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RESEARCH BRIEF

Stakeholders' Take on Sharing the Tasks in Providing Family Planning Services – Inquiring into the Issues on Midwives' Implant Insertion

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In line with the issues surrounding maternal mortality, the promotion and protection of the rights of women to better access to high quality healthcare and midwifery programs during pregnancy and delivery have been the foci of recent global initiatives. Based on a report, the "State of World's Midwifery 2011" the global community needs 350,000 skilled midwives to adequately address the needs for maternal and healthcare services (ten Hoope-Bender, Campbell, Fauveau, & Matthews, 2011). It noted too that two thirds of the cases of maternal and child mortality globally could be prevented through the implementation of high quality healthcare and midwifery programs. It pointed out that millions of lives could be saved annually by investing in the education and training of midwives. It added that educated midwives could perform 87% of all the services for maternal and newborn healthcare.

The World Health Organization (2012) also recognized the need to maximize the role of middle level health workers comprising nurses, midwives, and lay health workers to provide maternal and newborn care, including family planning (FP) services. In fact, the organization's Optimizing Health Worker Roles for Maternal and Newborn Health Framework recommends that the midwives should be mobilized to insert and remove contraceptive implants. Similarly, a panel of experts participating in a two-year study that aims to update the core competencies described by the International Confederation of Midwives in 2002 for basic midwifery practices has designated the insertion and removal of contraceptive implants as one of the skills that can be learned by midwives (Fullerton, Thompson, & Severino, 2011). While the contraceptive implant has been introduced in the Philippines 1985, its adoption is slow.(Contraceptive Research , Introduction and Use, 1998: p.109) It is also interesting to note that the Philippine Health Insurance Corporation (Circular No. 038-2015,) has made the contraceptive implant available in the country "to increase access to long-acting reversible family planning methods" (par. # 1 Circular No. 038-2015, December, 2015).

Thus, the WHO strongly recommends the inclusion of midwives in the task sharing of the insertion and removal of contraceptive implants. The midwives have evolved into multi-tasking personnel in the delivery of healthcare services. Applying the WHO-proffered solution to the Philippine setting, with 157,000 existing

registered midwives, one could only speculate how the mobilization of this workforce might dramatically increase FP services, and improve maternal healthcare. There are other reproductive health professionals in the FP program to do their share. Delineating the roles and responsibilities of all these actors is essential to have a concerted effort in the delivery of such services.

A 2015 study on task-sharing in the conduct of contraceptive implant insertion was done to describe precisely the share of midwives in the said task. It was supported by a non-government organization, the Population Services Pilipinas Inc. It analyzed the groups of actors' take on sharing the task in responding to the unmet need of FP service delivery particularly through the use of contraceptive implant that is doing insertion. (Developing Competencies of Middle Level Health Workers and Maximizing their Roles in Task-Sharing in the Philippines, Project Report, 2016)

FGD with Stakeholders on Task-Sharing

Ideas, issues, and insights on task-sharing were sought through focus group discussions (FGD). The FGDs included midwives, nurses, physicians, population workers, academe, community health team members, barangay health workers, and local health officials. FGDs were conducted in 2015, in Luzon on March 3 and April 24, and in Mindanao on May 14. The qualitative data were processed using the NVivo software. The key findings included the knowledge and skills of midwives, particularly the FP program, relevant to task-sharing: its delivery mechanisms, use of IEC materials, supply of commodities, characteristics of prospective clients, current accepters and users, and the situations, conditions, and issues surrounding its implementation.

Midwives' Knowledge, Skills and Their Roles in Family Planning

The results of study indicated that midwives are at the forefront of providing FP services at the grassroots. The public midwives know the constituent clients of the communities, their catchment area. They are known as being different from their co-workers in the reproductive and maternal health and childcare service delivery system, such as the nurses and the physicians in the rural health units or barangay health stations. They are known even in far-flung places as also being barangay health workers. Physicians and nurses alike, however, are on top in the monitoring and evaluation of the implementation of such program in their respective locale.

