

WHITE RIBBON ALLIANCE, TANZANIA
'IS IT WORTH IT FOR TANZANIA TO INVEST IN COMMUNITY MIDWIVES?'
DEBATE FORUM REPORT

23 August 2006

New Africa Hotel
Dar – es – Salaam, Tanzania

Signed

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Executive Summary

Tanzania has one of the highest rates of maternal morbidity in the world. Every hour of every day, one woman dies due to pregnancy, labor and delivery complications. 32 out of every 1,000 newborn babies die within one month of birth. Most shocking is the fact that the majority of these deaths are *preventable*, simply through the use of skilled health workers qualified to manage a normal pregnancy; but who also have the capacity to identify complications during delivery and can facilitate a transfer to a medical facility.

The current state of maternal health in Tanzania poses a significant challenge, one indicative of a growing health and social crisis that has the ability to influence the economic development of the nation and future generations. The White Ribbon Alliance for Safe Motherhood in Tanzania (WRATZ) works to promote public awareness and to develop action plans to make pregnancy and childbirth safer for all women and newborns in the developed and developing worlds.

On 23 August 2006, WRATZ in conjunction with the Ministry of Health and with support from UNICEF, convened a debate forum titled ‘Is it Worth it For Tanzania to Invest in Community Midwives?’ as a means to explore the issues impacting this maternal health crisis. This report is based on presentations made and feedback from participants of the debate forum. It is the intent of this report to summarize the information presented, extract the key points discussed and review the policy direction advocated for by WRATZ and partners.

The majority of women in Tanzania are unable to access the health services available to them. The most common reasons cited include: distance from a health facility, distrust of the level of care received from a facility, lack of financial means and social norms which promote the use of traditional birth attendants (TBAs) – birth assistants who have not undergone certified medical training.

Compounded with this is a human resources dilemma – large numbers of qualified, capable health workers are either unemployed or are employed, yet are overburdened and lack the incentives and/or motivation to work efficiently and effectively. A case in point: the minimum threshold of skilled workers worldwide is 2.5 for every 1,000 people. Tanzania faces a shortfall of 35,000 workers to reach the minimum threshold.¹

WRATZ has identified this shortage of health workers as the crux of the problem, and advocates for adequate, qualified staff to be employed to provide skilled attendance for quality maternal and neo natal health services at community and health facilities

¹ Joint Learning Initiative, 2004

at all levels in order to bring about sustainable change. The Ministry of Health is also making efforts to improve the quality of EMOC services and eventually aims to increase the number of health facilities available to women. The use of community midwives has generated much interest as a means of alleviating the situation in the short term, as these midwives have the required competencies, are typically based within the community, and would not only serve a vital function within their locality, but also play a key role in facilitating services and strengthening the link between facility and community. A number of the obstacles women face in accessing skilled care would thus be eliminated.

Part of this advocacy effort involves the dissemination of information and a call for action to WRATZ coalition members, non-government and government actors and donors to take steps to actively address and improve the situation.

Forum Objectives

The forum explored the current role and feasibility of promoting the use of community midwives to primarily provide support and guidance for women through all stages of pregnancy, but also to coordinate services between the facility and community and to manage the basic health of a community. Strategies that can be employed to remedy the current shortage of health workers and recruit new staff were also examined.

Forum Presentations

Presentations were made defining the role of midwives in Tanzanian society, citing the associated merits and drawbacks, and how the current health worker shortage has had an impact on this area of health care. Presentations provided the background information for a debate among attendees to determine if investing in midwives is the correct path for Tanzania at this time.

Attendees

The forum attendees represented a multi-sector effort to address this issue including, health care providers, policy makers, grassroots organizers, community health advocates, non-government organizations (NGOs) and government organizations, media and WRATZ members.

Conclusions & Policy Direction

Based on feedback offered by forum participants, consensus was reached that community midwives are vital in guiding women through safer pregnancies and saving the lives of women and newborns during childbirth and post pregnancy. They also have the capacity to manage the general health of the communities at large, thus making them an even greater asset. It was agreed that the recruitment, training and deployment of midwives would be a positive step forward in improving the accessibility of health services as well as reducing the existing burden on central health facilities. Key factors in producing an enabling environment for community midwives to perform their duties in will be public education and advocacy promoting their use.

Using the current pool of human resources more effectively was also stressed. Clear definition of responsibilities, improving the wage structure, introducing incentive schemes, providing additional training and continuing education options as well as updating human resource approaches were referenced as potential solutions. Collaboration between policy makers and other stakeholders to ensure these measures are carried out was strongly recommended.

The most immediate action called for is an updated review and census of the existing health structure and human resource capability – for example, what skill sets do the majority of birth attendants actually have? How can nursing schools attract greater numbers? What should the required proficiencies be for the next class of health professionals? Additionally, a survey of community midwives is also required in order to identify the support systems needed for them to carry out their prescribed functions, and how their work ties into the health services continuum. In order for this strategic review to accurately reflect the extent of reform needed, all stakeholders are urged to work together in order to make this advocacy goal a reality.

