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Original Article

Challenges of midwifery services in the health reform plan in Iran: A qualitative study

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Abstract

***Background & Aims*:** Improving the health reform plan implementation in terms of quality of health services and fulfilling the goals requires a review of the status quo of midwifery services and identification of their strengths, weaknesses, and challenges, especially in the health sector. The present study was conducted to investigate and comprehensively understand the challenges of midwifery services in the primary health care(PHC) system and provide recommendations for improving midwifery services.

***Materials & Methods*:** This Qualitative descriptive design study selected 44key informants using purposive sampling and collected their views on midwifery positions and midwifery tasks performed in the PHC system through semi-structured interviews conducted in 2015-16. These informants included 12 midwives, 10 public health experts, 10 faculty members, and 12 managers and officials, who worked in educational and healthcare centers affiliated with Kashan University of Medical Sciences, Kashan, Iran. The transcribed interviews were analyzed in MaxQDA-10 using conventional content analysis.

***Results*:** After analysis, the data of this study were classified into 14 categories and 6 themes. From the participants' point of view, the midwifery services challenges of the health system transformation plan in the field of health were: policymaking and management, rights, referral system, satisfaction, costs, and development and promotion. Most of the extracted codes are related to policymaking and management.

***Conclusion*:** The present findings showed the midwifery sector needs in the Iranian health system for reforms. It is recommended that the role of faculties in training human resources for the health sector be emphasized and new training requirements be integrated into the curriculum by educational departments promptly.

***Keywords*:** Midwifery, health services, Primary Health Care, qualitative study

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Introduction

In recent decades, improving maternal, newborn, and child health and reproductive and sexual health has been considered a major objective of health systems worldwide. To achieve the targets of Sustainable Development Goals, the World Health Organization (WHO) defined its main strategies to ensure the availability of health services involving reproductive and sexual health services to all females and their equal access to these services, eliminate all the factors related to mortality, morbidity, and disability in women and strengthen health systems to meet basic needs of women and girls (1). These strategies included strengthening the health service delivery system and the roles of midwives in policymaking and social practice, managing the performance of midwives in obviating patient needs, and increasing the involvement of midwives in different fields (2).

The government of the Islamic Republic of Iran has succeeded in training and recruiting the midwifery forces at different levels, especially at the PHC level. Midwives have a long history of providing services for women ranging from childbirth in deprived areas to basic services in health centers (3). According to the Iranian Ministry of Health and Medical Education, non-physicians or midwives working in PHC centers were responsible for maternal mortality in over 20% of the cases (4). Strengthening the roles of midwives in providing the PHC can improve access to equal maternal, reproductive, and sexual health services. Evidence suggests the long history of the role of midwives in the healthcare and educational sectors in Iran. Their role is, however, defined according to international principles and norms (3). Different care models designed to simulate the provision of midwifery services include those that focus on prenatal and postnatal care (4). To achieve this role, it is necessary to explain healthcare midwife's tasks in addition to the promotion of culture in personnel and society with the participation of the midwifery scientific community. This process helps clarify the role of midwives as healthcare providers, improve access to PHC provided by midwives for women of all ages, infants, and the community as a whole, especially in deprived areas, and promote the culture to accept their role as well as social justice and equality.

