PROGRAM IMPLEMENTATION BRIEF

USAID's MaMoni Maternal and Newborn Care Strengthening Project (MaMoni MNCSP)

Transitioning to the Midwife-led Care (MLC) model in Bangladesh

Bangladesh has made remarkable progress in reducing maternal, newborn and child (MNC) mortality. Yet challenges remain. USAID's **MaMoni Maternal and Newborn Care Strengthening Project (MaMoni MNCSP),** implemented by Save the Children and its consortium partners, worked to improve health outcomes for mothers and newborns in Bangladesh. The project supported the Health, Population and Nutrition Sector Program of the Bangladesh government to achieve its goal in reducing the maternal and neonatal mortality rate by 2022.

The project demonstrated proven maternal and newborn health (MNH) interventions in small areas, expanding those interventions in 17 project districts and one island, Sandwip, reaching an estimated 34.8 million people. MaMoni MNCSP supported the Ministry of Health and Family Welfare to scale up successful interventions across the country. It also strove to improve equitable access to quality MNH services, especially for the poor and marginalized, who are more susceptible to maternal and neonatal deaths. Additionally, it facilitated health system improvements and policy changes for sustained impact at scale.

Background & Context

Bangladesh has made significant progress in increasing the utilization of essential maternal and newborn care services, but more is needed to meet SDG targets by 2030. The Ministry of Health and Family Welfare (MOHFW) has taken several initiatives to address the challenges. The World Health Organization endorsed the use of midwife-led continuity-of-care in settings with well-functioning midwifery programs. Recent studies show that midwives could provide 87% of the essential care for women and newborns if they followed international standards of education. Midwife-led care can help to avert maternal deaths, stillbirths, and neonatal deaths.[1]

The Bangladesh government introduced an International Confederation of Midwives (ICM) accredited three-year diploma course in 2012 and deployed professional midwives into the health system in 2018. However, professional autonomy, poor facility readiness, and lack of continued professional development to practice midwifery care remain a challenge in transitioning to a midwife-led care model and achieving the desired impact4. USAID's MaMoni Maternal and Newborn Care Strengthening Project (MaMoni MNCSP) collaborated with the relevant health unit of the Government to support newly deployed midwives to provide midwife-led services by addressing clinical and systemic barriers in 101 project-supported Upazila Health Complexes (UHCs; sub-district hospitals).

Approach & Implementation

A Midwife-led Care (MLC) model at UHCs provides women with care from the same midwife or a small team of midwives during pregnancy, birth, and the postnatal period, with the appropriate involvement of a multidisciplinary team when needed. In the model, midwives are positioned as dedicated support in various reproductive health areas and are allowed to provide autonomous services as part of their scope of work, complying with evidence-based routine care and initial stabilization for obstetric emergencies and newborn resuscitation.

In 2022, 317 midwives were deployed (against 363 sanctioned posts) in 101 project supported UHCs. Fifty-eight hospitals (57%) had at least four midwives, which is the minimum requirement to maintain round-the-clock midwifery services. The project conducted sensitization meetings on the roles of midwives with facility managers, doctors, and nursing staff and provided support to facility readiness to establish enabling environments for midwives to lead the organization and provision of midwifery services at both inpatient and outpatient departments.

1. Homer CSE, Friberg IK, Dias MAB, Ten Hoope-Bender P, Sandall J, Speciale AM, et al. The projected effect of scaling up midwifery. Lancet. 2014;384(9948):1146–57.

Capacity Building and Mentorship

USAID's MaMoni MNCSP undertook several initiatives to improve the capacity of midwives to provide MNH services that comply with the maternal health (MH) standard operating procedures (SOPs). A total of 276 midwives were trained on a five-day MH package. MaMoni also organized training on family planning for the midwives to integrate them into family planning counseling and services. This was a 12-day skills-based training, covering all modern family planning methods, including postpartum family planning (PPFP), with proper counseling. A total of 101 midwives received the training.

The project also introduced a structured, facility-driven clinical mentorship approach into the government system for the frontline maternal and newborn health (MNH) service providers, and enrolled midwives as mentees. Among the mentorship techniques used were face-to-face consultation, direct observation of performance using checklists, bedside coaching, clinical reviews, and interviews on the topics of maternal and newborn health care and family planning.

Photo credit: USAID's MaMoni MNCSP/Save the Children

Quality Improvement Approaches within Midwifery Services

Midwives were involved with the project-initiated Quality Improvement (QI) intervention after being coached on QI intervention packages. For clinical work improvement, the midwives set a target in an area of interest, based on major gaps identified, and conducted Plan-Do-Check-Act (PDCA) cycles to test change ideas for improvement.

Recording and Reporting of Midwifery Services

The project provided technical assistance to government staff to improve the routine health management information system (HMIS) and utilization of the data at the local level, in collaboration with the MOHFW and district HMIS staff. Hospitals ensured an uninterrupted supply of registers and reporting forms, and provided routine supportive supervision and need-based, on-the-job training to midwives and other MNH service providers for error-free record keeping and reporting. The government integrated midwifery services data into the national HMIS in June 2021. A particular emphasis was placed on the use of District Health Information System-2 (DHIS2) for midwifery service data in the project facilities.