About White Ribbon Alliance for Safe Motherhood Tanzania (WRATZ)

White Ribbon Alliance for Safe Motherhood Tanzania (WRATZ) is part of the global White Ribbon Alliance, a coalition of organizations and individuals who have come together to promote awareness and advocate for a safer pregnancy and childbirth for all women and newborns. Today, national alliances exist in over fifteen countries throughout Asia and Africa.

WRATZ was organized in March 2004 in response to the alarming state of maternal health in Tanzania: the maternal mortality rate is 578 deaths per 100,000 births, among the highest in the world. Less than 46% of Tanzanian women receive skilled care during their pregnancy and delivery. More than half deliveries are performed away from a medical facility.

WRATZ Vision

WRATZ's vision is for all women and newborns in Tanzania to enjoy essential, quality and life saving safe motherhood services in a supportive environment. The Tanzania chapter is committed to promoting a multi sector force to address the challenges of safe motherhood in Tanzania by pursuing an action plan based on:

- Building alliances between all stakeholders involved in order cultivate and develop resources
- Raising awareness about safe motherhood issues from a rights based perspective
- Building capacity of grassroots and non government organizations
- Influencing policy direction by advocating and bringing safe motherhood issues to the forefront.

WRATZ Focal Areas and Advocacy Efforts

The main focal areas for WRATZ activities and advocacy efforts are:

- Improving birth preparedness among Tanzanians
- Increasing male involvement in reproductive health issues
- Assisting women to realize their right to skilled birth attendance
- Advocating for increased numbers of skilled birth attendants

In its advocacy strategy launched in 2006, WRATZ identified one of the primary issues impacting safe motherhood as being ‘a critical shortage of health workers at all levels of health facilities and community in Tanzania leading to increasing numbers of maternal and newborn deaths and devastating disabilities.’¹ It has been established that the most critical intervention in saving the lives of women and newborns is the presence of a skilled provider during childbirth and the immediate postpartum newborn period. A skilled provider has the knowledge and training to identify and manage complications should they arise, or to refer the patient to a facility. However the use of and access to these skilled providers has been limited for the majority of Tanzanian women thus far. The resulting advocacy goal has been a call for “adequate qualified staff to be employed to provide skilled attendance for quality maternal and neonatal health services at community and health facilities at all levels”. WRATZ has chosen to focus on the feasibility of investing in community midwives to assist women during their pregnancies, and will promote the concept to policymakers to put into action.

Presentations made during the WRATZ debate forum lay the foundation for analysis of this multifaceted issue. Various perspectives of the debate are offered – the role and importance of a community midwife, the barriers women in Tanzania face in accessing skilled health providers, and the human resources challenges facing a burdened health system.

Presentation Summaries:

Summary of Presentation by:

Rose Mlay, Coordinator, White Ribbon Alliance for Safe Motherhood Tanzania
‘Overview: Definition and Role of Community Midwives’

54% percent of Tanzanian women choose to give birth at home alone, with a relative or a traditional birth attendant (TBA) for a variety of reasons – among them: distrust of the level of care that will be provided at a health facility, distance from the nearest facility, lack of finances and social norms which promote the practice of home delivery. This is an extremely unsafe practice given the number of complications that can arise and that these deliveries are monitored by an untrained attendant. For example, the five most common causes of maternal death include: hemorrhaging, obstructed labor, abortion, infection and eclampsia. Each of these can be remedied if detected in time, however are fatal if the birth attendant lacks the proper training and experience to handle them.

Community midwives, also known as skilled birth attendants, are health professionals who have achieved a basic level of competency in public health and have the capacity to manage a normal pregnancy including pre and post natal care, labor and delivery. Most importantly, they are trained to identify complications during any stage of the pregnancy and have the knowledge to either manage the condition themselves or refer the patient to a higher level of care. The key concept is that the midwives have the necessary *training and skills* that qualify them to see a woman safely through her pregnancy.

Midwives are often affiliated with a health facility, but are posted in various areas surrounding the facility. While their specialty is monitoring pregnancy, they are typically well versed in the general health of the community in which they are based and are familiar with existing social norms and practices, thus are able to provide care for the community at large. In fact, midwives often act as resources for a community and provide education about public health issues ranging from HIV/AIDS testing to domestic violence, sanitation to breastfeeding.

Midwives provide a valuable connection between the community and health facility. While the importance of observing traditional norms should not be underestimated, every woman should have the option of being cared for by a skilled attendant equipped with the knowledge and skills to guide her through her pregnancy. By investing in the use of trained health professionals alongside TBAs, maternal mortality in Tanzania has the potential to be reduced.

