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Opportunities, challenges and strategies when building a midwifery profession. Findings from a qualitative study in Bangladesh and Nepal

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ABSTRACT

Objective: The aim of this paper was to identify opportunities and challenges when building a midwifery profession in Bangladesh and Nepal.

Methods: Data were collected through 33 semi-structured interviews with government officials, policy-makers, donors, and individuals from academia and non-government organizations with an influence in building a midwifery profession in their respective countries. Data were analyzed using content analysis.

Findings: The opportunities and challenges found in Bangladesh and Nepal when building a midwifery profession emerged the theme "A comprehensive collaborative approach, with a political desire, can build a midwifery profession while competing views, interest, priorities and unawareness hamper the process". Several factors were found to facilitate the establishment of a midwifery profession in both countries. For example, global and national standards brought together midwifery professionals and stakeholders, and helped in the establishment of midwifery associations. The challenges for both countries were national commitments without a full set of supporting policy documents, lack of professional recognition, and competing views, interests and priorities.

Conclusion and clinical application: This study demonstrated that building a midwifery profession requires a political comprehensive collaborative approach supported by a political commitment. Through bringing professionals together in a professional association will bring a professional status. Global standards and guidelines need to be contextualized into national policies and plans where midwives are included as part of the national health workforce. This is a key for creating recognized midwives with a protected title to autonomously practice midwifery, to upholding the sexual and reproductive health and rights for women and girls.

Introduction

Two South Asian countries were in focus in this research – Bangladesh and Nepal. Both countries have achieved significant improvements in maternal mortality ratio (MMR) between 1990 and 2015 [1], and both countries have decided that investing in professional midwives as a separate profession is the key to making further improvements [2,3] in women's sexual and reproductive health and rights.

Recent decades have seen significant achievements in the Millennium Development Goals and targets. Some of these have led to better access to sexual and reproductive health care, with fewer unwanted pregnancies, improved access to safe and legal abortion, and a reduction in maternal and newborn mortality. These improvements can be explained by developing health policies and can contribute to the discussion on regulatory frameworks [4,5] to increase the availability of family planning, safe abortion, antenatal care, and skilled attendance during pregnancy, childbirth, and the post-partum period [6,7]. However, for women from poor, marginalized communities, and those living in remote locations, reproductive health-related morbidity and mortality remain a serious challenge [8].

The global Sustainable Development Goals (SDGs) directly address and call for universal health care, including sexual and reproductive health, and gender equality: SDG 3, *ensure healthy lives and promote well-being at all ages*, including universal access to sexual and reproductive health care reducing maternal and neonatal mortality; SDG 5, *achieve gender equality and empower all women and girls*; and SDG 10, work towards *reduced inequalities*. With the support of the SDGs, the aim is to reach the maternal health targets by 2030 [9].

One critical approach to achieving the SDGs is education of professional midwives and integrating them into the national health system for greater access to sexual and reproductive health and rights (SRHR). Professional midwives are globally recognized as experts on sexual and reproductive health, and are dedicated to upholding the sexual and reproductive health rights of women and girls [7,10–12].

The establishment of the midwifery profession is hence a human

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rights concern [4]. According to evidence [11–14] there is a need for competent, cost-effective and skilled health care professionals with the necessary competence and resources to provide safe and high-quality reproductive, maternal and newborn care. The midwifery profession is identified as the key profession for providing such care. Midwives who are educated as per international standards can provide 87% of the essential care needed for women and newborns; investing in midwifery education, licensing and deployment to community-based services can potentially yield a 16-fold return on investment in terms of lives saved and costs of cesarean sections averted [13]. Against this background, there is a need for professional midwives [15]; i.e., those who have all the characteristics the profession demands, such as a scientific body of knowledge and trained skills; a license to practice; autonomy; an ethical code; and the formal recognition of society [16]. By promoting midwives, we promote the health and rights of women and girls. From a broader perspective, this means we need to understand how to promote countries' abilities to reduce morbidity and mortality among women and children by offering better strategies for building midwifery as a separate profession. Because of the urgent need for professional midwives in many low-income countries, the midwifery workforce has rapidly scaled up [13]. Lessons learnt from country specific descriptions of opportunities and challenges when scaling up has however not, to our knowledge been assessed. For countries, building a midwifery profession in low resource settings such lessons learnt can contribute to the discussion on policy frameworks. To close this gap, the aim of this paper was to identify the opportunities and challenges that arise when building a midwifery profession in Bangladesh and Nepal.