Despite all the valuable advances made and services provided over the years in Iran, this country has witnessed challenges in the structure and functioning of its health system. Given these problems, Iranian health authorities have been seeking to design and implement a health reform plan (HRP) in recent years. The treatment phase of the HRP was implemented in 2015 followed by its health phase. According to the HRP, midwives working in community health centers were asked to take different roles of health service providers. Rather than scientifically defining and explaining the role of midwives in fulfilling national and global health objectives, certain actions performed as per the HRP included removing the midwife's specific role from community health centers and removing the description of midwifery tasks from guidelines on the reforming (version 3). These actions have, however, created ambiguous and multiple expectations of midwives as healthcare providers such as managers' contradictory behavior, experts' dissatisfaction, uncertainties in service delivery, and sometimes a threat to reduced quality of pregnancy and reproductive services (5). The lack of a universal definition of the roles complicates the integration of the roles and confuses the public and other professionals as to the definition of specialized practices and their discriminatory criterion from advanced practices (6, 7). According to the HRP, the task of providing maternal care as the previously sole responsibility of midwives was shared among health professionals as well. Dehghan et al. reported the lack of manpower is the most important problem of this HRP from the perspective of managers (8) and Nakhaei and colleagues also reported dissatisfaction with the working environment as the most important reason for nurses' dissatisfaction with the implementation of the HRP (9). Kalhor and Samiei Rad emphasized that in this plan, it is necessary to pay special attention to a power supply and increasing workload, salaries, benefits, and satisfaction of medical staff (10).

Improving the HRP implementation in terms of quality of health services and fulfilling the goals requires a review of the status quo of midwifery services and identification of their strengths, weaknesses, and challenges, especially in the health sector. Given that so far, no study has been conducted to examine the challenges in the field of midwifery, the present study adopted a qualitative approach to investigate the challenges facing the HRP in providing high-quality, affordable, and need-based midwifery services in Iran and therefore provide executive solutions, ensure the implementation of PHC principles and promote midwifery services. Qualitative research is the most appropriate tool for explaining the behaviors, attitudes, experiences, and beliefs of individuals and their interactions.

Materials & Methods

The present study was conducted in 2015-16 using a qualitative descriptive design as a valid research method for data analysis, including the subjective interpretation of textual data through systematic classification, coding, theming, and designing known patterns (11). The research setting included community health centers and educational departments affiliated with Kashan University of Medical Sciences. The experts in other universities were telephone interviewed. The study sample comprising 12 midwifery managers and officials, 10 members of the midwifery faculty, 12 midwives and family physicians working in urban community health centers, and 10 public health experts were selected using purposive sampling with sufficient knowledge in the field of services provided in the health transformation plan by midwives and willingness to participate in the study. More than eight individual interviews and five focus group sessions were held with the midwifery process owners, including the faculty members, the staff experts, the midwives, and the female public health experts at the health centers. Telephone interviews were also conducted with several experts from Iranian universities of medical sciences in Yazd, Qom, Kerman, Isfahan, Arak, Lorestan, and Khorasan. The inclusion criteria for the service providers included a formal-contractual employment contract, a minimum of five years of work experience in different fields and sectors of health centers and departments, and a bachelor’s degree as the minimum education level. Sampling continued until data saturation was reached no new categories were emerging. Maximum variation was observed in terms of age, work experience, and workplace in the managers and service providers selected.

The participants were interviewed individually and in groups after obtaining their written informed consent and briefing on the study objectives. In-depth semi-structured interviews lasting 30-60 minutes and field notes were used to collect the data. Each interview began with questions such as “What challenges do you think the HRP reform plan faces in providing midwifery services in the health sector?”. The exploratory questions raised depending on the participants' responses included “Can you elaborate on this?” and “What do you mean by that?”. The subsequent interview questions were adjusted based on the categories extracted from the data analysis. The data obtained from the participants were analyzed in MaxQDA-10 using a qualitative approach with conventional content analysis. In this way, immediately after recording each session of the interview, the researcher (A.B) wrote the interviews word by word, then the transcript was read line by line. Next, the important sentences and phrases were identified and underlined and the essence was named (coding). Similar codes were merged and categorized, and the formed category was named based on the idea in question. The extracted category was compared and, if similar, put together, and the themes emerged. Participants' manuscripts were also collected and analyzed. Sampling was continued until the researcher obtained new information while analyzing and coding the data. The lead researcher was in charge of coding and the codes were reviewed by the second researcher and revised if necessary. The transcriptions were then entered into MaxQDA-10 and coded. The extracted categories were employed to explain the challenges facing the HRP in providing midwifery services in the health sector.