“Everybody needs to work together to ensure a better environment – not only midwives but also the populace must work together to improve the resources available, demand quality services and health centers in their towns.” – Forum Attendee

Summary of Presentation by:

J.A. Safe, Chief Nursing Officer (Retd.), Ministry of Health
'Community Midwives in Tanzania a Necessity'

In order to reflect on the question of whether community midwives in Tanzania are necessary, any analysis should incorporate facts about the current situation:

- At present, there are 7,157,619 women at reproductive age in the country with a projected average fertility rate of 5.7 children
- The maternal mortality rate is 578 per 100,000 live births
- 75% of the population live in rural areas
- More than half of all births occur at home
- 83% of those delivered at home do not receive post natal care
- The current ratio is one midwife to 2,536 patients

These statistics paint an accurate picture of the main obstacles facing the Tanzanian health system today. The maternal mortality rate in the country is unacceptably high, primarily caused by treatable complications such as hemorrhaging, obstructed labor, pregnancy induced hypertension sepsis and abortion. Women do not seem to be able to access the health facilities due to distance from the facility, financial constraints, lack of a proper functioning referral system, inadequate resources and care at the health facility. And should a woman be able to access a health worker, each trained midwife is charged with the care of 2,536 patients!

There are clearly not enough trained, skilled professionals available to meet the needs of the female population. Moreover, the professionals that *are* available are faced with inevitable burnout given the sheer volume of their workload. How has the system gotten to this point?

During Tanzania's colonial past, there were health nurses who rendered services in the home, similar to the community midwives that have been repeatedly referred to during this forum. These health nurses were involved in conducting deliveries, monitoring pregnancies, immunizations, home visits and the general wellbeing of the mother and child. This particular cadre of health professionals ceased when colonialism ended and the nurses returned to their countries.

The notion however was not abandoned. Village midwives were then trained to work in local dispensaries after an increase in maternal mortality and newborn death became apparent. In 1974 the Ministry of Health trained and made available maternal and child health aides in order to provide comprehensive health services for mothers and children throughout Tanzania.

However this system slowly moved from being community based to facility based. More services were being offered at the facility itself rather than through home visits. As the services became more centralized, the burden on health professionals in the facilities also

increased, prompting high levels of stress and burn out. Today, patients complain of overcrowding in facilities and appalling bedside manner from hassled attendants.

While there is no simple solution that will rectify all the issues facing today's health system, the re-introduction, recruitment and training of community midwives will provide some level of relief to an overburdened system. Women will eventually be able to access the skilled care that they need, as well as obtain the necessary referrals in a timely manner. This, in turn will also relieve the health facility by reducing the burden on on-site staff, reducing congestion and overcrowding in the hospitals and allowing each patient to be cared for in a suitable manner.

This change cannot be implemented at the push of a button, it is undoubtedly a long process, however the process must be initiated if there to be any improvement in maternal mortality rates. Government, non-government organizations and individuals need to work together to address each of these challenges to the system. They must advocate for current policy review and address any necessary changes. A multi sector approach is vital if any progress is to be made. Perhaps the first step is to agree that community midwives are indeed necessary in Tanzania.

“The question is not whether we need midwives, but rather how we can reduce the current work level and obstacles in the way of those who are currently serving health facilities. How can we make the system more efficient?” – Forum Attendee

Summary of Presentation by:

Ismat Dewji Sheriff, Coordinator, CARE Tanzania

‘Should Tanzania Invest in Community Midwives? The International Experience.’

When weighing the case for or against investing in community midwives in Tanzania, one of the most valuable resources available is to evaluate the experiences of other countries; what has already been tried, what worked, what didn't work, and to extricate any best practices that were developed in the process.

Four international care models were analyzed. Model 1 was based on a non-professional delivering at home – dealing with a normal delivery, with the capacity to recognize complications, and organized access to an emergency obstetric care facility. Model 2 involves a skilled attendant delivering at home with the background training and skills to enabling them to efficiently manage a delivery, can recognize complications and also refer patient to an emergency obstetric care facility. Model 3 involves access to a health facility in which emergency obstetric care can be performed, as well as skilled attendants on site who recognize the need for emergency obstetric care and are able to administer it. Model 4 is based on delivery at a center for emergency obstetric care which delivers basic and comprehensive care, and where there are skilled attendants to monitor the patient.

A review of the maternal mortality rates accompanying each of these models revealed that while the ability to implement each of these models was limited to the resources of

the country, most countries, regardless of the model they chose, took between a decade to seven decades to see a sizable decline in the MMR. What is most evident is that countries which took a greater amount of time to reach their current MMR also showed greater improvement, thus this time lag suggests fundamental changes to the entire *health system* have taken place.

