policy

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INVESTING IN MIDWIFERY IN MALAWI

DELIVERING ON COMMITMENTS

Brief

White Ribbon Alliance Malawi

Photo by: White Ribbon Alliance Malawi

Introduction

In Malawi, an overall shortage of midwives, coupled with poor working conditions and status, are affecting the provision of high-quality maternity care for women. As a result, many women are giving birth at home without skilled attendants, increasing the risk of maternal and neonatal illness and death.

The Government of Malawi has made a commitment to strengthen human resources for health, including accelerating training and recruitment of health professionals to fill all available positions in the health sector. This policy brief examines the status of midwifery in Malawi, the government's progress in meeting its commitments to develop and improve midwifery services through increased investment, and the actions government and key partners can take to fast-track further improvement.

The White Ribbon Alliance for Safe Motherhood in Malawi (WRASM) is working to support the reduction of maternal and newborn mortality through advocacy to promote midwifery. In 2013, WRASM, through the USAID-funded Health Policy Project, launched a "Happy Midwives for Happy and Healthy Mothers" campaign to draw attention to the poor status and substandard working conditions of midwives and the impact on the provision of high-quality care.

> "…Where I am working it is bad. I am one of only ten midwives. We work day and night—not only in maternity, but in general wards too. We are trying our best just to give life to the mothers and babies—but the care we are giving is compromised. Because there are so few midwives, there are times when there is only one midwife to care for six to seven women who are all in labor at the same time."
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> Eness Banda, Nurse Midwife, Malawi, at the WRA Stakeholders Meeting in 2012

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Specifically, WRASM is advocating for

- The provision of adequate resources to address the gap in needed and available midwives;
- An increase in the national budget for training and deploying professional midwives to maternity units and communities where services are needed and for conducting community dialogue to improve community perceptions and promote professional midwifery;
- Institutionalisation of the newly created direct-entry programme for aspiring midwives (until recently, students had to train as nurses first and then choose midwifery); and
- Increased respect and improved conditions for midwives, and the profession of midwifery as a clear career path.

WRASM is calling for the government to bolster midwifery and midwives through its policies, but having supportive policies in place is only half of the battle. The government must also allocate additional resources to better support and recognise the profession of midwifery.

Advocacy by WRASM and its partners has already contributed to improvements in the status of midwifery. Since the campaign's launch, the Directorate of Nursing at the Ministry of Health has been renamed the

Existing Need for Maternity Care and Available Workforce

WHAT WOMEN AND NEWBORNS NEED (2012)

951,000 PREGNANCIES A YEAR = HOW MANY EPISODES OF CARE?

Number and distribution of pregnancies (2012)

APPROX.

PRE-PREGNANCY (all women of reproductive age) = 7,775,000 family planning visits

ANTENATAL (pregnancies x 4) = 3,802,000 routine visits

BIRTH = 655,000 skilled birth attendance

POST-PARTUM (births x 4)

POSTNATAL (newborns x 4) = 2,619,000 routine visits

0 <0.09 0.10-0.19 0.20-0.49 0.50-0.99 1.00-1.49 1.50-1.99 2.00-2.49 2.50-10.00 >10.00

WORKFORCE AVAILABILITY (2012)

Country classification of staff working in MNH[1]	Time spent on MNH %
Midwives	*na*	*na*
Midwives, auxiliary	48	100
Nurse-midwives	3,037	75
Nurses	*na*	*na*
Nurses or nurse-midwives, auxiliary	*na*	*na*
Clinical officers & medical assistants	1033	25
Physicians, generalists	125	35
Obstetricians & gynaecologists	25	100

PRE-PREGNANCY

ANTENATAL

BIRTH

POST-PARTUM

POSTNATAL

ESTIMATED MET NEED = 20%

workforce time available / *workforce time needed*

Estimate of met need (national aggregate) based on available data.

Source: UNFPA, 2014, p. 132.

Directorate of Nursing and Midwifery. In addition, 5 out of 10 colleges have been renamed the Colleges of Nursing and Midwifery.

