Midwifery Workforce Management and Innovation

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Introduction

The close correlation between access to a skilled, motivated, and supported midwife and maternal and child health is well established (Ahmed, et al, 2011:3). Worldwide however, there is an estimated shortage of 4.3 million midwives, nurses, and doctors, with the shortage most severe in 57 priority countries (WHO, 2006). Only some 40% of births in low-income countries are assisted by properly skilled birth attendants (Fauveau et al, 2008). Meanwhile, research indicates that teams of midwives and midwife assistants working in facilities could increase coverage of maternity care by up to an additional 40% by 2015 (Koblinsky et al, 2006).

Countries shown in red have a severe shortage of midwives, nurses, and doctors

What will it take to improve this unacceptable situation? We know nations are on the right track when they put at center stage the recruitment, retention, and motivation of midwives in their response to addressing women and children's health. Many countries, such as Malawi and Rwanda, have shown that by prioritizing strengthening of the health workforce, they can turn around their health outcomes and make significant progress for achieving MDG 4 within a matter of years.

This paper focuses on three overarching aspects essential to midwifery workforce management: managing entry to the workforce, managing stay in the workforce, and managing exit from the workforce. Various factors influence midwifery recruitment (i.e. entry to the workforce), retention (i.e. staying in the workforce), and motivation to prevent exit from the midwifery workforce.

Recruitment

One of the key requirements to recruit into the midwifery workforce is the availability of sufficient numbers of willing persons, ready to be trained, recruited, or deployed to work as midwives. Why do people choose or accept to take up midwifery as a profession? Why do people already trained in midwifery accept to serve in areas where their skills are needed most? The innovation examples from Nigeria and Sri Lanka described in this chapter show us that a coherent national program, backed up with the right policies and resources,
supported by all the key stakeholders - especially the national government - can achieve desired results. Government leadership exercising its stewardship role is critical (WHO, 2000). Programs with these essential elements have been able to attract, recruit, and deploy newly qualified, unemployed, and in some cases, retired but still productive midwives to areas where their skills can make a difference in saving lives and improving the health of women and newborns.

People may choose midwifery as a profession for various reasons including the desire to save lives, serve the community, emulate role models, or simply due to a conviction that it is a worthwhile career choice for employment. Studies show that health workers recruited from rural areas into training programs are more likely to go back or stay and serve in similar settings (WHO, 2010). Innovations in Nigeria and Sri Lanka, described in this chapter, are examples of successful strategies that have increased access to skilled birth attendance where most needed. This has been achieved through recruitment of newly qualified midwives and the training of lay health workers such as family welfare assistants. In the case of the Bangladesh innovation, recruiting people who may already be serving in a different capacity and giving them the opportunity to upgrade their status and skills through training in essential midwifery skills, while they continue to serve in their communities, is a strong incentive to enter or be recruited into the midwifery workforce.
Nigeria: Midwives Service Scheme

The problem
Nigeria has had a very poor record regarding maternal and child health (MCH) outcomes. An estimated 53,000 women and 250,000 newborns die annually, mostly from preventable causes.

The innovation
The National Primary Health Care Development Agency was tasked with establishing the Midwives Service Scheme (MSS). The MSS is a public sector initiative and a collaborative effort between the three tiers of government in Nigeria. A memorandum of understanding (MOU) between the federal, state, and local governments sets out the shared roles and responsibilities, which are supported by the strategic partners of the MSS. The MOU has been signed by all 36 states of Nigeria and is designed to mobilize midwives, including newly qualified, unemployed, and retired midwives, for deployment to selected primary care centers (PCCs) in rural communities. The aim is to facilitate an increase in the coverage of skilled birth attendance to reduce maternal, newborn, and child mortality.

A technical working group meets to receive updates, review progress, and advise to provide strategic direction, support, and guidance for the implementation of the MSS. The secretariat of the MSS is responsible for day-to-day management, while state focal persons serve as contact people for the midwives in the MSS.