“The single most critical intervention is to ensure that a health worker with midwifery skills is present at every birth, and transportation is available in case of emergency. A sufficient number of health workers must be trained and provided with essential supplies and equipment, especially in poor and rural communities.”² This notion has far reaching implications - adequate numbers of skilled midwives need to be recruited, the basic needs of these health workers also need to be met if they are to manage the health of the population – namely housing, salaries and incentives. Midwives must understand the local culture and customs of the region they are in, but similarly the public must also be educated on the importance of having them in their towns. To do their work efficiently, midwives need to be equipped with proper tools including required medications, supplies and emergency kits. They must have access to a referral network and most importantly access to transportation to a health facility. Finally, they must also be supervised to ensure a level of competence and quality is maintained.

While a complete overhaul of the health system may not seem plausible, the need for an updated policy approach aimed at reaching all mothers requiring delivery care, and providing them with the option of having a skilled midwife tend to them and/or the access to a health facility is paramount if Tanzania is to make any progress in reducing its maternal mortality rate.

“Tanzania has tried various approaches to maternal mortality in the past, we need to re-examine where we are and where we came from, what worked and what didn’t. Only then can we extrapolate the best practices that have worked in the past and re-incorporate them into a new policy direction.” – Forum Attendee

Summary of Presentation by:

Eliaremisa Ayo, Assistant Director Nurse/Midwife Training, Ministry of Health
‘Current Human Resource Situation in the Health Sector’

The cornerstone of any health care system is its human resources. However the health system is currently facing a human resources crisis in that there is an acute shortage of health workers ranging from 30% - 70% depending on the region. In this instance, the

² (IAG 1997, p.2)

focus is on skilled service providers, also known as midwives, who provide care for women during all stages of their pregnancies.

The importance of these midwives cannot be underestimated – they play a key role in ensuring adequate care for mothers and their newborns. For example, they are tasked with detecting any complications during a pregnancy and providing appropriate treatment, ensuring birth preparedness and anticipating any potential complications and educating a woman on the healthy care of her newborn. Any reduction in the maternal mortality rate of the country will require use of these professionals.

The reasons for this shortage are multifold – there has been little employment for newly qualified staff since the 1990's, despite healthy numbers of midwives graduating from training programs each year – for example, almost 1,600 midwives graduated from 54 training schools in the country last year. The lack of employment prospects has led to the migration of younger health professionals away from the country or to different fields of work within the country. The small percentage of health workers that are employed lack the motivation to work due to low salaries, find few incentives to work efficiently due to poor work environments, lack of recognition for their work and overcrowded workplaces, and often find themselves assigned to remote areas which are difficult to assimilate to; making improving motivation of workers a key goal.

While Tanzania is currently facing a human resources crisis, it does not have to remain this way. The resources do exist in the country, however need to be harnessed properly. Focus on current staff and recent graduates, provide them with opportunities and nurture their work environments. Make going to work a positive experience by using the most valuable resource wisely.

Conclusion and Policy Direction

The maternal mortality rate in Tanzania remains unacceptably high – according to some data sources, the maternal mortality rate has remained static for almost a decade.

Statistics and information provided at this forum lead to one basic conclusion – that the majority of maternal and newborn deaths are *preventable*. The single most critical intervention in saving the lives of women and newborns is the presence of a skilled provider during childbirth and the immediate postpartum period. A skilled provider is a healthcare provider with the knowledge, skills and qualifications necessary to deliver essential maternal and newborn care and who also has the ability to refer patients to medical facilities. Facilitating access to these skilled health workers will undoubtedly improve the maternal mortality rate in the long term.

The WRATZ has put forward an advocacy package highlighting the recruitment and use of community midwives as an initial step in reducing the maternal mortality rate of the country. The feasibility of investing in community midwives by training and installing them in communities with links to surrounding health facilities was debated during a forum hosted by WRATZ. The ensuing result was clearly in favor of community midwives.

Prior to moving forward, WRATZ coalition members called for an updated review of the existing capacity of the health sector, survey of the resources available and a more accurate picture of the gaps that exist in the continuum of services offered to women. This review must be launched in a timely manner in order to be included in the budget for the next fiscal year. As a means of moving this agenda forward, WRATZ, in conjunction with UNICEF will hold a special meeting on community level birth attendants as a starting point in the review process. The Ministry of Health will also be holding joint meetings of the entire health sector, with participation from local health authorities to civil society groups with a focus on the factors impacting maternal mortality in Tanzania.