Midwives in private practice are even identified with their clinics, popularly called *paanakan* (birthing clinic). The *paanakan* is a landmark, as residents know exactly where it is located. Public midwives are well known at the grassroots, in government health facilities. They are known even in the remotest rural areas as the *nagpapaanak* (one who gives birth). The midwife knows every mother in every household, those at the prime of their reproductive stage, as well as their matriarchs, their spouses, and the children they have given birth to. The midwife is a "walking birth registrar" so to speak.

Midwives are known to have a thorough knowledge of FP program, its organizational structure, its actual implementation, and the mechanisms for reporting the end results of all its activities. As frontline health workers, they facilitate the full implementation of the said program since they are the first ones whom mothers approach during their maternity and even prior to conception, especially among those who have opted to plan their pregnancy systematically. Midwives promote FP to help mothers become healthy, and after every pregnancy to recover fully from the strain of such experience. They help mothers understand the need to recuperate from pregnancy, thereby permitting their bodies to restore the capacity for growth and to remain in a state of wellness, particularly in their reproductive and maternal health. Thus, mothers who, they argued, are adherents to FP strategies are better able to care for their growing children, as they are more knowledgeable about maternal and child healthcare. Midwives emphasize the responsibility of mothers beyond giving birth to their children, that is, providing them proper nutrition and education. This they believed could be achieved if mothers and their spouses persevere and adhere to an FP method that is fit for them, allowing for spacing of birth and promoting healthy living.

The midwives noted that advising mothers to consider birth spacing is something they do automatically, a reminder they give before and after pregnancy. Midwives are mindful of this primary objective of fostering reproductive health among their clients. They know fully well that there is a higher risk for mothers who are frequently pregnant than for those who choose to practice birth spacing. Counselling for couples, both for those who will apply for a marriage license and for those considering FP, involves lectures on fertility awareness, birth spacing, and responsible parenting.

Midwives are FP commodity-conscious. They distribute commodities to their clients for their continued use. They knew that the adherence to the use of FP methods and the commodities that come with them is key to the program's success. While local government units issue the commodities—specifically, contraceptive pills to be distributed in communities—midwives must address concerns related to their incorrect use and the wrong practices of couples. They noted that contraceptive pills are only taken prior to coitus. Similarly, the spouses' use of condoms is regarded as "unnatural," such that they claim it reduces the experience of sexual pleasure. The other reason for not using such prophylaxis is more attitudinal and social concern, as couples are ashamed to purchase condoms over the counter. Midwives have to combat the commercialization of these commodities, as they imply that couples miss the more important component of the FP program, counseling. They reported that contraceptive pills are sold in sari-sari stores. As merchandise, these commodities are seen as a quick fix for fertility concerns.

Competency Building for Contraceptive Implant Insertion

As midwives are very sensitive with regard to the constant need for commodities, they keep themselves updated on the availability not only of those that are currently in full use but also of those newly developed ones. Thus, the contraceptive implant is uppermost in their minds since it has become available for use in the reproductive healthcare. The supply of commodities for the FP program in public health facilities falls under the City/Municipal Health Office which is now under the local government units. These supplies come from the Department of Health (DOH). There are non-government organizations (NGO) that also participate in providing commodities but have to observe government regulations. Yet there were NGOs that failed to pay courtesy calls to local health executives and did not coordinate in providing FP services to the communities. This resulted in some confusion as these NGOs have limited information about the current users of FP services in the catchment areas. Public midwives were aware of the mandate to carry out the task of providing FP methods. They know that the supply of commodities is essential in the program; thus, they have to ensure that these are received in good condition by clients to prevent spoilage and consequent wastage.

It is imperative for midwives to educate their clients about the commodities and FP methods to effect the desired behavior change—adherence and compliance with the choice of FP methods for its effectiveness. IEC (information-education-communication) materials are made available to clients in government health facilities. Midwives in private practice make IEC materials readily available in their clinics. There were technology-aided presentations of IECs on FP such as documentaries and films shown on digital TV screens. Midwives are keen on knowing client characteristics. Thus, in order to match the FP method to the client's current behavior, they study their characteristics as users or accepters of the program. Midwives conduct thorough interviews of clients to come up with an FP program user profile. Midwives are able to determine client preferences, which translate to choice of FP methods. Thus, they are knowledgeable about both FP methods and the characteristics of clients.