The MSS is based on a cluster model in which four selected PCCs with capacity to provide basic essential obstetric care are clustered around a general hospital with capacity to provide comprehensive emergency obstetric care. A midwife is deployed to each selected PCC, ensuring 24 hour MCH services and access to skilled attendance at all births to reduce maternal, newborn, and child mortality and morbidity. The MSS currently covers 163 clusters, which have 652 PCCs and 163 general hospitals. The MSS aims to strengthen the primary health care system by distributing basic equipment (midwifery kits, blood pressure apparatus, etc.) to 652 facilities through the vaccine logistics system. The MSS has established or reactivated ward development committees at all MSS PCCs to ensure community participation and ownership in its implementation.

Achievements
2,488 midwives applied to the MSS and were deployed to PCCs. The midwives were then given an orientation to familiarize them with the scheme. As of July 2010, 2,622 midwives had been deployed to PCCs in rural areas. The MSS provided capacity building through training to improve midwives’ skills and proficiency in providing quality maternal and child health services. The midwives then underwent competency training offered by principals of schools of midwifery. The MSS plans to implement support to improve communication and has detailed a monitoring and evaluation framework for the scheme.

There has been a two-pronged approach to program communication focused at political leaders, decision makers, and clients through radio, TV, billboards, community outreach, health center branding, and posters.

The MSS still faces a number of challenges such as: full implementation of the MOU, availability of qualified midwives, retention, capacity building of midwives, and sustaining linkages. More support and commitment are needed from officials in relevant government departments. This can be achieved by ensuring clarity of the objectives and aim of the MSS.

Over the years, several initiatives and programs have been introduced to reduce maternal and child mortality in Nigeria. Despite these efforts, poor maternal and child health indices have continued to be one of the most serious development challenges facing the country. Progress has been accomplished in the implementation of the MSS initiative, although it will take a few years to confirm changes in service coverage. Best practices identified under this scheme will continue to be consolidated in order to overcome the various challenges (National Primary Health Care Development Agency, 2010).
Sri Lanka: Public Health Midwives' contribution to better health in rural communities

The problem
Sri Lanka faces challenges in providing health services and retaining its health workforce in remote rural areas. This is due to a lack of qualified medical personnel as well as reluctance on the part of those qualified to work in remote areas, where they are cut off from continuous professional development and other services that are available in urban hubs.

The innovation
Since the early 20th century, Public Health Midwives (PHMs) have been an important part of Sri Lanka's primary health care system. Traditionally focusing only on midwifery, PHMs have evolved into a professional cadre, playing a role in preventive health covering many aspects other than midwifery. Their services are immensely valued in rural settings where health resources are scarce.

The government of Sri Lanka adopted various strategies to encourage PHMs to work in rural settings. Preference is given to recruitment of PHMs in remote rural areas. More PHMs are allocated to areas with poor health indicators. More than 90% of PHM trainees are posted in rural settings after their training is completed. Each province in the country has at least 1 regional training center where PHMs are trained in maternal and child health to ensure an appropriate level of technical knowledge to deliver quality healthcare services. PHMs get continuous professional development opportunities once in their posts - even if based in particularly remote areas. PHM trainees are required to serve a bond period of 5 years once they have qualified and must work anywhere in the province in which they are trained, which ensures available health workers in particularly under-resourced areas. Financial incentives encourage PHMs to remain in rural areas with various benefits such as allowances, pension schemes, and subsidized mobile communication facilities.

Achievements
The success of the Sri Lankan primary health care system lies in its ability to ensure the availability of vital healthcare skills in rural areas while also retaining grass roots level primary health workers in remote regions of the country. The success of PHM recruitment, training, and posting systems in the rural sector has contributed to the dramatic reductions in both child and maternal mortality in the country and has helped fill the gap that had existed in health care availability in rural areas.

It is innovations like this which have made Sri Lanka one of the few low and middle income countries on track to achieve MDGs 4 and 5 (Pubudu de Silva, 2010).