State of Midwifery

Midwifery is a key element of sexual, reproductive, maternal, and newborn healthcare. According to the recently launched *State of the World's Midwifery Report* (SoWMy) 2014, investing in midwives could yield a 16-fold return on investment in terms of lives saved; free doctors, nurses, and other health cadres to focus on other health needs; and contribute to ending preventable maternal mortality and newborn deaths (UNFPA, 2014).

Giving birth without a midwife or skilled birth attendant puts women and their babies at a much higher risk of death from one of the many serious complications that can occur during childbirth. It is vital to have a trained midwife and other skilled birth attendants present to identify these complications early, as they are often unpredictable and must be dealt with or referred immediately. In highly developed countries where almost every birth is attended by someone with the right training, equipment, and supplies, many of these complications are avoided or resolved quickly. In poor countries with a serious shortage of midwives, all too often they are fatal.

The SoWMy report details the goals of Midwifery2030—a pathway for policy and planning—which urges countries to make transformative changes to increase the availability, accessibility, acceptability, and quality of health services to achieve universal access to sexual and reproductive healthcare and a reduction in maternal and newborn mortality.

Midwifery 2030 Goals

1. All women of reproductive age, including adolescents, have universal access to midwifery care when needed (the first and second components of universal health care [UHC]).
2. Governments provide and are held accountable for a supportive policy environment.
3. Governments and health systems provide and are held accountable for a fully enabled environment.
4. Data collection and analysis are fully embedded in service delivery and development.
5. Midwifery care is prioritised in national health budgets; all women obtain universal financial protection (the third component of UHC).
6. Midwifery care is delivered in collaborative practice with health-care professionals, associates and lay health workers.
7. First-level midwifery care is close to the woman and her family with seamless transfer to the next-level care.
8. The midwifery workforce, in communities, facilities and hospitals, is supported through quality education, regulation and effective human and other resource management.
9. All health-care professionals provide, and are enabled to deliver respectful, quality care.
10. Professional associations provide leadership to their members to facilitate quality care through advocacy, policy engagement and collaboration.

Source: UNFPA, 2014, p. 36.

In Malawi, in 2012, "of an estimated total population of 15.9 million, 13 million (82%) were living in rural areas and 3.5 million (22%) were women of reproductive age…By 2030, the population is projected to increase by 63% to 26 million. To achieve universal access to sexual, reproductive, maternal and newborn [SRMNH] care, midwifery services must respond to 1.3 million pregnancies per annum by 2030, 79% of these in rural settings. The health system implications include how best to configure and equitably deploy the SRMNH workforce to cover at least 86 million antenatal visits, 14.8 million births and 59.3 million post-partum/ postnatal visits between 2012 and 2030" (UNFPA, 2014, p. 132).

Data limitation poses a challenge to both advocates and policymakers. Stakeholders have questioned the number of midwives cited in various reports. For instance, the Malawi Nursing and Midwifery Council states that the recommended ratio in Malawi is 1 midwife for every 5 women, and currently, there is 1 midwife for every 10 women. However, the council's data only include registered midwives, and registered does not necessarily mean practising. Further analysis is needed to more accurately determine how many midwives are practising in Malawi.

"As we train more and more nurse-midwives, we need to create more and more positions so that people can progress."

Sheila Bandazi, Ministry of Health, Malawi, at the WRA Stakeholders Meeting in 2012

Colleges have increased their intake of students to respond to the gap in numbers of midwives. However, the country still faces major challenges with poor retention, compounded by internal migration and frequent migration to foreign countries. This is largely due to poor remuneration and a lack of incentives, such as housing, and contributes to midwives leaving their jobs to pursue more appealing opportunities in urban areas offering better housing and health infrastructure.