Midwives and other health workers alike also observed that the number of accepters of the FP program continue to climb. Such increase is attributed to program effectiveness, as more mothers are able to create some spaces in giving birth. Yet, the most sought-after commodity remains to be contraceptive pills for their ease of use and availability. Many adhere to the use of contraceptive pills not because it is the most effective, but because it is most readily available and accessible.

Health workers and midwives reported that most mothers forget to take the pill and resort to injectable pills, which are good for a period of one month. However, they noted that there are more mothers who opted for an intrauterine device (IUD), as this FP method is more effective than the injectable pills. The midwives are skillful in IUD insertion. When contraceptive implant became available for use in FP, private midwives presented this alternative to clients who use injectable contraceptive pills and the IUD. They noted that there was acceptance of this method among their clients, even if they could only provide a clear description of its effectiveness and ease of use (implanted). Yet, they lack training in the insertion of contraceptive implant as the technology is relatively new. Stakeholders all agree that such FP technology requires a new set of skills for all reproductive health workers. They noted that given the prior training acquired by these health professionals in FP, they could acquire the skill of providing implant with ease. Training is essentially a requisite for building the competency of all professionals in reproductive healthcare services, and in this case for contraceptive implants.

Health workers concurred that competent midwives fully trained in implants can share the task of providing contraceptive implant. Midwives have full knowledge of the fundamentals of FP as this is at the core of their study in midwifery. They are knowledgeable about the use of IUD, which they described as being delicate, sensitive, intricate, even intimate a procedure. Women do prefer it over injectable pills, thus giving credence to the skill of the hand in manipulating tools and in the use of techniques. Midwives noted that it is even more complex a task to insert the IUD than perhaps making an implant. They said that IUD insertion requires patience, perseverance, and practice. Given the same conditions for learning a new technology such as doing an implant insertion they believe would make them competent and confident professionals. Health workers, though, quipped that the removal of the implant had to be at the dispensation of a physician, who also must have had training in implants. Dissenting views on building the capacity of midwives in insertion of an implant, however, come from some midwives and other health professionals. While they argued that the procedure of insertion of implants is more complicated than IUD insertion, midwives could be provided training in it, and practice is a necessary criterion for competency. They insisted that 10 insertions of implant practice would indicate competency.

Factors That May Facilitate and Hinder the Provision of Contraceptive Implants

The health workers were able to identify the factors that may facilitate and hinder the provision of contraceptive implants. These factors pertain to policies and programs of the local government on population. Those that may facilitate the insertion of implants relate to the FP methods that are widely used in the locality, that is, what is most currently utilized by clients in the catchment areas. It is noted that the artificial FP methods are the ones in place in many areas. This prompted population workers to advocate for natural FP methods like the standard days method as an alternative to the artificial ones. Still what remains popular are the artificial FP methods, since the natural ones have very few accepters. This is in reference to the supply of commodities such as injectable contraceptive pills, as they would normally run out of such for distribution. They believed that given the present structure in the implementation of the government population program, such innovation in FP as insertion of implant could be supported and sustained. If government leaders have the political will to implement FP, the health workers are committed and duty-bound to carry out the task of providing healthcare services. They noted that leaders who are pro-reproductive health are more progressive and positive about FP. They initiate activities such as insertion of implants during medical missions and permitting midwives to participate in capacity building, skills training, and knowledge development.

Stakeholders noted that there exist in the health delivery system mechanisms that would enable health workers to be mobilized to provide healthcare at the grassroots where there is dire need. There is a functional community health team (CHT) that is always available to be tapped in delivering their services directly to the community. The team leader of the CHT is a midwife who coordinates the activities

of the group in providing healthcare services. The other relevant mechanisms are the conduct of referral and of monitoring and evaluation of FP activities and outcomes. Implementers of FP from the top could very well rely on the effectiveness of midwives in the delivery of healthcare services. As midwives are most accessible to communities, they could share the task of insertion of implant if supported by medical professionals who are also trained in the procedure, and the local health officials.