Retention
Previously we have seen examples of successful innovative strategies to attract and recruit personnel into midwifery service. Challenges mentioned earlier notwithstanding, getting midwives into service may be the easy part. Retaining them in the midwifery workforce may be even harder. How can people possessing essential midwifery skills be retained in the workforce and continue to perform their tasks effectively? To stay in the job they need the same or greater level of commitment, enthusiasm, and dedication as when they were recruited. The circumstances in which they are likely to work may be less appealing once the initial attraction wanes and they have to deal with day to day realities, such as heavy workload, inadequate pay, and lack of basic supplies.

Rural areas in low-income countries are places with the most grave need for midwives. Yet midwives often are not willing to live in rural areas, where opportunities for education and their careers are limited. Midwives may feel insecure in communities where they are strangers, about issues such as living conditions, sexual harassment, and cultural
unfamiliarity. Political instability or civil war also can adversely affect the retention of midwives in both urban and rural areas (Pettersson et al, 2004; WHO, 2010).

One specific strategy for improving midwife retention and services in remote and rural areas, illustrated in the Sri Lanka innovation example in this chapter, is a bonding mechanism. Under this scheme midwives agree to provide services in remote areas for a minimum duration of time in exchange for scholarships for higher degrees, career path, and monetary incentives. This bonding strategy has been very effective in several middle income countries (Henderson, L.N. and Tulloch, J., 2008). Its effectiveness in developing countries however, will depend on the unbiased application of rules and regulations.

In French speaking countries in West Africa, such as Benin, Burkina Faso, Togo, Mali, Niger, and Côte d'Ivoire, availability of career path seems to be the most important factor in retaining the scarce midwives. In these countries increasing numbers of midwives are abandoning midwifery for other professions such as surgical, ophthalmological, or dentist assistant. These other occupations allow them to benefit from a career path, automatic increase in salary and allowances, and achieve leadership positions. Such findings have been confirmed through a study conducted in January 2011 (Blami, Zerbo, and Hounton, unpublished data, 2011).

In Burkina Faso, to increase midwife retention, motivation, and address the career path bottleneck, in 2009 a master level degree program in midwifery was launched at the Alfred Comlan Quenum National School of Public Health. The demand by midwives for such degree has been tremendous – 180 applicants for 10 admission places. Research conducted among midwives from Benin and Burkina Faso showed that 94% of midwives felt the degree is a major motivating factor that will ensure retention in the midwifery field (Blami, Zerbo, and Hounton, unpublished data, 2011).
Bangladesh: Innovations in improving community skilled birth attendance

The problem
Ninety per cent of all births in Bangladesh take place in the home, only 13% with a skilled birth attendant. Confronting this situation, Bangladesh is one of many developing countries that formally recognized the role of traditional birth attendants (TBAs) and introduced training programs for them. It was shown however, that in most cases even trained TBAs did not achieve the desired results or contribute significantly to the reduction of maternal deaths. Alternative strategies were needed to provide skilled delivery services to pregnant women in the community close to where they live (WHO, 2004a; WHO 2004b; Nasreen et al, 2007).

The innovation
The Ministry of Health and Family Welfare, with technical and financial support from the WHO and UNFPA, and operational support from The Obstetrical and Gynecological Society of Bangladesh piloted and developed a competency based direct entry program for community-based skilled birth attendants (CSBAs) at the level of an auxiliary midwife. The program recruited and trained family welfare assistants and female health assistants on selected essential midwifery skills and abilities. The Bangladesh Nursing Council provided certification as community midwife for trainees who completed the training. Training content included providing clean home delivery services, recognizing danger signs, mobilizing community support for those women who are unable to go for institutional delivery, and practical field work. CSBAs’ activities were monitored and supervised by trained family welfare visitors who received special training in midwifery, focused on life-saving skills, and got separate training on supportive supervision. The supportive supervision of CSBAs is but one component of a comprehensive supervision mechanism which will eventually encompass all levels of maternal healthcare provision (UNFPA-ICM Joint Initiative, 2006).

After initial positive findings the government of Bangladesh scaled up the CSBA training program across Bangladesh (Nasreen et al, 2007). NGOs and the private sector could also train their paramedics as SBAs following the same government standards.

