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Promoting Safe Motherhood through Midwife Training and Advocacy

Each year, nearly 530,000 women and girls die due to pregnancy- and childbirth-related causes and another 8 to 20 million suffer serious injuries and disabilities (WHO, 2003; UNFPA, 2005). The majority of maternal deaths occur immediately after or within one day of delivery, often due to severe hemorrhaging, obstructed labor, infection/sepsis, and eclampsia/hypertension. While proper care and nutrition throughout pregnancy (including regular antenatal checkups) are essential for reducing and identifying risks, researchers, health professionals, and policymakers are increasingly recognizing that skilled delivery assistance, access to emergency obstetric care, and prevention and treatment of postpartum hemorrhage are the most important strategies for preventing maternal and neonatal deaths and disabilities. It is skilled assistance at the critical time of delivery that can make the difference between life and death for thousands of women and their babies around the world.

A skilled attendant is “an accredited health professional—such as a midwife, doctor, or nurse—who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the management, identification and referral of complications in women and newborns” (WHO, 2004, p. 1). Fewer than 6 of 10 pregnant women in developing countries (57%) deliver with the assistance of skilled attendants, and this proportion masks significant differences based on wealth and geographic (e.g., rural vs. urban) distribution (United Nations, 2005). The reasons that many women in developing countries deliver at home without the benefit of a skilled attendant are based on limitations within public healthcare systems, cultural preferences, and unaffordable user fees.

For example, in India—which alone accounts for one-fourth of all maternal deaths worldwide—about 75 percent of women in rural areas give birth at home (International Institute for Population Sciences and ORC Macro, 2000). Midwives are among the most important providers of delivery assistance (at home and in institutions). Because of their training and ability to assist pregnant women in health facilities and in their homes, midwives are an essential component of safe motherhood initiatives (see Box 1).

Box 1. An international definition of a midwife...

- Successfully completes a prescribed course in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.
- Provides supervision, care, and advice to women during pregnancy, labor, and the postpartum period.
- Is able to conduct normal deliveries, detect abnormal conditions in the mother and child, procure medical assistance, and execute emergency procedures in the absence of outside medical help.
- Provides health counseling and education on antenatal care, preparation for parenthood, gynecology, family planning, and child care.
- May practice in hospitals, clinics, health units, other service settings, and within homes.

Source: International Confederation of Midwives, n.d.

Midwives are significant not only in terms of their role in service delivery; their involvement is also needed in safe motherhood policy and planning efforts. Failure to reduce maternal mortality—despite the preventable nature of many of these deaths and disabilities—reflects a lack of political commitment and the low priority given to women’s health needs. Strengthening the capacity of midwives to act as “policy champions” for maternal health issues can help foster greater commitment for addressing women’s health. Their involvement in planning, monitoring, and evaluation helps ensure that policies and programs benefit from the knowledge and experiences of those who provide services on the ground and understand the needs of women. Active community participation of midwives also increases their ownership and support for policies and programs. The remainder of this brief highlights the strategies of the POLICY Project for building the leadership capacity of midwives through training, small grants, and support for young midwives.

MIDWIFERY ADVOCACY AND LEADERSHIP TRAINING INITIATIVE

Midwives have firsthand knowledge of the healthcare needs of women and families. They are critical players in efforts to prevent maternal and neonatal mortality, and they understand the training and support needs of fellow midwives and healthcare providers. As such, midwives are well-positioned to advocate for increased support for a range of maternal and reproductive health issues in both the community and national arena. Advocacy involves targeted actions designed to promote policy dialogue and encourage decisionmakers to take specific steps, such as allocating resources to safe motherhood programs or improving training courses for those who provide maternal healthcare (see Box 2).

While midwives have specialized healthcare training, they may lack the skills needed to encourage policy change among government officials, health system administrators and personnel, and other decisionmakers. In February 2001, the International Confederation of Midwives (ICM) and the USAID-funded Maternal and Neonatal Health (MNH) Project convened a working group session, titled “Meeting of the Minds,” in which midwives identified five critical issues facing the profession. Advocacy and leadership were the two top concerns. POLICY staff attended the meeting and shared information on advocacy and networking skills.

