this alliance is to promote and sustain utilization of high-impact clinical interventions in facilities through the support of members from the three United States based professional associations noted above. Members from the three associations provide support to a host country's professional association to strengthen capacity and implement country-identified priorities for clinical interventions. To date, volunteers from the ACNM membership have participated and supported clinical trainings, professional association-strengthening workshops, and preservice assessments in Burma (Myanmar), Malawi, Tanzania, Zimbabwe, and Afghanistan.

LOOKING TO THE FUTURE

While progress has been made, there is still much to be done. Maternal mortality has significantly decreased since the early 1990s through targeted in-service programming and emphasis on emergency obstetric and newborn skills. While these are laudable

accomplishments, as we look to the future, we must carefully assess what is needed to further ensure maternal, child, and newborn health equity and decrease preventable deaths.

Healthcare workers tend to migrate for higher salaries. Midwives' salaries continue to be among the lowest of healthcare workers in low and lower-middle-income countries, often falling below the minimum requirement for a decent standard of living.⁶ Recruitment and retention of midwives has been shown to be a serious problem in low-resource settings.^{23,24} Qualifications that are recognized internationally should attract higher salaries and prevent the continuous outflow of midwives to high-resource countries. Healthcare workers will continuously upgrade their skills when the rewards for doing so exceed the cost.²⁵

As understanding increases of the requirements and infrastructure needed to build the architecture of a functioning healthcare system, the issue of quality of care becomes more and more prominent. Midwives who have difficulties achieving competency during their educational programs then become midwives in the workforce who provide care that does not always meet international standards. Their ability to practice safely and effectively is often hampered by a dysfunctional physical environment, poorly defined career ladders characterized by inadequate or irregularly paid salaries, and unsafe or sub-standard living conditions. These compounding factors can lead to providers who are not well-equipped to deliver quality of care. The culture of care may be so deleterious that community members do not present to facilities in a timely fashion, reinforcing a perception that the system cannot help them.

Ideally a health system is comprised of healthcare workers who have been fully educated and trained to operate within a functioning physical infrastructure with adequate supplies and equipment. Responding to the *Call to Action* from the 50th anniversary of ACNM, midwives around the globe have worked tirelessly to improve working conditions in low resource settings, improve care for mothers and newborns, and strengthen professional development. As a profession, we must continue to advocate for a strong midwifery workforce to end preventable maternal, child, and newborn deaths through: 1) ensuring quality midwifery education; 2) strengthening health systems to provide an enabling environment with adequate resources and working conditions to support midwives in providing quality healthcare; 3) engage in national policy dialogue to increase midwifery salaries and provide professional development opportunities to keep midwives abreast of evidence based practices to improve maternal, child, and newborn health outcomes and end preventable deaths. When human resources within healthcare systems are sufficient in all respects, the long-sought goal of improving and sustaining maternal and newborn health will be realized.

Acknowledgments

Financial support: The development of this article was supported in part by research grant 1 K01 TW008763-01A1 from Fogarty International, National Institutes of Health (Dr. Jody R. Lori, principle investigator). The views expressed in this article by named authors are solely the responsibility of the authors and in no way reflect the official opinions of the coordinating agency or funding bodies.

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Table 1

Millennium Development Goals

Goal	Target
Goal #1: Eradicate extreme poverty and hunger	Halve, between 1990 and 2015, the proportion of people whose income is less than \$1 a day
Goal #2: Achieve universal primary education	Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling
Goal #3: Promote gender equality and empower women	Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015
Goal #4: Reduce child mortality	Reduce by two thirds, between 1990 and 2015, the under-five mortality rate
Goal #5: Improve maternal health	Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio
Goal #6: Combat HIV/AIDS, malaria and other diseases	Have halted by 2015 and begun to reverse the spread of HIV/AIDS
Goal #7: Ensure environmental sustainability	Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources
Goal #8: Develop a global partnership for development	Develop further an open, rule-based, predictable, non-discriminatory trading and financial system

Adapted from: Millennium Development Goals and Beyond 2015. <http://www.un.org/millenniumgoals/>