“This is a process that has to go step by step, we have to involve all stakeholders if we want this to succeed.” – Forum Attendee

¹ Source: WRATZ Advocacy Strategy paper

APPENDICES

A.1 Forum Program

PROGRAM FOR A FORUM TO DEBATE ON COMMUNITY MIDWIVES IN TANZANIA

August 23, 2006
NEW AFRICA HOTEL

No	Time	Event
1	0800 – 0830	Registration
2	0830 – 0900	What is Community Midwives in Tanzania Context? (Not a Trained TBA) And what are their roles? Presenter: Rose Mlay
3	0900 – 0945	The Experience of the Shortage of Human Resources at the Health Sector in Tanzania and the consequences by: Ms. Joyce Safe
4	0945- 1030	TEA
5	1030 – 1115	The Current Situation of Human Resources at the Health Sector and its implications Presenter: Ms. Eliaremisa Ayo
6	1115- 1200	Community Midwives at International Level Presenter: Ms. Ismat Dewji Sheriff
8	1200 – 1330	Debate
9	1330 – 1430	Lunch
10	1430 – 1530	What Investments are needed for community midwives to be a reality in Tanzania? Open Forum
11	1530 – 1630	Conclusions

A.2 List of Attendees

Attendee Name	Organization		
A.M. Makuwani	MOHSW		
Agatha Haule	EGPAF		
Agatha Mshanga	TVT		
Catherine Kamuguya	WDP		
Columba Mbekenga	MUCHS		
Dorcas Robinson	CARE		
Dr. Ali Mzige	TPHA		
Dr. Chetan Ramada	TMJ Hospital Ltd.		
Dr. Elizabeth Hirr	URC / QAP		
Dr. Kidawto HL	AGOTA		
Dr. Nelly Itebe	UNFPA / MEWATA		
Dr. RB Kaunga	MOHSW		
Eliaremisa Ayo	MOH		
EM Rwamushaw	JHPIEGO		
Godfrey Hicheka	Reach the Children		
Halina Sheriff	Health Policy Unit		
Ismat Dewji Sheriff	CARE		
Jacqueline Maro	Upenda Redco		
Josephine Lwambuka	MNH		
Kerida McDonald	UNICEF		
Keziah Kapesa	PRINMAT		
Khairunnisa Dhawani	AKU – TIHE		
L. Mfalila	MOH/SW		
Margareth Philemon	School of Nursing		
Margreth Kimambo	TZ		
Mary Jo O'Hara	MUCHS / TAMA		
Method Simba	MOHSW		
Moses Mwalusamba	TVT		
N. Paul Msangi	PST		
Prof. Richard Lana	AGOTA		
PT Lisanga	MCCTF		
Pudensiana L	MEWATA	Rose Laisser	TARENA / TANNA
R. Steve nson	USAID	Rose Mlay	WRATZ
Reem Siddiqi	Consultant	Theresia Matasha	KCMC
Rehema Kahando	Engender Health	Zuberi Mussa	The Express
Rehema Ndehwa	THW		

A.3 Forum Presentations

Debate/Discussion Forum: “Should Tanzania Invest On Community Midwives?”

Rose Mlay

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Who are Community Midwives?

Community midwives are health professionals with competencies public health and taking care of normal pregnancy, labor and delivery and 42 days.

Community Midwives have competencies in detecting complications during pregnancy, labor and delivery, manage or refer on time to higher levels of the health system

Community midwives spend more time working within the community, rather than in a health facility although they may be employed by a health facility and answerable to health facility director

The Roles of Community Midwives

To provide safe and evidence based including risk and danger signs assessment, individual needs of each woman

To provide community-based care

To advise women on relevant tests, discuss results of tests and guide actions

Conduct normal deliveries at home or at health facility

Community Midwives involve themselves in improving the health of the public

Involved in Health promotion

Provide advice and guidance in cessation of drugs, alcohol, tobacco

Work with vulnerable groups, e.g. people living with HIV/AIDS

Work against domestic violence and abuse with the community by raising awareness of the problem

Vital Link Between Community-Based and Health Facility-Based Care

Community midwives can offer child-care education, family planning within local geographical area.

Can be involved with facilitating the community aspect of training student, nurses, midwives and medical students

Women who prefer to deliver their baby at home can discuss with their community midwife, who will support them, but each case must be discussed on individual basis Home Birth

Currently 54% of Tanzania women chose to give birth at home with the help of a relative, alone or a traditional birth attendant (TBA). The practice is unsafe because complications may not be detected and managed by these helpers.

Community Midwife will discuss with women of possible complications

Home Birth

Discussion of complications should be simple, e.g. postpartum hemorrhage in the mother or breathing difficulties in the baby. The 2 complications need expert care very fast, thus means to reach EMOC should be discussed

After assisting a home birth the community midwife will continue to care for the woman and baby post-delivery

Conditions for Which Health Facility Delivery must be Recommended

Placenta Praevia: The only safe delivery is caesarean section, usually at 38 weeks

Known cephalopelvic disproportion- pelvic outlet is too small to allow the baby's head to be born

High Blood Pressure – pre-eclampsia

Pre-existing disease e.g. cardiac, kidney, diabetes mellitus and sexually transmitted diseases including HIV/AIDS

Other Conditions that a Community Midwife might Recommend Hospital Delivery

Mothers past obstetric history

Mother's age – below 18 or above 35

First Birth

Multiple pregnancy – the worry is each baby will be smaller and vulnerable than singletons and sometimes born pre-term

Breech presentation – always there is concerns about delivery of the head after the body

Health Visiting

Community Midwives will receive orientation/training to visit families at their homes

During home visiting they will look after the welfare of mothers, babies and young children in the families. Home visits can be periodically after the daily visit in the first 10 days post delivery depending on condition of mother and children

Health Visiting Continue

Home visiting require appointments that are kept, if unable to meet the family must know a head of time

Community Midwife is a vital link

Community Midwives in Tanzania a Necessity
Debate forum 23th Aug 2006
New Africa Hotel

Presented by J.A Safe

Is it worthy for Tanzania Government to invest on this cadre?

