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State of Midwives in Nepal: HRH to Improve Maternal and Neonatal Health and Survival

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ABSTRACT

Improving health and survival of mothers and newborns depends on the delivery of evidence-based cost effective interventions through a skilled care provider. Evidence suggests that midwives are compassionate skilled care providers to mothers, and ensuring these skilled human resources is a key to progress towards Millennium Development Goals 4 and 5. With this in mind, this article analyses the state of midwifery in Nepal and what strategies are needed to ensuretheir accessibility and availability. In Nepal, as a result of community mobilization through Female Community Health Volunteers for birth preparedness and complication readiness, there has been a demand for skilled care at birth. However the supply of skilled birth attendants has been inadequate both in terms of number as well as quality of care.

Keywords: alliance; human resource for health; midwives; mothers; newborns.

INTRODUCTION

As many as 3.6 million maternal, fetal and newborn deaths per year could be averted if all women had access to the full package of reproductive, maternal and newborn care.[1] The millennium development goal (MDG) 5to improve maternal health has the target to reduce maternal mortality by three quarters between 1990 and 2015 through universal access to reproductive health from skilled personnel.[2] Moreover, the critical interventions to reduce neonatal and child mortality to reach MDG 4 by 2015 is linked to care by a skilled birth attendant at birth as well as during the post-neonatal period.[3-6]

In order to save the lives of both mothers and new borns complete routine care from skilled birth attendants and doctors at birth is crucial. For example, effective midwifery practices ensures non-traumatic birth and reduces mortality and morbidity from birth asphyxia,[7] simultaneously strict hygiene at delivery and proper cord care reduce the risk of infection.[8] Skilled care makes it possible to resuscitate babies who cannot breathe, has difficulty in breathingat birth and to deal with or refer unpredictable complications as they happen to mother or baby. When the birth is appropriately managed by a skilled healthcare provider like a midwife it is safer for both mothers and newborns.[9] Midwives are at the front line of maternal health service provision, interacting with colleagues across primary, secondary and tertiary care services and competent and proficient midwives are capable of providing routine care and managing complications during pregnancy, birth and beyond. Therefore there has been an international recognition to improve the distribution and quality of midwives as an estimated 52 million births occur without a skilled birth attendant (SBA).[10,11]

This article reviews the state of midwifery in Nepal to identify and highlight the current challenges to ensurethe availability of midwives, equitably distributed to provide quality of care for all.

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SITUATIONAL ANALYSIS OF NEPAL

In Nepal there is a strong community network of volunteers focusing their service on counseling to women encouraging them to utilize antenatal care and to promote birth preparedness and delivery at health facility. Over the last 10 years there has been a paradigm shift in women's utilization patterns; the proportion of women going to a health facility for antenatal and delivery care has trebled and the preparations for birth has tremendously improved.[12-18] In line with Thaddeus and Maine's model of three delays influencing the provision and use of obstetric services to prevent maternal deaths,[19] an increase in birth preparedness and complication readiness means an increased involvement of skilled birth attendant (midwives, nurses and doctors) at birth.[20] Between 2006 to 2010, 36% of the births were attended by skilled birth attendant which hasdoubled from that of 2001 to 2005.[14,15]

In the public health system of Nepal, the first point of contact forbasic emergency obstetric care in a community setting is the health post and primary health care center.[12,21] These health facilities are manned with nurses, thus the delay in receiving care is determined by the midwifery competency of nurses stationed in these peripheral health facilities.

Unlike some of the neighboring countries where there is a direct entry for midwifery education, midwifery education in Nepal is combined with nursing education. Moreover, midwifery education in Nepal existsthrough a multitude of courses (Table 1). Nepal lacks a government approved regulatory body for midwives, a protected title for midwives and a system for licensing to practice covering public and private sector.

Table 1. Different nurse-midwife cadre in Nepal and their midwifery course in pre-service training.

Existing Nursing Cadres	Duration of training	Midwifery course
Auxiliary Nurse Midwife (ANM)	18 months after grade 10	
Proficiency Certificate Nursing (PCL)	36 months after grade 10	One year
Generic Bachelor of nursing (BSc)	48 months after grade 12	One year
Post Basic Bachelor nursing (PBN)	48 months after proficiency in nursing	Varied

Until 2011, there were 37897 nurse-midwives registered at Nepal Nursing Council, with 110 nurse academic institutes producing 5000 graduates each year. However, there is a data gap onthe distribution of nurse midwives.

One of the benchmark used to plan midwifery workforce supply is that on average one midwife should attend 175 births per year.[1] This means that six midwives are required toprovide care for 1,000 births in one year. In Nepal, there is however only 4 nurse midwives to provide care to 1000 birth in a year emphasizing that there is still a gap of nurse midwives in Nepal.