Achievements
By the end of 2010 the CSBA pilot program was expected to have trained and developed up to 10,000 CSBAs. Evaluation showed that the CSBAs were making a significant contribution to increasing the proportion of births attended by trained health providers, and communities were satisfied with their services. Of particular significance is the fact that the program increased referrals to health centers and district hospitals of women with complications who otherwise would not have been seen by trained health providers for professional management (Nasreen et al, 2007).

The CSBA program is among the innovations that have been made in Bangladesh and positioned the country to be one of the few low and middle income countries to be on track to achieve MDGs 4 and 5.

Motivation
Motivation is an important factor for midwife performance and preventing their exit from the workforce. Factors that provide motivation for midwives to enter and stay in the midwifery workforce can be financial (increase in salaries, allowances, etc.) or non financial (working environment, working hours, availability of tools and supplies, supervision, career path, recognition, rewards, etc.). An evaluation of effectiveness and cost-effectiveness of task-shifting strategies for midwives in Burkina Faso revealed the main de-motivating factors to be absence of career path, lack of supervision, and lack of opportunities for salary increase (Hounton et al, 2009; Traore et al, 2011). Various country experiences of financially
motivating health workers to serve in remote areas produced little success in achieving adequate geographical distribution or retention (Mathauer and Imhoff, 2006). Peer support and networking of staff, especially those working in isolated areas where there is little professional support, can improve both retention and quality of care.

Often midwives working at the community level encounter problems and complications that they never experienced in their initial training. Providing continuous quality control and improvements is essential for midwife motivation and retention. Supportive supervision has been neglected until recently and best practice models are scarce. In many countries lack of supervision has been strongly associated with lack of funds. Supervision that builds capacity is more than just filling in administrative checklists. It should be undertaken by someone with midwifery knowledge and experience, be supportive, allow free and open discussion of clinical practices, and give midwives an opportunity to acknowledge their weaknesses and need for further support or training. Supervision should empower midwives to work to the full extent of their role (ENB, 1999, Fauveau, et al, 2008).

As illustrated in the three innovation examples from Bangladesh, Nigeria, and Sri Lanka, availability of motivation of community midwives or incentives for midwives to serve in rural areas will succeed and be sustainable only if there is a motivation package that includes possibility for career path development, working conditions, and supervision.

Conclusions

The three innovative approaches presented in this paper have four elements in common:

1. government support and political will;
2. they are relatively simple in nature and depart from past unsuccessful or unsustainable efforts to scale-up the midwifery workforce;
3. they demonstrate success in implementing and financing the scaling up of midwives in resource-scarce countries;
4. they apply a direct entry approach to midwifery training.

Strong midwife retention helps maintain a stable and predictable midwifery workforce. Evidence from countries with direct entry midwife training shows higher midwife retention than where nurse training is required first (e.g. Australia, Scotland, England, Denmark, Trinidad, Netherlands). Findings from surveys of the 57 priority countries with severe health workforce shortages indicate that direct entry is the most favored education method, but significant diversity exists across countries (Global Health Workforce Alliance, 2010). Nurses are one of the two most significant groups of health care workers that migrate to urban areas and to richer countries. De-linking nursing and midwifery training is likely to help countries maintain and increase their midwifery workforces, reducing the migration-driven brain and skills drain. The evidence showing improved population health outcomes indeed indicates that the direct entry approach makes sense.

For decision makers two key messages appear clear:

1. where there is political will, there is a way. Numerous countries have developed, implemented, and sustained innovative approaches to managing their midwifery workforces, achieving improved population health outcomes, particularly in maternal and child health. The Bangladesh and Sri Lanka examples are demonstrative of such achievements.
2. increasing direct entry midwifery training programs may reduce the migration of nurse/midwives.

Addressing challenges related to the management of a country’s midwifery workforce, particularly in the 57 countries suffering from the most acute shortage of midwives, nurses, and doctors, calls for innovative thinking and innovative approaches. Strategic decisions are needed to address recruitment, retention, and the motivation of midwives. As a number of countries have demonstrated, meeting these challenges can be done, can be managed, and can be financed in resource-scarce settings.

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