Facts. DHS 2004-05

-TZ Population 35,788,095

(2002 Census)

-Women at reproductive age 7,157,619.

-Annual population growth rate 2.8

-Total fertility 5.7 children(no change in 10 years)

Facts continues

●Fertility rate is lower in urban areas 3.6 but higher in rural 6.5 and highest in poorest households 7.3

●Maternal mortality rate 578 per 100,000 live births

●Life expectance 49 years for females

●75 % of the population live in rural areas.

Facts cont...

●In 1980 about 45% of pop lived within one km to a health facility

●72% within 5km

●93.1 % within 10km

●People to be served:

-Dispensary 6-10 per1000 people

-Health Center 50 -80 per1000 people

-District hospital 250,000 people

-Regional hospital serves for 4-8 District hospitals

-Total health facilities 4,990, of these; 2877 are govt. owned, 848 faith based, 283 parastatal, 832 private owned

●

Facts cont...

●Human resource

-Total number of registered Midwives 14,115

-(Enrolled 8810 Registered 5305)

Ratio 1: 2536

Facts cont...

Place of delivery:

More than ½ of births occur at home

83% of those delivered at home do not receive post natal care
Proportion of births attended by skilled health professionals 46.3 %

Facts cont...

Results from community based study on fistula in Tanzania 2005 revealed that:

- Majority of women planned to deliver in HF
- ½ of the women said they faced constraints of distance to hospital and money

Facts cont...

- Other reasons include lack of functioning referral system
- Inadequate capacity in terms of space, skilled personnel, commodity and social cultural aspects surrounding the women
- Gender inequalities in decision making and access to resources

Causes of Maternal Mortality

- Obstetric Hemorrhages
- Obstructed labor
- Pregnancy induced hypertension sepsis and abortions
- NB Can be prevented if only pregnant women can be assured access to a skilled attendant at child birth and emergency obstetric care

Who is a community midwife?

- ...A professional health with personnel with midwifery skills who works at health facilities that are at the grassroots. They are a link between the community and the nearby health facilities and the community knows and accepts them.
- They can conduct deliveries at home or at the facility
- They identify maternal, newborn and child health problems and manage or refer.
- They provide counseling to individuals and provide health education to group/meetings or any other gatherings

History on training

- During colonial days there were health nurses who were rendering services at homes.
- The services included:
Conducting deliveries, monitoring child growth, weighing the children, giving immunizations and home visiting
- This kind of services ceased immediately after independence due to the whites nursing sisters going back to Europe

History on Training Continues...

- Village midwives were then trained to work in dispensaries after seeing that there were many problems with pregnant women and many children under 5 years were dying.
- The training was conducted in Nzega and in some district hospitals

-
- The Health Nurses training was in Tukuyu Mbeya region and later the training was transferred to Tanga
 - All this time there were the baby- well clinics especially in towns.
 - In 1974 the Ministry of health thought of having Maternal and child health Aiders in order to provide comprehensive maternal and child health services through out Tanzania
 - In 1975 the existing Health Nurses were upgraded to Public Health Nurses who became teachers for the MCHA schools and some became the MCH coordinators.
 - The trained MCHA were deployed in the dispensaries to render MCH services.
 - Services were facility based thou some home deliveries have been conducted by MCHAs

Why community midwives?

- Not a new concept.
- Need for a skilled attendant at every birth
- High maternal mortality 578/100,000 live births
- All pregnancies are at risk
- 53% of births are home deliveries By Whom?
- Studies have shown that homebirths with unskilled attendant is often the norm resulting in high maternal and neonatal mortality
- Active management of 3rd stage of labor for prevention of post partum hemorrhages
- Need for linkage between HF and the community (early referrals)
- Prevention of fistulas
- Mouthpiece of the community in case of need for policy changes or its development
- To curb the overcrowding in our health facilities
- An alternative for addressing the acute and critical problem of shortage of human resource in our HFs
- To relive the existing work force from burn out

What is needed

- Support- govt, NGO Community and individuals.
- Recognition
- Motivation-incentives working tools
- Commitments

Thank you

Ismat Dewji Sheriff
WRATZ Community Midwives Forum, 23 Aug '06
The International Experience

“The single most critical intervention is to ensure that a health worker with midwifery skills is present at every birth, and transportation is available in case of emergency. A sufficient number of health workers must be trained and provided with essential supplies and equipment, especially in poor and rural communities” (IAG 1997, p.2)

Loudon (1996) decided that of all the conclusions he had reached as a result of working on the history of maternal mortality over many years, the one that surprised him most was the fact that wherever a high proportion of deliveries were home deliveries undertaken by “trained and supervised midwives” the maternal mortality was the lowest. He added, “I found no exceptions to this rule” (Maclean, 2003)

Thus it is important to remember... a skilled attendant alone will not help the situation, s/he must have...