As a next step, ICM, the MNH Project, and POLICY embarked on an initiative to strengthen the advocacy, leadership, and networking capacity of midwives. The goals were to enable midwives to participate in the policymaking process; raise awareness among decisionmakers at all levels (e.g., government, facility, community, family) of the dangers women face during pregnancy, delivery, and the postpartum period; and raise awareness of the value of trained midwives as essential maternal healthcare providers

and skilled birth attendants. Key components of the “Midwifery Advocacy and Leadership Training Initiative” included the design and dissemination of training materials, regional training workshops, and small grants to support the implementation of action plans (discussed in the next section).

Maternal Health Advocacy Training Supplement

It was recognized that advocacy training materials would be needed that specifically address maternal health issues, which had not been high on the priority list in many developing countries. POLICY and the MNH Project collaborated to write the Maternal Health Supplement (POLICY Project, 2003) to POLICY’s reproductive health advocacy training manual, *Networking for Policy Change* (POLICY Project, 1999). The supplement provides guidance on how to form networks and implement advocacy strategies using examples and information relevant for maternal health—including evidence on the magnitude of the problem, the impact of maternal mortality on families and communities, and implementation of best practices to improve maternal health.

Box 2. What is “advocacy”?

Advocacy is “a set of targeted actions directed at decisionmakers in support of a specific policy issue” (POLICY Project, 1999, p. III-2). Effective advocacy is strategic, targeted, and well designed. Advocacy moves beyond simple awareness raising; it identifies an issue requiring attention and proposes a specific, actionable solution.

Maternal health advocates, such as trained midwives, can engage audiences in dialogue regarding various aspects of maternal health. At the national level, they might encourage allocation of resources for safe motherhood activities. At the operational policy level, advocates might work to establish new training programs for midwives and other medical personnel on ways to handle obstetric emergencies (POLICY Project, 2003).

Table 1. Regional Training Workshops

Region	Date	Location	Number of Participants	Countries Represented
Africa	December 2001	Ghana	27	Ethiopia, Gambia, Ghana, Kenya, Malawi, South Africa, Tanzania, Uganda, and Zimbabwe
Asia and the Near East	July 2002	Philippines	26	Cambodia, Egypt, Indonesia, Jordan, Nepal, Pakistan, Philippines, and Vietnam
Latin America and Caribbean	February 2003	Peru	28	Argentina, Bolivia, Ecuador, Guatemala, Mexico, Paraguay, Peru, and Uruguay

The supplement was pilot-tested in two training workshops, with facilitator comments subsequently incorporated in the final version. The supplement continues to serve as a training resource for midwives and other maternal health advocates.

Regional Workshops

Between December 2001 and February 2003, regional workshops were convened in Ghana, Philippines, and Peru (see Table 1). Participants included teams of 2–7 midwives from 8–9 countries in each region, resulting in more than 80 midwives from 25 countries receiving training. During each five- to six-day training workshop, midwives identified critical issues to address and, following capacity-building on the advocacy process, designed detailed action plans to meet their stated objectives. Country-specific advocacy issues included supporting more and higher quality education for midwives; establishing improved guidelines for governing midwifery; improving access to emergency obstetric care and emergency transportation; and increasing support for postpartum family planning.

Having received advocacy training and related materials at the regional workshops, the midwife teams are better able to influence the

decisions that affect maternal health policies and programs in their home countries as well as share the skills learned with their counterparts.

SMALL GRANTS: FROM TRAINING TO ACTION

As a follow-up to the advocacy training workshops, participating midwife teams were encouraged to apply for small grants to support implementation of their newly developed action plans. Six

midwifery groups and associations received small grants, ranging from US\$3,900–5,700, enabling them to apply what they learned in the workshops and realize their power to influence policymaking processes. Highlights from the activities of three grantees are presented in the following sections of this brief.

Maternity and Child Welfare Association (Sindh Chapter, Pakistan)

Members of the Sindh Province Maternity and Child Welfare

A woman looks lovingly at her child in "The Only Way," a short video drama that tells the story of a generation of Pakistan's people, 1993. © CCP, Courtesy of Photoshare.