The criteria proposed by Lincoln and Guba (1985), i.e. credibility, dependability, transferability, and confirmability, were used to confirm the validity of the study (12). There was ongoing engagement with the research subject and data. The interview transcripts and the extracted codes and sub-categories were shared with some of the participants, five members of the Faculty of Nursing and Midwifery, and the university authorities, and their comments were utilized. In two focus group sessions and three individual sessions, the analysis results, codes, and categories were presented to a group of participants and the necessary corrections were made. Efforts were made to observe maximum variation in the sampling. All the activities, which were accurately recorded, included the research steps and the data collection. Data collection and integration involving the interviews, focus group discussions, field notes, and spatial integration was used (Kashan, Aran-o Bidgol). The obtained data were shared with one faculty member and two midwives from community health centers, as out-of-study participants with similar positions as those of the study participants.

Results

Table 1 presents the characteristics of the study's key informants. After eliminating 208 extra codes from 338 codes initially obtained from implementing the interviews and codes in MaxQDA, similar codes were merged, yielding 108 codes. The challenges of midwifery services were ultimately divided into six themes, i.e. policymaking and management, rights, referral system, satisfaction, costs, and development and promotion. Most of the extracted codes are related to policymaking and management. These themes individually comprised categories and sub-categories.

Table 1. Individual characteristics of midwives and healthcare providers participating in the study

Variable / participants	Age (years)	work experience (years)	Education (number)	Post (number)	Total
Midwife, reproductive health	42.3 (26-50)	15.5 (5-24)	Bachelor (24) Master's degree (1) Ph.D. (9)	managers and officials (12) faculty members (10) midwives and family physicians working in urban community health centers (12)	34
Healthcare providers	47 (40-53)	12.4 (5-25)	Associate & Bachelor degree (10)	Public health Experts (10)	10

Table 2. Explanation of current challenges in the provision of midwifery services in the health system

Row	Theme	Category	Sub Category
1	Policy-making and management	Structure	Lack of midwifery offices in the health sector
		stakeholders	Lack of stakeholders' participation in policy making in the health sector
		infrastructure	Multiple approaches to planning, supervision, and operation
2	Rights	Staff	Non-compliance with staff rights
			Legal threats due to unmatched tasks

		Clients	Non-compliance with clients' rights
3	Referral system	Referral process	Lack of approach for the development of referral system
		Productivity	Decreased human productivity in the referral system
4	Quality	Service provision system	Increasing the importance of multiple job holding on technical services Increasing the importance of a number of services compared to the quality
		Provider	Decreasing the confidence and trust Decreasing desire for responsiveness Ignoring personnel's needs
		Receiver	Decreasing the women's access to better service Ignoring the skill and knowledge qualification Non-fulfillment of clients' needs
5	Cost	Financial	Increasing cost of unnecessary education Non-use of saving facilities Increasing cost of referral
		Non-financial	Wasting time Loss of human resources
6	Development and promotion	Education	Lack of observance of university philosophy in the student training Restrictions of disciplines in the international field
		Graduates	Lack of attention to technical re-training for personnel Lack of attention to complementary packages for midwifery services

Policymaking and management:

This theme included categories of structure, stakeholders, and infrastructure. According to the majority of the participants, the problems were mainly rooted in a lack of informed, responsible and competent midwifery authorities with power and task in the health sector of the ministry. Despite the large number of midwives working in the health sector, only one midwifery office was available. Describing her experience, a participant said, "In my opinion, there should be a place in the ministry as the department of midwifery. We have a large number of midwives in the health sector of Iran. Are not mothers' and women's indicators among global goals? Given the unavailability of accountable people in this field, we have to tolerate the misery".