Method

Study design

This study is based on individual interviews with policy-makers, donors, and individuals from governments, academia and non-government organizations with influence in building a midwifery profession in Bangladesh and Nepal. The term influence, is in this paper referring to promotion, advocacy, and work towards strengthening a cadre of professional midwives. Interviews were analyzed using content analysis [17]. The study followed ethical principles for research [18] and was approved by the respective nursing councils in 2013 (Bangladesh) and 2014 (Nepal).

Setting

Bangladesh is a lower middle-income country [19] with approximately 3.1 million live births a year [20]. The majority of the population resides in rural areas, which contributes to an overall low ratio of skilled attendance at birth of 42% and a high MMR at around 176 maternal deaths for every 100,000 live births [1].

Nepal is a low-income country [19] with approximately 593,000 live births a year [21]. Most of the population resides in hill/mountain areas, which contributes to an overall low ratio of skilled attendance at birth of 58% and a high MMR at around 239 maternal deaths for every 100,000 live births [21].

Data collection

The study was carried out in Bangladesh in April–May 2013, and in Nepal in April 2014. Purposive sampling [22] was used in relation to the participants positions and policy influence in their respective organization, to ensure the selection of rich information and insights from policy-makers, donors, and individuals from governments, academia and non-government organizations, with influence in the establishment of the midwifery profession in the respective countries. A total of 33 individual were invited and all agreed to participate in the study. Sixteen individual interviews were conducted in Bangladesh and 17 in Nepal (Table 1). The participants received oral and written information about the study, including details about confidentiality in handling the data. Only the authors had access to the data. The participants were informed about the voluntary nature of their participation, including the fact that they could terminate their participation at any time. Written informed consent was obtained from each participant prior the interview.

Table 1
Stakeholders organizational belonging.

	Stakeholders organizational belonging	Participants interviewed (n = 33)
Bangladesh	Policy-makers/government officials	2
	Donors	6
	Academia	2
	Non-Government Organizations including Midwifery Association	6
Nepal	Policy-makers/government officials	3
	Donors	4
	Academia	7
	Non-Government Organizations including Midwifery Association	3

Data were collected by the first author through semi-structured interviews using an interview guide with four key areas: (1) organization and its resources, (2) collaboration, (3) communication channels, and (4) future plans. The opening question was: "tell me about how your organization contributes to strengthening the midwifery profession". The participants were encouraged to speak freely, and probing questions such as "please give an example".

Most of the interviews took place in a separate room at the participants' workplace; they were conducted in English as the English language was the common working language among government officials, policy-makers, donors, and individuals from academia and non-government organizations in Bangladesh and Nepal. The interviews were recorded and lasted 30 min to an hour.

Data analysis

All interviews were transcribed verbatim, and the transcripts were analyzed using qualitative inductive content analysis, inspired by Elo and Kyngas [17]. The transcripts were read several times by both authors, to get a sense of the content concerning opportunities and challenges when building a midwifery profession in Bangladesh and Nepal.

The analysis was performed in the following concurrent flows: (1) the transcripts were condensed and, with the study aim constantly in mind, data from each individual participant were labelled separately; (2) codes corresponding to opportunities and challenges when building a midwifery profession in Bangladesh and Nepal were imported into a designed coding sheet; and (3) the codes were clustered into emerging categories. To ensure a standard approach to each step of the analysis the two authors discussed the interpretation of the data until consensus was established. The following categories were agreed on under the heading "opportunities": "Supported by global and national standards, Bringing professionals together through a professional association and Collaboration between stakeholders - essential for building a midwifery profession". And the following categories were agreed on under the heading "challenges": "Commitment without supporting documents, Lack of profession recognition, and Competing views interests and priorities"

Findings

The overall theme that emerged regarding opportunities and challenges found in Bangladesh and Nepal when building a midwifery