Association identified the lack of trained midwives in villages as its priority action issue. In Sindh, as elsewhere in Pakistan, midwives are not widely available in rural communities, leaving family members or less trained traditional birth attendants to assist with deliveries, often resulting in high maternal mortality. While established midwifery training institutions exist in Pakistan, there are few practicing midwives due to various medical, legal, educational, cultural, and social barriers. Moreover, midwifery training is often conducted by nursing teachers who can provide theoretical and academic knowledge of maternal healthcare, but little or no practical “hands-on” training.

To address this problem, the association decided that it would advocate for the placement of at least one midwifery teacher in all public and private midwifery schools in the province. In addition, to ensure high-quality midwifery care, the midwifery curriculum needed to be revised, approved, and implemented. To achieve its objectives, the team used its small grant funding to carry out numerous activities, including:

- ✦ a team meeting to complete the advocacy action plan;
- ✦ the writing of a letter to the Sindh Province Minister of Health, a key decisionmaker in the policy process, providing him with data that identified the problem and the midwives’ proposed solution;
- ✦ the submission of a letter to the Pakistani Nursing Council, asking it to revise the midwifery curriculum;
- ✦ a follow-up meeting with the Minister of Health to discuss the proposed solutions;
- ✦ a meeting with the nursing superintendents in charge of midwifery schools to discuss proposed changes in the midwifery curriculum; and

- ✦ meetings with midwifery instructors to solicit their views on the revised curriculum (marking the first time that instructors had input in the process).

Box 3. A midwife mentor

Eighty-six year-old Imtiaz Kamal is known as the “grandmother of midwifery” in Pakistan. Imtiaz was a member of the team from Pakistan that attended the regional advocacy training in the Philippines in July 2002. She left the workshop with the objective of mentoring her two teammates to enable them to serve as effective advocates for safe motherhood. Imtiaz cultivated the confidence and skills of her teammates, inspiring them to become strong advocates for mothers, newborns, and families. Her efforts built the confidence of midwifery advocates to carry on the mission of promoting involvement of midwives in policy dialogue and keeping safe motherhood issues high on the policy agenda.

As a result of the team’s hard work and dedication, the Minister of Health committed to appointing one specialized and clinically-skilled

midwifery teacher to all 13 public midwifery schools and all 17 private midwifery schools in the province. Input from various stakeholders contributed to the revised curriculum, which was submitted for final review by the Nursing Council in January 2003. The council approved and disseminated the curriculum in March 2004. In addition, Directors of Health in all provinces initiated action to appoint midwifery teachers.

Nursing Association of Nepal

The Nepal midwifery team members, who are members of the Nursing Association of Nepal, identified the lack of a uniform national midwifery education program as its priority advocacy issue. In Nepal, 90 percent of all births occur at home, and 88 percent of those deliveries are without the assistance of a trained attendant. Unmet need for emergency obstetric care is an alarming 95 percent (Nursing Association of Nepal, 2003). In addition, family and cultural norms isolate women during and after childbirth, further delaying the seeking of emergency care and increasing maternal and infant mortality.

Although the Ministry of Health (MOH) had recognized the need to improve maternal health,

A mother and child in Nepal. © Caroline Jacoby, Courtesy of Photoshare.





A traditional birth attendant and her child in Chimaltenango, Guatemala during a training of traditional midwives conducted by Midwives for Midwives, an NGO dedicated to improving the knowledge and skills of birth attendants, 2002. © Virginia Lamprecht, Courtesy of Photoshare.

decrease maternal mortality, and increase the number of midwives available at the community level, the development of a formal midwifery education program had not been put on the national policy agenda. To address this barrier to increasing the number of midwives and quality of midwifery care, the Nursing Association decided to advocate for the MOH's approval of and commitment to a midwifery education program.