According to the participants, all the stakeholders, including midwives, should play a role in different dimensions of the reform planned by the ministry in the health sector of Iran. This role ranges from policymaking to acting and midwifery promotion packages should be prepared and proposed in the units associated with the stakeholders. The majority of the participants identified the successful implementation of family physician programs in cities with populations of below 20,000 as an appropriate model for employing the midwifery workforce in the health system. Given that the implementation guidelines can be generalized to urban health development, they should be revised based on successful experiences, and midwifery professionals and faculty members are actively involved. Lack of communication and unavailability of managers and designers of the transformation plan has disrupted the transmission of criticism and suggestions of service providers to higher levels. Participants in the study pointed out that the infrastructure for the implementation of this large program was not provided

before the implementation in the city and the decision to implement the program in the city was made in precipitancy; As a result, many challenges have been created in the implementation process of the program.

Referral system:

There were two categories: referral process, and productivity. Despite the weakened referral system by current approaches, the participants identified the midwifery service packages of the health development program as the most effective components in strengthening and optimizing the referral system. A public health expert said, "It's not like that I'm unwilling to refer pregnant women to midwives, but she waits for half an hour, most the referrals need to be visited by a midwife, but they prefer the specialist." In the midwifery sector, given the priority of providing diagnostic and treatment services such as common diseases and complaints of women, sexually-transmitted infections and counseling are neglected and uninsured, leading to enormous costs and loss of opportunity for service delivery.

Rights:

There were two categories: staff and clients. According to the participants, the implementation of transformation programs in the field of midwifery is such that the rights of clients and employees are weakened and increase distrust in the system which can increase the risk of legal cases in the future. Some of the participants found their professional rights never to be respected; for instance, the hasty removal of the midwife's name, calling everyone a healthcare provider, disrespectful behaviors, and the midwife's return to centers without naming them, midwives.

A participant said, "I was a midwifery expert who became a caregiver according to the service package. I had no problems with it, but there were still expectations for the midwifery job. You cannot eliminate one's identity, break their wings and expect them to jump if they need".

According to some of the participants, even managers had to oppose the ministry for this part of the program, because current guidelines did not apply to deprived areas, thereby increasing the pressure on managers. According to some participants, the tasks that are expected of them or that the system forces them to do are not commensurate with their academic training or even post-graduate retraining and are left out of any written notice, and in the event of any incident, they have no safeguard to defend their rights. Implementing the current program violated patient rights by using illegal measures and providing care by unskilled or irrelevant individuals.

Service quality:

According to the results of the study, this area had three categories: service delivery system, service provider, and service recipient. The quality of midwifery services has decreased in the current service delivery system. The majority of the participants identified multiple jobs as the priority of this program. Eliminating job identities, increasing staff dissatisfaction, providing specialized services by unspecialized individuals, discontinuing scientific disciplines, and removing international disciplines such as public health and midwifery were degrading the service quality. The majority of the participants found using recorded statistics and data in the integrated health system (SIB) and increasing the number of services to be preferred to the quality of service. It is a false competition between staff; and even many midwifery experts prefer working as healthcare providers because the midwifery service, which is very time-consuming and has tough responsibility, is only recorded as a service, but much more services are recorded for other items (child care, older adult care). The priority of quantity over quality can cause irreversible consequences at least for pregnant women and develop indifference in midwives to the importance of prenatal care and reproductive health.

The participants mentioned the failure of the HRP to address the needs of midwifery staff as a major population of stakeholders, which decreases the quality of service and reduces or disrupts women's access to care services in different ways. The unavailability of midwives at the health center can be explained by their responsibility for providing services such as fluoride therapy, school examinations, and their participation in acquired immune deficiency syndrome (AIDS) and

influenza training sessions. Pregnant women may have to visit a healthcare provider despite the presence of midwives. It is unclear why this service should be provided by healthcare providers despite the presence of midwives with higher qualifications, clinical skills, and competence.

Costs:

Participating data in this area were divided into two categories of financial and non-financial expenses. The participants found the current process of using midwifery services to impose financial costs on the system. Utilizing the potential of the midwifery workforce can decrease health problems at no extra cost or technological requirements. Additional problems created for the system and community as a result of failing to pay attention to this sector include the inability to prescribe despite all available infrastructures for midwives, the lack of insurance coverage, and the visit of all people who need treatment to external sectors. Due to neglect of education, job descriptions, and midwifery capabilities, we have an extra burden of unnecessary referrals to other departments. Each additional referral has several costs (The cost of training a midwifery student, both instructor, and student, the cost of employing medical staff for additional referrals, the cost of spending two manpower for one job and parallel work or multiple reworks) that must be saved. These problems should be therefore solved and family physicians in this field should be well experienced.