Monitoring and Review

The project utilized the government-prescribed hospital QI committees for monitoring midwifery services. District government managers, including district public health nurses, conducted supervisory visits at the UHCs to oversee the quality of midwifery services. Major MNH service data extracted from DHIS2 was routinely shared in the district and upazila monthly performance review meetings so that effective decisions could be taken to improve MNH services, including those related to the supply system and capacity building of staff.

Results

National HMIS data from 101 project supported UHCs for July 2021 to December 2022 found that midwives contributed substantially to key MNH services. Midwives conducted about two-thirds of all antenatal care (ANC) 1 visits, ANC 4 visits, and normal vaginal deliveries, and 84% of postnatal care (PNC) 1 visits. Midwives led 77% of all newborn resuscitations and 24% of initial stabilizations of postpartum hemorrhage (PPH) and pre-eclampsia/eclampsia (PE/E) complications reported by these hospitals. More than half (54%) of all PPFP services were provided by midwives. (Table 1).

Table 1: Contribution of midwives in major MNH services

Indicators	Total # of clients	Contribution by midwives	% contribution
Total ANC1	184,655	118,559	64
Total ANC 4	65,730	44,417	68
Normal Delivery	71,873	45,224	63
PNC 1	77,030	64,573	84
Newborn Resuscitation	2,911	2,233	77
Initial stabilization of PPH and PE/E cases	3,561	861	24
PPFP	60,059	32,141	54
Data source: DHIS2			

A project-led learning study revealed that targeted facilities maintained separate rosters for midwives dedicated to ANC, PNC, and normal delivery services and ensured the provision of equipment and supplies necessary for midwifery practices. Most midwives were oriented on routine evidence-based maternal and newborn care. Many of them expressed confidence to provide initial stabilization and timely referrals for PE/E and PPH patients. A manager at the Kalkini UHC remarked, "Those midwives who are here are highly cooperative, experienced, and skilled. So, their communication with the patients is very good. No patient has lodged a complaint, or no such problem has occurred so far. So, I would say that they are performing their duties in a satisfactory manner."

The learning study, based on the quantitative data analysis from HMIS, showed that at the district hospital level, live birth outcomes of the normal births conducted by certified midwives increased from 94% in 2019 to 99% in 2021. Also, the live birth outcome by all providers improved from 96% in 2019 to 99% in 2021. At the UHC level, the live birth outcomes among births attended by diploma midwives remained as high as 98 to 99% in 2019 and 2021. The live birth outcome of all providers improved from 94% in 2019 to 97% in 2021. Overall, the study demonstrated that midwives' performance improved and contributed to improving the performance of all providers.

Photo credit: USAID's MaMoni MNCSP/Save the Children

Challenges

- A shortage of midwives at UHCs made it difficult to ensure effective round-the-clock midwifery services. Only 57% of the 101 UHCs had the minimum required number of midwives (at least four per facility) for 24/7 midwifery-led services. About 13% of midwife positions in the project supported UHCs were vacant in mid-2021. Midwives have been transferred without proper replacement due to a coordination gap between the Directorate General of Nursing and Midwifery (DGNM), which has administrative authority regarding the placement and transfer of midwives, and the Directorate General of Health Services (DGHS), which provides health facility availabilities for midwives to work.

- Hospital managers, as well as community members broadly, are not familiar with the scope of work of midwives. This is a barrier to having dedicated and autonomous service provision by midwives.

- There is suboptimal utilization of midwives due to a lack of pre-service practicums and in-service training in various areas, such as post-abortion care, cervical cancer, fistula screening, and long-acting and permanent family planning methods.

LESSONS LEARNED

- The deployment of the new cadre of midwives presented an opportunity to address human resource gaps in MNH services at UHCs. However, to maximize the contribution of midwives, it is important to deliberately work with facility managers and other senior staff to empower the midwives to take the lead in the provision of these services, including inpatient management and readiness to deliver services related to midwives' scopes of practice.

- Retention of midwives at UHCs is vital to ensure midwifery-led care. Regarding the posting and transfer of midwives, effective coordination between DGNM and DGHS is imperative to ensure the minimum number of midwives per facility is maintained.

- Mentorship of midwives by hospitals' MNH clinical experts improves teamwork and helps to establish positive enabling environments. Further information on mentorship is provided in the brief titled "Introducing the Facility-Driven Clinical Mentorship Program within the Public Health System to Improve Maternal and Newborn Quality of Care."

Recommendations

- Strong coordination, particularly for the positioning of midwives, is required between the DGNM and DGHS to further establish midwifery-led care.

- Continued professional development of midwives through in-service training and structured mentoring through existing resources is important to increase adherence to quality practices. Additionally, pre-service practicums should be strengthened to ensure midwives have the relevant skillset when they graduate, so they will be able to provide the relevant MNH services without significant in-service training.

- Hospital managers should be oriented on the role of midwives, their skills, and their scope of practice. Efforts should be made to ensure community members are aware of the availability of midwifery services at the subdistrict level and some lower-level facilities.

- While there is an SOP on midwifery-led care, guidance on how to establish midwifery-led care, including management, the requirements involved, and the roles and responsibilities of other providers and staff in midwifery-led care, should be strengthened within the existing document.

Conclusion

A holistic approach, including continued capacity building, advocacy with local health authorities for creating enabling environments for midwifery services, and coordination among relevant directorates, is essential to fully integrate midwifery-led care into the health system.

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