In 2006 the Ministry of Health and Population, Family Health Division took its first stride to provide additional skills of midwifery to nurses and doctors through the Skilled Birth Attendant Policy[22] outlining a need to develop and deploy a separate cadre of midwife by 2015. However, since then, the government has focused its priority to its short term goal to provide competency based training to 7000 nurses and doctors 2015. It has also been struggling to provide in-service training to 3000 nurses and doctors by mid 2012. A recent gap analysis of the midwifery curricula for Auxillary Nurse Midwives (ANM), Proficiency Certificate Level nursing (PCL), Bachelor of Nursing and Post Basic Bachelor nursing as per the International Confederation of Midwives (ICM) essential competency curriculaindicates gaps in each of the courses.[23] All this indicates that the implementation of the policy to develop a separate cadre to provide midwifery competency is still to be realized. Therefore a professional body for midwives, Midwifery Society of Nepal (MIDSON) was established in 2010 and advocacy efforts by UN agencies, donors and the International Confederation of Midwives (ICM) has been made topromote availability, accessibility and utilization of midwives in the country.

WAY FORWARDS

The current gap in coverage and quality of midwifery skills indicates the need to draw a strategic plan for the professional development of midwifery according to ICM global standards as well as initiate the integration of core midwifery competencies in nursing education and develop a long-term plan to establish a separate midwifery cadre. This could be done through a set of strategies:

Alliance for giving midwives a voice

Currently midwifery society for Nepal is the voice of the midwifery workforce.A formal alliance needs to be formed which hasNepal Nursing Council, Nursing Association of Nepal, academia-nursing institutes, government bodies-Ministry of health and population, Ministry of Education, NGO's and UN agencies working in human resource for health to generate evidence for improving the midwifery education and lay out a plan for establishing midwife as a cadre. The alliance should regularly voice its progress and challenges in both the

national and international arena and build its strengths for negotiation and endorsement of (increased) access to continuing education, development of career opportunities and improvement of working conditions for midwives.

Creating a facilitating environment through regulation, professional accreditation, licensure and legal issues

An important component for the development of midwifery is proper regulation based on legislation. The regulatory body Nepal Nursing Council must address midwifery as an autonomous profession, setting specific codes of conduct and licensure criteria, as well as ensuring that education requirements are consistent with the international midwifery competencies. Regulation would be a key for proficient and effective workforce. It remains core to ensuring quality care and reducing maternal and newborn mortality. Regulating the midwifery profession involves licensing and re-licensing on the basis of maintaining competencies and providing quality of care in the respect of patients' rights.

Institutional capacity building in midwifery education

Midwifery Society of Nepal need to collaboratewith Nursing Association of Nepal, Nepal Nursing Council, Ministry of Health and Population, Ministry of Education and Council for Technical Education and Vocational Training (CTEVT) to increase both the quantity and quality of existing nursing faculty in midwifery education by strengthening the organizational capacity of pre-service training institutes. This can be done through production of midwives with midwifery skills of international standards. For pre-service education that includes a large component of hands-on, supervised practical training is required. At least 50 percent of midwifery education should be practice-based, and provide experience in clinical and community settings, in direct contact with women and other members of the maternal health team. In support of practical training, students require access to skills labs with appropriate anatomic models and equipment. Midwifery educators need improved capacity to develop and maintain curriculum, facilitate and assess student learning, and manage precious educational resources.

Policy coherence

Midwifery is not a vertical intervention. Therefore these services should be integrated into all public health systems. The Ministry of Health and Population's organogram needs to be reviewed to establish midwives as a separate cadre. A review of national health plans and human resources for health strategies need to be done to ensure that midwivesare incorporated as a cadre at health posts, primary health care centers and district hospitals. Once aligned, plans and strategies must be costed to facilitate decisions on resource allocation (domestic and external).

Human resource management

Human resource management will need to be improved, requiring supportive supervision, in-service training, career development opportunities and attention to security and gender issues, especially in rural areas.

Establishing a service delivery model

A service delivery model withmidwife-led maternity unitsneeds to be established at birthing centers and Basic Emergency Obstetric and Neonatal Care facilities. This team of midwives will provide essential health care including managing complications and referring women and newborns to the next level of service, Comprehensive Emergency and Obstetric Neonatal Careas appropriate, thuslinking community and primary health care facilities with effective referral pathways.

The Ministry of Health and Population needs to review the SBA policy to adhere to the plan of it being an interim strategy by developing a system of producing and deploying midwives in the long run. The currently run skilled birth attendant in-service training package needs is to speed up the process of integrating core ICM competencies in the existing pre-service nursing curricula and develop a strategy of having separate cadre of midwives in order to be sustainable both in terms of cost efficiency and effectiveness. A competent midwife is a compassionate friend to mothers and a caretaker ofnewborns at birth and a component ofthe empowerment ofwomen for a successful progress towards development goals.

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