The Midwifery Services Framework: Lessons learned from the initial stages of implementation in six countries

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**A R T I C L E I N F O**

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**A B S T R A C T**

In 2015, the International Confederation of Midwives (ICM) launched the Midwifery Services Framework (MSF): an evidence-based tool to guide countries through the process of improving their sexual, reproductive, maternal and newborn health services through strengthening and developing the midwifery workforce. The MSF is aligned with key global architecture for sexual, reproductive, maternal and newborn health and human resources for health. This third in a series of three papers describes the experience of starting to implement the MSF in the first six countries that requested ICM support to adopt the tool, and the lessons learned during these early stages of implementation. The early adopting countries selected a variety of priority work areas, but nearly all highlighted the importance of improving the attractiveness of midwifery as a career so as to improve attraction and retention, and several saw the need for improvements to midwifery regulation, pre-service education, availability and/or accessibility of midwives. Key lessons from the early stages of implementation include the need to ensure a broad range of stakeholder involvement from the outset and the need for an in-country lead organisation to maintain the momentum of implementation even when there are changes in political leadership, security concerns or other barriers to progress.

**Introduction**

In 2015, the International Confederation of Midwives (ICM) launched the Midwifery Services Framework (MSF): a tool to assist countries to operationalise the process of strengthening the midwifery profession (ICM, 2015a). It was a response to global calls for improved health outcomes via investment in the health workforce (United Nations, 2016; WHO, 2016), but a dearth of practical guidance about how to strengthen the workforce and the health system. Since its launch, implementation of the MSF has begun in eight countries: Afghanistan, Bangladesh, Ghana, Kyrgyzstan, Lesotho, Togo, Uganda and Zimbabwe. In addition, India, Malawi, Nepal and Timor Leste have expressed interest in the MSF, and funding is being sought to initiate the process in these countries.

The content of the MSF is based on compelling evidence that investment in midwifery is a cost-effective way to improve sexual, reproductive, maternal and newborn health (SRMNH) outcomes (The Lancet, 2014; UNFPA et al., 2014). It can therefore be considered as a method of promoting the systematic uptake of evidence to improve the effective coverage of SRMNH services. It is anticipated that successful implementation of the MSF will lead to a number of outcomes at multiple levels of the health system, such as a broader sense of ownership of and responsibility for the delivery and quality of SRMNH services (due to the multi-sectoral and multi-stakeholder nature of the process), and services being shaped around the needs of women and their families (due to use of data and evidence, and to the involvement of women and families in the process). For women and their families, this should result in improved availability, accessibility, acceptability and quality of SRMNH services and thus improved SRMNH outcomes.

It is too early to assess the extent to which these outcomes have occurred, but it is possible at this stage to document what has happened so far in each country, and what lessons have been learned. This may help the early adopting countries to make adjustments during the remainder of the process, and will also help to streamline the process for countries that decide to implement the MSF in future. This paper focuses on six...
of the eight early adopting countries: Uganda and Zimbabwe are not included because they are at a very early stage of implementation, having so far only held some introductory meetings. This is the third in a series of three papers about the MSF; it aims to document the early outcomes of the process and describe the lessons learned so far in the six remaining countries. The first paper explained how and why the MSF came into being (Nove et al., 2017), and the second paper described the process of MSF implementation (Nove et al., 2018).

The information in this paper was collected from ICM technical staff (n=3), associate consultants who were involved in the implementation process (n=2), and representatives of lead organisations in the implementing countries (n=6). Country representatives provided written submissions using a reporting template devised by ICM, in which they were informed that their responses may be published in a paper and asked to record: the country context, how they heard about the MSF, their experiences of implementation (country workshops, creation of technical working groups (TWGs) and national steering committees), and their perceptions of the advantages and challenges of MSF implementation. ICM staff and consultants provided their feedback verbally. The information was analysed using an inductive process, and all contributors were invited to comment on an early draft of this manuscript to check that they were in agreement with the content.

Country contexts

The experience of initiating the MSF process has been different in each country. This variation is due to a number of factors, e.g. different health system configuration, stage of economic development, status of midwifery, policy context. These varying contexts are discussed in this section, and the issues encountered during MSF initiation are considered in relation to them.