Government Commitments

In 2005, Malawi was one of the first African nations to develop a road map for improving maternal and neonatal health and was one of only two countries that successfully secured over 50 percent of the funding necessary to implement its first phase (Nove, 2011). The road map aims to increase the availability, accessibility, utilisation, and quality of skilled obstetric care at all levels of the health system. It identifies numerous contributing factors to Malawi's high maternal mortality ratio, which is currently 510 deaths per 100,000 live births (WHO et al., 2014). The four most important factors include

1. Staff shortages and weak human resource management
2. Limited availability and utilisation of maternal healthcare services
3. Weak referral systems
4. Weak community participation

The Government of Malawi has made a commitment to strengthen the health workforce in order to increase basic emergency obstetric care and neonatal coverage and reduce maternal and newborn mortality. The Ministry of Health (MOH) has been actively contributing to collaborative efforts to address the situation. Examples include the following:

- Between 1998 and 2004, a Safe Motherhood Project was run in the Southern region.
- The MOH implemented a six-year pre-service training plan that ran from 2002–2008, with the aim of increasing and improving the supply and distribution of essential health service providers.
- In 2003, the Health Service Commission was established, with the responsibility of filling health worker vacancies.
- A Sector Wide Approach (SWAp) was adopted in 2004 to coordinate the activities and expenditure of all health development partners.
- In 2007, Malawi ratified the African Union's Maputo Plan of Action on Sexual Reproductive Health and Rights, which seeks to improve the delivery of high-quality and affordable services in order to promote

safe motherhood, child survival, and maternal, newborn, and child health.

- Malawi was one of the first countries to join the Campaign for Accelerated Reduction of Maternal Mortality (CARMMA) in 2009.
- In 2011, a direct-entry programme was created for training midwives and a new cadre of community-based midwives was educated.

However, despite the government's demonstrated support, the investment in midwifery is still too inadequate to significantly improve poor working conditions, low pay, a lack of equipment, and ultimately, the retention of midwives. In spite of improvements in training, education, and regulation, Malawi's problems with retention will prevent any real benefit from taking hold. The provision of equipment and supplies needs to be enhanced throughout the country in order to optimise the performance of midwives in rural areas.

The total health budget decreased from K76,150.15 billion (US$192.78 million) in 2012/2013 to K48,729.23 billion (US$123.36 million) in 2013/2014. This represents a decrease in the share of the national budget from 13.56 percent to 11.95 percent, respectively. It should be noted that 14.1 percent of the whole national health budget goes to MOH headquarters, while most district hospitals are only allocated 10 percent, which contributes to the lack of equipment and supplies necessary for midwives to properly undertake their jobs (MHEN, 2013/2014).

In addition, there is no single line for midwifery in the health budget, which makes it difficult to track how much resources are allocated annually to midwifery. In an environment of competing priorities, it is important to draw attention to the urgent need for increased funding for midwifery services.

Policy and Budget Recommendations

WRASM calls on policymakers and the Government of Malawi, through the ministries of health and finance, to create a midwifery line in the national health budget to enable clear, trackable funding for midwifery services.

Having a midwifery budget line will

- Improve services and motivate midwives by instilling pride in their profession.
- Enable advocates and other stakeholders to monitor and push the MOH to increase national budgetary allocations for training, recruitment, and retention of more professional midwives to meet the ever-growing demands of midwifery services.
- Allow the MOH to allocate specific resources for incentives to encourage the retention of midwives in remote, hard-to-reach and underserved communities.
- Ensure that midwifery services are specifically recognised in district health budget allocations and that these allocations are increased to improve midwifery services.

In addition, WRASM calls on the MOH and sector-wide donors and partners to

- Consider organising a national conference on midwifery financing, which could mobilise political support and much-needed financing to scale up investment in midwifery.
- Start compiling an annual State of Malawi's Midwifery report, and create a mechanism for providing evidence-based data and information specific to Malawi so that nongovernmental organisations, academia, donors, and key stakeholders can play a role in enhancing midwifery in the country. At present, information on midwifery is not easily accessible.

Conclusion

Despite Malawi's commitments to improve midwifery, the government's investment in midwifery remains low. As the country looks towards the post-2015 development agenda, midwifery must become a top priority—not only to reduce maternal and newborn mortality but also to position Malawi as an example and authority at this year's United Nations General Assembly discussions on the Sustainable Development Goals.

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WRA Malawi was established in 2002, registered in 2003, and affiliated to the WRA Global Secretariat in 2007. WRA Malawi has a membership of 157 individuals and 61 organisations, including the Kamuzu College of Nursing, Association of Malawian Midwives, Save the Children/Malawi, United Nations Population Fund/Malawi, and United Nations Children's Fund/Malawi.