International Journal of Gynecology and Obstetrics 132 (2016) 126–129

Contents lists available at ScienceDirect

International Journal of Gynecology and Obstetrics

journal homepage: www.elsevier.com/locate/ijgo

EVIDENCE FOR ACTION

Evidence for action on improving the maternal and newborn health workforce: The basis for quality care

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ARTICLE INFO

Keywords:
Accountability
Evidence
Health workforce
Maternal mortality
Midwifery
Neonatal mortality
Quality of care

ABSTRACT

Ambitious new goals to end preventable maternal and newborn deaths will not only require increased coverage but also improved quality of care. Unfortunately, current levels of quality in the delivery of maternal and newborn care are low in high-burden countries, for reasons that are intimately linked with inadequate planning and management of the maternal and newborn health workforce. The Global Strategy on Human Resources for Health is a key opportunity to strengthen global and country-level accountability frameworks for the health workforce and its capacity to deliver quality care. In order to succeed, maternal and newborn health specialists must embrace this strategy and its linkages with the new Global Strategy for Women's, Children's, and Adolescents' Health; action is needed across high- and low-income countries; and any accountability framework must be underpinned by ambitious, measurable indicators and strengthened data collection on human resources for health.

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1. Ambitious new goals for maternal and newborn health

The Millennium Development Goals (MDGs) have been credited with generating attention and mobilizing resources for health development priorities, including in maternal and newborn health (MNH). A 45% decline in maternal mortality between 1990 and 2013 was achieved alongside a 24% decline in neonatal deaths [1]. The MDGs created a momentum for improvement: many individual countries will achieve their goals, while others are well on their way [2]. However, overall targets for women and children set by the Millennium Declaration will not be met and lag behind other goals [3]. The new Sustainable Development Goals (SDGs) will therefore need to ensure that further sustainable declines in mortality rates take place in the next decades.

New proposed global targets to end preventable deaths are ambitious. New goals were agreed in April 2014 at a consultation with representatives from 30 countries, hosted by WHO, UNFPA, USAID, the Maternal Health Task Force, and the Maternal and Child Health Integrated Program (MCHIP) (Figs. 1 and 2). These targets suggest that, given sustained efforts, a global maternal mortality ratio (MMR) of 70 per 100 000 live births and a global newborn mortality rate (NMR) of less than 12 deaths per 1000 live births can be reached by the year 2030.

2. Quality of care: A necessary condition for accelerated progress

Evidence that improving quality of care is a necessary condition for accelerating the pace of progress toward these new targets is now overwhelming. Although expanding accessibility is still needed, greater access to poor quality care will not decrease morbidity and mortality effectively, as shown in a variety of contexts such as India [4], Nepal [5], and Uganda [6], and in cross-sectional analysis [7]. Furthermore, poor quality care also dissuades women from accessing care [8]. Historical analyses in Sweden, Europe, and the USA have shown that the professionalization of the midwifery profession coincided with significant drops in maternal mortality, while cross-country data show that only countries with systems for skilled professional birth attendance reduced MMR below 50 per 100 000 live births [7]. Further evidence compiled by the Lancet Series on Midwifery demonstrates that a competent and motivated midwifery workforce is associated with progress in quality of care and maternal and newborn survival [9].

Quality of maternal and newborn care remains poor in many countries. A recent WHO survey of secondary and tertiary facilities in 29 high MMR countries [10] found that maternal mortality was on average two to three times greater than what would be expected given a similar level of patient risk in a moderate MMR context, such as Mexico. Furthermore, an extremely high percentage of women in high mortality hospitals received the recommended interventions, suggesting a quality rather than a coverage problem. Countries such as the Dominican Republic have not been able to tackle their high

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http://dx.doi.org/10.1016/j.ijgo.2015.11.003
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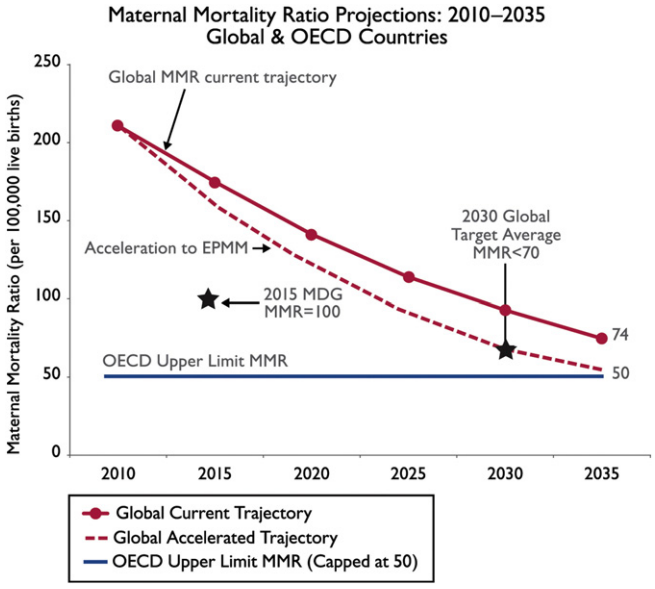

Fig. 1. New targets for maternal mortality. Reproduced with permission from USAID [25].