- Training
- Supervision
- Access to a referral network and transportation
- Emergency drugs and supplies

Presentation Outline

- The different models – What works for Safe Motherhood?
- Community Midwives for what purpose?
- International experience...
- Conditions needed for the intervention to work
- Would Tanzania benefit?

The different models – What works for Safe Motherhood?

Model 2: Community Midwives for what purpose?

- Prenatal Care
- Identification of Risks
- Normal Delivery
- Referral
- Postpartum Care
- Family Planning
- Maternal and Child Care: Nutrition, infection control etc.

International Experience

- Malaysia (from 320 to 43 in 39 yrs)
- Rural China (from 1500 to 115 in 46 yrs)
- Brazil (Trairi County - MMR: 102)
- Sri Lanka (from 2200 to 70 in 77 yrs)
- Cuba (from 118 to 31 in 22 yrs)
- Thailand (from 420 to 98 in 20 yrs)
- Egypt (from 174 to 84 in 7 yrs)
- Honduras (from 182 to 108 in 7 yrs)
- Yunnan (China) (from 149 to 101 in 10 yrs)
- Zimbabwe (from 283 to 695 in 4 yrs)

International Experience: Brazil

- Trairi County: MMR – 120 with 55% of women delivering at home
- Training session and practical training for TBA's
- Periodic supervision and instruction
- Uniforms, supplies, and transport reimbursements – no salaries
- Telephones to arrange transport
- Did not try to manage complications but preferred to refer

International Experience: Malaysia

- MMR 670 (1948) – 320 (1957)
- Mid 1970's-mid 1980's – SBA's attended home deliveries, TBA's shifted to role of family support – MMR decreased to 50 per 100,000 (by 1995, 95% of home deliveries covered by professional midwives, 1% by TBA's)

International Experience: Malaysia

- Responsibilities: prenatal and postpartum home visits, normal delivery, referral, FP, child health care services, could also administer drugs and oxytocin but not antibiotics
- 2 year training
- Salaries and housing for midwives
- Trained midwives posted to villages
- Supported by health units (one per 50,000), 4 sub-centers and 20 clinics with resident midwives
- 1975: ratio of midwife to population – 1:4300
- Prior knowledge of the community to be accepted within them
- Needed to be mature enough to be deemed as experienced
- Accountable: MCH committees to audit maternal deaths and coordinate local training sessions for health center staff
- Free services

International Experience: Malaysia (by 1996)

- MMR: 43 per 100,000
- 1:3000-5000 popln (midwife ratio)
- Primary care unit within 5 kms
- Of 510 gov facilities, 494 provide EmOC
- Referral available (transfer by ambulance)
- Free services for the poor
- Over 94% of births in hospitals, the rest at home with trained personnel.

International Experience: Rural China

- Expansion of rural health services in the 1960-80 period.
- Barefoot doctor trained in each commune
- By 1997 one female doctor working in every village.
- Referral system linked them to township health centers, county maternal and child health institutes or hospitals.
- Cooperative insurance scheme, by 1975 moved to fee-for-service system which caused a drop in demand for prenatal and postpartum care.
- Legalization of abortion in 1957
- Maternal audits (committees formed in the rural areas)

International Experience: Honduras

In addition to SBA's, Honduras invested in dedicated birthing centers (sometimes a room attached to the midwife's home) – this accommodated strong traditions of home delivery and attracted women to deliver with the SBA – in turn more complicated deliveries were referred, it is estimated that 6-10% of maternal deaths were avoided. (Danel, 1999)

Caution: The case of Indonesia

- Professional midwives in the villages increased # of births with a SBA but had little impact on providing adequate care
- Proportion of births attended by SBA increased from 37 to 59%
- Postpartum visits (36 to 72%)
- Despite these improvements, c-section rates declined from 1.7 to 1.4%
- Number of women admitted to hospital for life-saving treatment dropped from 1.1 to 0.7%
- Most likely reasons: lack of transportation, cultural aversion to use of health care facilities for obstetric care, and the high cost of EmOC.

Community Midwives for what purpose?