To meet this objective, the team completed the following tasks:

- dissemination of a position paper highlighting gaps between current nurse training programs and the scope of skills required to practice as a trained midwife;
- submission of a proposal to the MOH advocating for the creation of a formal midwifery education program;
- organization of regional workshops and consensus-

building efforts to actively involve key stakeholders—such as district health officers, regional hospital superintendents and matrons, nursing campus chiefs, and public health and private hospital nurses—in the policy process; and

- formation of advocacy groups to follow up on the proposal to MOH and track it through the approval process.

The team's efforts led to the successful creation of a formal Midwifery Education Program, with the purpose of increasing the number of skilled midwives at all levels of healthcare in Nepal. The government officially incorporated the program into the 2004 National Health Plan.

Ghana Registered Midwives Association

The Ghana midwifery team felt strongly that the skills they acquired at the Africa regional

workshop should be shared with the entire leadership of the Ghana Registered Midwives Association (GRMA). As a result, in March 2003, the GRMA used its grant to conduct a five-day advocacy workshop for representative leaders of the organization. A second aim of the workshop was to build on previous POLICY support in the establishment of six reproductive health advocacy networks in Eastern Ghana (see Callender, 2000). The GRMA felt that by building the skills of its leadership, it could better advocate for improved maternal and child healthcare services at all levels in Ghana.

The team's specific advocacy objective was to build the capacity of 15 council members and nine regional representatives of the GRMA to encourage decisionmakers at the national, regional, district, and community levels to formulate effective policies to improve maternal and neonatal health. The team used



Cover photo: A mother and trader in the Urubamba Valley of Peru carries her child during a day at work, 2005. © Anja Lendvay, Courtesy of Photoshare.

its grant money to support numerous activities, including:

- ✦ facilitation of a five-day advocacy skills workshop for GRMA members;
- ✦ preparation of a fact sheet on maternal health records of attendance at midwives' maternity homes, region-by-region;
- ✦ preparation of a PowerPoint presentation for policymakers describing the issues and how to address them;
- ✦ organization of meetings, seminars, and symposia with stakeholders to present the issues and gain their support for solutions; and
- ✦ organization of meetings with the Regional Director of Health Services to share the

fact sheet and presentation and gain his support for the issues identified by the GRMA leadership.

Action plans drafted during the workshop included objectives such as raising awareness among district assemblies and male opinion leaders, increasing awareness of specific obstetric risk factors for adolescents, and increasing recognition of the importance of seeking maternal healthcare early in pregnancy. Policymakers were invited to the closing session and declared their continued commitment to collaboration with GRMA as frontline advocates for maternal healthcare in Ghana. The GRMA continues to be an active partner in the development of maternal health, midwifery, and child survival efforts in Ghana. Additionally, they routinely hold technical update trainings for their members in diverse areas as prevention of mother-to-child

transmission of HIV, prevention and control of malaria in pregnancy, and community outreach, among other beneficial activities.

Through the small grants, the midwife teams received the support needed to put their advocacy plans into action. These efforts have led to increased awareness of maternal health issues and the role of trained midwives in preventing maternal and newborn deaths. The ability to take what was learned at the training workshops and put the concepts into action has also helped to further institutionalize the midwives' newly acquired advocacy and leadership skills.

YOUNG MIDWIFERY LEADERS PROGRAM

As a result of the fruitful collaboration on the Midwifery Advocacy and Leadership Training

Initiative, the ICM asked the POLICY Project to support a new mentoring program focusing on the development of leadership skills for young midwives. The Young Midwifery Leaders Program (YMLP) aims to identify and develop the capabilities of young midwives to lead and serve in key positions at national, regional, and international levels. The young midwifery leaders and their mentors are drawn from Germany, Malawi, Scotland, Slovenia, South Africa, and Trinidad/Tobago.

The objectives of the program are to:

- develop young midwifery leaders, who have a broad understanding of current and emerging issues, through a program that enhances their ability to identify emerging needs and new directions;
- provide opportunities for learning and sharing experiences with each other and regional midwifery leaders; and
- establish a network that will support participants to further strengthen their leadership potential.