MMR problems without tackling quality of care [11]. Underestimation of severity, vertical care, poor implementation, inadequate prevention of infection, and delays in providing care all play their part in keeping MMR unnecessarily high, as well as broader determinants such as delayed access to the facility, undernutrition and pre-existing anemia as possible explanatory factors. Improving quality—although clearly not the only key remaining challenge—should therefore be at the core of scaling-up maternal and newborn health services toward universal health coverage.

As discussed by Hulton et al. [12] in this issue of *IJGO*, quality of care has several dimensions, including human resources, though many other aspects of quality care such as respectful care or clinical practice are channeled through health workers. Researchers have tackled the question of how to create a workforce capable of delivering quality MNH care within an enabling environment for many years. Much attention has been given to interim strategies such as task-shifting [13], and the possible contributions of voluntary health cadres [14]. However, the problems inherent in creating, deploying, building, and maintaining a quality professional workforce for MNH are only just gaining the prominence they deserve [15,16]. Often, supposedly skilled birth attendants do not receive the required midwifery training [16] or do not have the relevant competencies [17,18] to assist at birth. Fig. 3 shows the scale of this mismatch using data collected by the State of the World's Midwifery 2014 report [16] from 73 countries with the highest burden of maternal and child mortality across the world. It shows the 10-fold difference between the human resources that are available and skilled to provide reproductive, maternal, and newborn health (RMNH) care based on a headcount of RMNH-related staff, and the amount of time spent by "truly skilled" birth attendants on these tasks.

A lack of attention to the need for teamwork between skilled health professionals has had obvious implications for quality care, as not all women require the same type of professional assistance when giving birth. The recent State of the World's Midwifery's "Midwifery 2030 Vision" and the *Lancet* series on midwifery both stress the importance of collaborative and supportive teams of health workers where each professional's scope of practice is respected and supported [16,19]. The skills and competencies of the workforce, as well as collaborative working between midwives, nurses, obstetricians, doctors, and other health staff must clearly underpin any strategy to improve quality care.

Unfortunately, the forward planning needed to put a quality workforce into place is often not a focus for policy. The scale of the human resources challenge if the new SDGs are to be realized is significant and not widely understood. Africa in particular faces persistent health challenges and a rising population, and so demand for health workers continues to outstrip supply [20]. Despite some progress in closing the workforce gap, 39 African countries are deemed to have a critical health worker shortage [21]. Achieving global health and development goals therefore depends on strengthening health workforces in Africa.

3. An opportunity for accountability and action toward the new Sustainable Development Goals

As the new Sustainable Development Goals (SDG) have now been agreed, we should seize the opportunity to build an accountability framework and its accompanying indicator set that is capable of delivering improved quality MNH care with a stronger workforce. Unless urgent action is taken to address the shortage and uneven distribution of health workers, none of these new goals can be met. It is predicted that by 2030, an additional 10 million health workers will need to be trained and deployed in low- and middle-income countries. That is

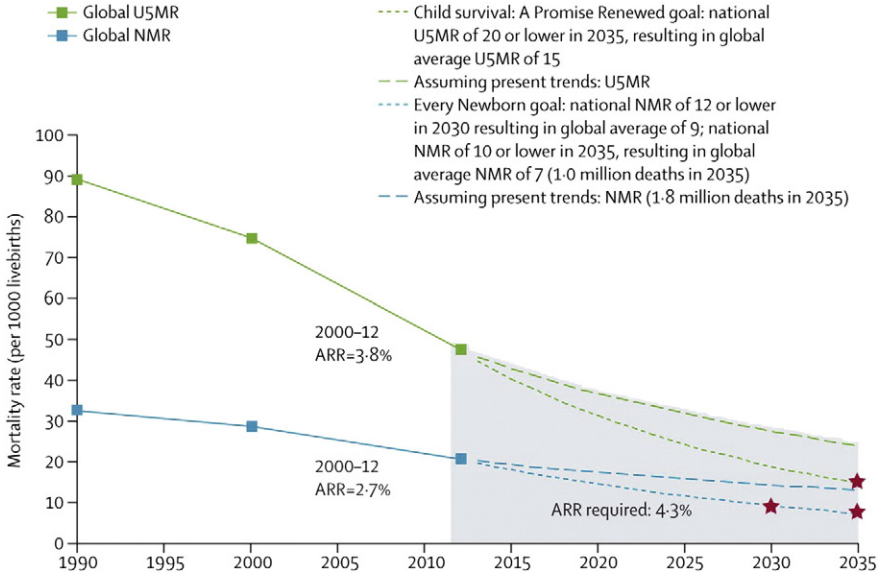

Fig. 2. New targets for newborn mortality. Reproduced with permission granted by Elsevier from Lawn et al. [26].

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