Development and promotion:

The data of the participants in this field were divided into two categories of student education and graduate students. Implementing the HRP contradicts the philosophy of student learning in universities. The contradictions cited by the participants in included ignoring the curriculum content, disregarding student recruitment according to need, failing to provide student trainings in the health sector, lack of coordination between departments of education and health, and neglecting teaching units for students. The participants identified severe restrictions on the approved international fields of public health and midwifery for development and growth given the movements in implementing the HRP in Iran. The officials argued that, instead of university students, healthcare providers were trained to work in the health sector.

Not much attention is paid to the retraining required by midwifery professionals who can provide specialized and technical services to the public. From in-facility deliveries, activities to reduce mortality rates, and Near Miss checklists without considering assessment to explain retraining needs. According to the participants, descriptions of midwifery tasks, empowerment and service experience of midwives in previous years, and addressing social needs in pursuit of Sustainable Development Goals have introduced midwifery as an accountable discipline. The HRP, however, lacks foundations for preparing and providing complementary and promotional packages for midwifery services such as service of midwife-based models, specialized sexual and reproductive health consultation, treatment of sexually-transmitted diseases, and specialized family planning.

Discussion

Reviewing several quantitative and qualitative studies and evaluating them from different perspectives helped start the implementation of the HRP in Iran in May 2008 to correct or eliminate major health system problems. This study was conducted to investigate the challenges of the HRP in midwifery services from the perspectives of midwives, health service managers, and healthcare providers. Providing maternal and child health through the HRP is integral to the PHC. As a step towards developing PHC principles in Iran, providing midwifery services through the PHC delivery system (13) makes educated midwives available to women, infants, and families in the most remote and deprived regions of Iran (14-16).

The present findings helped divide current challenges in delivering midwifery services into six themes, i.e. policymaking and management, rights, referral system, quality, costs, and development and promotion. Not all the midwifery stakeholders were involved in developing and implementing a

comprehensive HRP, and technical requirements for services in this field are not satisfied in many places despite the global importance of the issue (17-19). Integrated care is expected to shift the tasks and responsibilities for taking care of women to a higher number of professionals, which can affect experienced job independence (20). Maintaining the independence of different specialists in the health team is crucial for successfully implementing an integrated maternity care program (21). This issue has not been, however, addressed in the HRP in Iran.

Shortcomings in the HRP include giving priority to the quantity rather than the quality of service decreases in the efficiency and underdevelopment of the services and even legal violations. The participants reported urgent needs for a midwifery office or department in the health sector to revise the existing instructions and prepare and complete valid checklists of midwifery services and perform appropriate monitoring. Midwifery services in the health sector include childbirth and postpartum services at facility centers accompanying women in distant places in emergency conditions and counseling and supervision in mobile teams for the family physician unit. Providing comprehensive midwifery services across a country as vast as Iran is impossible using a few instructions that are prepared and implemented in different units. In midwifery offices required in the health sector, the stakeholders manage policymaking and service delivery to cover the remaining regions of the country. The guidelines issued by the WHO recommend that midwifery roles be highlighted in terms of policymaking to service delivery in a country (2). The participation of the midwifery community in the present study was, however, very low, although this community is expected to actively participate in health development packages for service delivery.

According to the participants, midwifery development goals are not included in the new packages and maternal and female care appears underestimated, whereas according to the WHO guidelines, "It's time to highlight specialized roles of midwives in the PHC system to improve maternal indicators such as maternal mortality and cesarean section rates" (22, 23). The present findings showed that the development and promotion of professional midwifery services have been neglected in this system and that midwifery services will face many challenges, including returning to the past in the future.