The YMLP began in 2004 with a workshop to introduce the midwives and their mentors to the program and provide them with introductory leadership and advocacy training. Participants learned about advocacy and the policy process, including the important role midwives can play as champions for mothers and their newborns. In early 2005, a four-day, intensive advocacy and leadership workshop for the midwives was convened. At this workshop, the midwives and their mentors identified the priority safe motherhood issues they wanted to address and began drafting advocacy action plans. With technical assistance, the midwives have finalized and begun implementation of their action plans. As an additional project component, the

ICM program manager responsible for the YMLP received training and guidance to draft an action plan to support the young midwives as they implement their advocacy strategies.

These midwife mentoring and advocacy training efforts are helping to cultivate new generations of policy champions for maternal health issues.

CONCLUSION

Ensuring that midwives have the tools, skills, and support to advocate for policy change is essential for keeping maternal health issues high on policy agendas—and, ultimately, for reducing maternal and neonatal mortality and morbidity. Through the development of training materials, strengthened leadership capacity, and grant support for advocacy plans, midwives are increasingly being recognized as legitimate partners in the policymaking process at all levels. The Midwives Advocacy

and Leadership Training activity expanded the influence of those with firsthand knowledge of the health needs of women, their newborns, and families. The Young Midwifery Leaders Program and the GRMA's continuation of advocacy training in Ghana ensure that valuable knowledge and skills will continue to spread throughout the midwifery community. Materials such as the Maternal Health Supplement to the advocacy manual are widely available for use by civil society groups advocating for policy change that will further strengthen support for maternal and reproductive health issues. To date, midwife-led advocacy efforts, in countries such as Nepal and Pakistan, have resulted in improved midwifery curricula and expanded training programs, with the aim of increasing access to skilled birth attendants in rural areas. In these ways, midwives have become champions for maternal health issues and are advocating for change to support healthy outcomes for the women and families they serve.

A mother smiles happily at her child as she leaves the clinic in Bahir Dar, Ethiopia, 2003. © Chandrakant Ruparelia, Courtesy of Photoshare.



REFERENCES

Callender, E. 2000. "Eastern Region Reproductive Health Advocacy Networks: A Case Study of District-level Networks in Ghana, 1996–2000." Washington, DC: Futures Group/Policy Project.

International Confederation of Midwives (ICM). n.d. "Definition of the Midwife." The Hague, The Netherlands: ICM. Available at <http://www.internationalmidwives.org/Statements/Definition%20of%20the%20Midwife.htm> [accessed March 17, 2006].

International Institute for Population Sciences and ORC Macro. 2000. National Family Health Survey (NFHS 2), 1998–99: India. Mumbai, India, and Calverton, Maryland, USA: International Institute for Population Sciences.

Nursing Association of Nepal. 2003. "A Report on Midwifery Education Advocacy in Nepal. Project Report Submitted to Futures Group/POLICY Project." Kathmandu, Nepal: Nursing Association of Nepal.

POLICY Project. 1999. Networking for Policy Change: An Advocacy Training Manual. Washington, DC: Futures Group/POLICY Project. Available at <http://www.policyproject.com/pubs/AdvocacyManual.cfm> [accessed March 21, 2006].

POLICY Project. 2003. Networking for Policy Change: An Advocacy Training Manual—Maternal Health Supplement. Washington, DC: Futures Group/POLICY Project. Available at http://www.policyproject.com/pubs/manuals/MH_FULL.pdf [accessed March 20, 2006].

United Nations. 2005. The Millennium Development Goals 2005 Report. New York, NY: United Nations.

United Nations Population Fund (UNFPA). 2005. "State of the World Population 2005: Reproductive Health Fact Sheet." New York, NY:

UNFPA. Available at http://www.unfpa.org/swp/2005/presskit/factsheets/facts_rh.htm [accessed March 17, 2006].

World Health Organization (WHO). 2003. Maternal Mortality in 2000: Estimates Developed by WHO, UNICEF, and UNFPA. Geneva, Switzerland: WHO.

World Health Organization (WHO). 2004. Making Pregnancy Safer: The Critical Role of the Skilled Attendant—A Joint Statement by WHO, ICM and FIGO. Geneva: WHO.



Bianca, a one-year old, with her mother in Nairobi, Kenya. © Sammy Ndwiga, Courtesy of Photoshare

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