- To reduce the incidence of unplanned deliveries (50% of home deliveries in two communities in Nepal)
- Timely referral
- Better quality of care with personal interactions
- Access: prenatal and postpartum care

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- Reduced rates of infection and anemia
 - Better family planning (reduction of unplanned pregnancies and complicated unsafe abortions)
 - Early treatment of infection and bleeding from unsafe abortions

International Experience: Proposed rates of SBA

- 1:5000 (WHO,1999) – assuming a crude birth rate of 40 per 1000 births, each midwife would manage about 200 births per year.
- This would ensure retention of his or her skills

Conditions needed for the intervention to work

- Adequate number of skilled midwives
- Enabling environment: housing, salaries and incentives
- Trust and respect of community: midwives should speak the local language, allows traditional birthing positions, respects delivery rituals and privacy, does not disregard TBA, be mature
- Supportive Supervision
- Adequate referral – access to transport and EmOC services
- Availability of emergency drugs and supplies + delivery kits
- Availability of Family Planning supplies
- Held accountable by local authority/committee – maternal death audits

Tanzania in the Present

- National policy aimed at reaching all mothers with delivery care in health facilities
- Less than half deliver in health facilities at present
- Dispensaries and Health Centers often lacking critical drugs and supplies
- EmOC not widely available at present

An option...

- Small delivery box to be created for midwives at front-line service delivery stations with essential delivery equipment
- Bicycles made available to do home deliveries
- Remuneration: paid per delivery (as done in Europe in the last century and currently in Nepal) although responsibilities include post and prenatal care. Maybe an extra incentive for those who reach women in the community?
- This would strengthen the referral system as midwife would recognize danger signs faster and may be able to mobilize community transport mechanisms for pregnant women
- Would potentially improve relationships between clients and providers
- Knowledge of midwives would improve (need to carry out at least 120 deliveries per year to remain up to date)

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- More competent handling of post-partum care and infections, as well as adequate post-abortion care
 - Competent care of the newborn would reduce perinatal mortality

**TITLE: CURRENT HUMAN RESOURCE AT THE HEALTH
SECTOR SITUATION**

**IS IT WORTH INVESTING ON COMMUNITY
MIDWIVES?**

**PRESENTED: IN THE COMMUNITY MIDWIVES IN
TANZANIA DEBATE FORUM**

VENUE: NEW AFRICAN HOTEL

DATE: 23RD AUGUST 2006

**By: Mrs. Eliaremisa Ayo
ASSISSTANT DIRECTOR NURSES TRAINING**

Introduction.

Human resource is a necessary requirement in managing health care services. In this particular presentation our main concern is the skilled service provider for women during pregnancy, childbirth, postpartum and for the newborn.

The Skilled Service Provider.

The skilled service provider discussed here is the midwife. She/him has the knowledge, skills and qualifications necessary to deliver essential maternal and newborn care in any setting. Has certain defined core basic and life saving competencies. These core competencies reflect the minimum skills set of the skilled personnel-midwife.

It is the skilled service provider who is expected to provide quality basic care to woman during pregnancy, childbirth, postpartum including the newborn babies by:

- Promoting health and preventing diseases to the women.
- Detecting any existing disease and provide treatment or initiate the management.
- Detecting and managing complications at an earlier stage and
- Ensuring birth preparedness and being ready for complication.

The current human resource situation

It is clear that there is a big shortage of staff at workplace ranging form 30% to 70%. All places are affected though some areas suffer more than the others.

The reasons are varied could be

- there were no employments for newly qualified staff since early 1990s
- The few employed one not motivated to work due to low salaries
no incentives – good working conditions, appreciation etc
hardship areas – poor transportation even getting their salaries takes a day or two going to get it.
- Cultural barriers/attitude

Training of nurse midwives in Tanzania

A number of nurses and midwives are qualifying each year but have not been employed adequately in the health sector. The following data shows how many midwives have been qualifying each year.

Table: Showing midwives who have qualified from 2001 - 2005

N	Cadre	Year				
		2005	2004	2003	2002	2001
1.	Adva Dip	38	-	40	-	-
2.	Diploma	500	300	380	300	320
3.	Certificate	506	498	429	515	408

These midwives take community health nursing as a course. They do community midwifery practices during their training.

In the training system we have MCHA who in the past upgraded as public health nurses (PHN B). Recently this kind of training was converted to certificate in nursing and midwifery. The rationale for this change is that when such PHNB nurses were posted in areas which did not have general nurses, they could not provide the more general nursing care to clients.

So their curriculum has a lot of hours on community and midwifery as well as general nursing.

Is it worth investing on community midwifery in Tanzania?

Definitely we need people who will be providing care to women and their new born at all levels.

- I am aware that at least nurses and midwifery can now be employed according to request and number from local govt. Civil Service respectively.
- Replacement of the deceased ones retired staff.
- Salaries have also improved.
- Maintaining good working conditions – interpersonal relationship etc
- Being culturally sensitive and commitment to work will also help to

retain those posted at the community level.

Conclusion

I believe that we have adequate unemployed qualified staff.

Therefore if these newly qualified staff will be employed then women at the community level will be getting the essential basic care.

Thank you so much for your attention