SRMNH outcomes and health system indicators

Table 1 shows that, even at a national aggregate level, none of the six countries currently meets global targets for public spending on health or maternal mortality. Furthermore, in 2012 (the most recent year for which comparable data are available) only Bangladesh and Kyrgyzstan met the recommendation of at least 1 midwife per 175 births (WHO, 2005). In the case of Bangladesh, however, these figures are somewhat misleading because in 2012 the country estimated that on average nurse-midwives spent only 20% of their time on SRMNH (UNFPA et al., 2014) and at that time, Bangladesh’s nurse-midwives did not meet the ICM definition of a midwife (Bogren et al., 2017). Furthermore, national data often mask sub-national inequity (UNFPA et al., 2014), making it very likely that the situation is worse in some parts of the focus countries. Based on these data, all six countries will need to take additional steps if they are to achieve global and national SRMNH targets. Table 1 also shows that the countries exhibit some diversity in terms of geographical location, midwife availability, fertility rate, health spending and mortality rates.

Strength of the midwifery profession

ICM maintains that the strength of a health profession in a country rests on the strength of systems for that profession’s education, regulation and professional association (ICM, 2017a). Information on these three aspects of the midwifery profession for the six early adopting countries is shown in Table 2, which indicates that the policy environment in terms of education, regulation and association is generally strong, but in many cases still quite new. Moreover, the 2014 State of the World’s Midwifery report noted that the implementation of policy is sometimes weak, resulting in poor quality education, regulation and association (UNFPA et al., 2014). Table 2 also indicates that only two of the six countries officially recognise midwifery as a separate profession from nursing (e.g. midwives are educated, registered and licensed using a separate process to the one used for nurses). In others (e.g. Bangladesh) steps are being taken in this direction such as separate registration of nurses and midwives.

Social, political and health system context

Afghanistan’s strategic geopolitical location has resulted in a conflict-ridden history, most recently including Soviet occupation (1979–1989) and civil war (1990–1996), followed by Taliban rule (1996–2001), United States of America-led invasion in 2001 and fragile civilian government with an international military presence since 2002. In the early 2000s, the health system had virtually collapsed and Afghanistan’s SRMNH outcomes were among the worst in the world. Since that time steady progress has been made despite the significant challenges presented by the country’s topography and climate (Akseer et al., 2016). However, Afghanistan remains one of the least developed countries in the world with one of the lowest levels of gender equity (UNDP, 2016). Investment in midwives has been a key element of Afghanistan’s health strategy since 2003, and it was one of the first countries in Asia to introduce a degree-level midwifery qualification (UNFPA, 2014). However, the 2014 State of the World’s Midwifery report highlighted that the country was not producing anywhere near enough graduate midwives to compensate for projected future outflows due to death, retirement and voluntary attrition (UNFPA et al., 2014).

Bangladesh: Since independence in 1971, there has been significant socioeconomic development, and Bangladesh is currently in the ‘medium’ human development category (UNDP, 2016) and classified as

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<td>Afghanistan</td>
<td>200</td>
<td>396</td>
<td>36</td>
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<td>3.89</td>
<td>6.3</td>
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<tr>
<td>Kyrgyzstan</td>
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<td>76</td>
<td>12</td>
<td>2.91</td>
<td>14.9</td>
<td>2.6</td>
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<tr>
<td>Lesotho</td>
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<td>487</td>
<td>33</td>
<td>3.01</td>
<td>3.4</td>
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<tr>
<td>Togo</td>
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<td>368</td>
<td>27</td>
<td>4.35</td>
<td>2.4</td>
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<td>Global target/ recommended level</td>
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<td>70</td>
<td>12</td>
<td>–</td>
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<td>1.0</td>
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* (Every Woman Every Child, 2017); ** (WHO et al., 2015); (Healthy Newborn Network, 2017); UNPD, 2017; Estimate derived from State of the World’s Midwifery 2014 (UNFPA et al., 2014) and UN Population Division estimates; McIntyre and Meheus, 2014; United Nations, 2015; (WHO, 2005).

Note that this excludes donor funding, and that it does not take into account inter-country variations in what can be purchased with this level of spending. ** Those with the job title midwife or nurse-midwife (i.e. excluding nurses and auxiliary cadres).
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