The factors that could hinder the provision of contraceptive implants are related to lack of skills training, limitations related to supply of commodities, non-supportive local chief executives and health officials, no link between demand generation and service delivery, restrictions that pertain to medical science practices, and some characteristics of clients, users, and accepters of FP. Stakeholders noted that midwives need skills training in the insertion of implants as such procedure requires proficiency. This requirement holds true for all health professionals who would have to undergo skills training in contraceptive implants. They noted that the insertion of implants suggest a surgical procedure that requires precision and accuracy. They argued that the competency had to be established through training—mid-level skills training is needed to do insertion, and high-skills training is required to do both insertion and removal of implant.

Midwives believed that they could do insertion to share the task in contraceptive implants, but not its removal. They think that removal of implants is more complicated, requiring high precision which medical doctors are prepared to do. There are midwives who would feel more confident about doing insertion of implants if there was a medical doctor who would supervise the task. They argued that if ever there is need for a medical intervention, such as when there are complications resulting from the insertion of implant, a doctor would be accessible and available to provide aid. Thus, this concern to have medical doctors supervise midwives' insertion is biased on the mothers, and their need to be protected when they seek healthcare.

Stakeholders commented on how certain practices in medical science affect perceptions related to the provision of contraceptive implants. While there are midwives who think they could perform the insertion of implant confidently and competently given the correct skills training, there are also midwives who believe otherwise. Nonetheless, they all agree that removal has to be done by physicians who are trained in implants as well. This suggests that insertion and removal of implants is a surgical procedure. This is resolved in having a trained physician in implants to supervise the task midwives and nurses have to share with them. The challenges that are associated with the success of implants involve the characteristics of the client, users, and accepters. There is always that need to correctly counsel the clients and educate them prior to their acceptance of any FP method, to keep them in the program and abstain from pregnancy. Health workers must constantly be engaged in conversations about FP effectivity with prospective clients as well as its accepters and users, since behavior compliance is most difficult to monitor. Adherence to FP is a long-time engagement of spouses or couples and not only of women. Thus, it is suggested that husbands have to be counseled and educated along with wives. In the case of contraceptive implants, the husband's consent is sought prior to insertion so as to ensure its effectiveness.

Drawing Insights from the Discussions

The midwives are on the frontline of FP program tasked to bring down to the grassroots such program to prevent maternal and child mortality and maintain the family well-being. Midwives who currently undergo training are required to have a midwifery degree, which equips them with the knowledge, skills, and attitudes of a professional ally of high-level health workers in FP service delivery. A professional organization that advances their interest in the field through continuing education and scientific conferences is in place to keep them updated with developments in the practice of midwifery. They are in direct contact with the clients of FP—the expectant mothers, women of reproductive age and couples-to-be—as they have to reach out to counsel and coach them about the benefits of birth spacing through natural or artificial FP methods. An intimate relationship develops between midwives and the mothers in their respective communities, as they have come to know the children they have given birth to whom have grown to be residents in these

localities. While making their clients adhere to a chosen FP method remains a challenge to midwives in the conduct of fostering maternal and child healthcare, they steadfastly work with health staff to address the problems of mortality and poverty. Midwives are team leaders in CHTs who dare to go to the remotest places in rural areas to provide healthcare.

The midwives are equipped with knowledge and skills in family planning and responsible parenting. As professionals, midwives' practice is regulated by the State, in the same way that licensed nurses and physicians are. Midwives are given continuing education that upgrades their competency and keeps them abreast of innovations in their field. In relation to contraceptive implants as an innovation in FP technology, if midwives are given skills training in insertion but not removal—as doing both tasks suggests a surgical procedure that is only proper in the present time to physicians' practice— and if insertion is done under the supervision of a trained medical doctor in implants, they could competently share in performing the task. Competency in the insertion of contraceptive implants is indicated by a proficiency level acquired after having performed at least 10 insertions during on-the-job training. Midwives are apt to learn about the insertion of implants, as they have had prior practice in similar tasks. If skills training in implant insertion is provided to them and pass a proficiency level test, they could very well share in the task of competently providing contraceptive implants.

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