The access means that all women in a family can access a responsible midwife for their care in the closest place to their house to receive essential midwifery services (24). The present study found getting access to midwives to be difficult despite their presence in the centers, as the women were first referred to healthcare providers and then to midwives if they needed midwifery services such as pregnancy care. According to the current procedure, part of the PHC is often delayed according to the clinical specialist's booklet and then referred to midwives, which lowers the quality of services and focus on the care process and results in rework and legal violations. It is therefore recommended that proper referral pathways be defined between midwives and public healthcare providers and implemented in the system to ensure justice in using midwifery services.

The proper technology in delivering midwifery services means providing the best available service for women and mothers (25). Providing high-quality midwifery services for women by a midwifery expert rather than health specialists is equivalent to the appropriate technology at an affordable cost and with higher quality. Warmelink found midwives to be quite satisfied with their direct contact with patients, organized and innovation in the practice in which they work, and the independence, freedom, diversity, and opportunities they have experienced in their work. To improve performance, midwives tend to reduce irrelevant activities for patients such as paperwork, lower work pressure, reduce case-loads and increase time to meet clients' needs (26). This issue is not, however, considered important in the system currently in place in Iran, which has caused midwife dissatisfaction. The present study results also showed the failure to utilize appropriate technology in providing midwifery services, which caused uncertainty and

duality in the referral system. The findings of the present study showed that with the implementation of the Health Transformation Plan, the costs imposed on the health system have increased. Keyvan Ara et al. (2013) at Isfahan University of Medical Sciences also showed that induced demand leads to uncontrollable cost growth, imposing unnecessary costs and doubling financial pressure on insurance organizations (27).

Although midwifery can be performed by female-specific healthcare providers, services such as assessing non-communicable diseases at different ages, child care, male care in different areas, vaccination and student health assessment can be included in the job description of public healthcare providers, which is perfectly consistent with the goals of public health training. It is ultimately recommended that distinct and independent roles be defined for midwives and public healthcare providers. The results indicated significant cost savings, which are not addressed in the current trend. Using the potential of midwives for delivering the PHC and in the insurance-supported referral system can reduce unnecessary costs.

A large body of literature on HRP is devoted to treatment and midwifery services is rarely emphasized. The present study was therefore conducted to address the challenges of this project in providing midwifery services. The innovations and strengths of this study lie in using the broad experiences of the participants who were involved in the HRP. Given the subjective nature of qualitative research and that its results are rooted in the data obtained from special situations or groups, the present findings should be cautiously generalized to other circumstances. Efforts were made in this study to carefully select the participants, observe maximum variations in terms of their characteristics, increase the level of abstraction in the findings and provide in-depth and analytical descriptions of the research context. The present research required the active participation of midwifery staff in different fields of treatment and education, faculty members, health workers, and authorities of health centers of Iranian universities of medical sciences; nevertheless, the majority of colleagues refused participation for fear of avoiding marginal issues. Some of the universities also announced that their participation in the study was subject to approval by the Iranian Ministry of Health. These problems were, however, solved over time by gaining the confidence of the authorities in the scientific objectives of the study and persuading them to cooperate by ensuring the confidentiality of information during the study.

Conclusion

The present study results showed the midwifery sector needs in the Iranian health system for reforms in terms of policymaking and management, rights, referral system, quality, costs, and development and growth. Given maternal and neonatal health as an important indicator of Sustainable Development Goals and the high number and broad scope of work of midwives employed in the health sector, it is essential to establish a midwifery department or office in the Ministry of Health and constantly evaluate the promotion and validity of relevant services. It is recommended that the role of faculties in training human resources for the health sector be emphasized and new training requirements be integrated into the curriculum by educational departments promptly.

Ethics permissions

The ethical principles applied to this study included making the necessary arrangements with the authorities of the educational centers of Kashan University of Medical Sciences, briefing the participants on the study objectives and methods and purposes of audio recording and obtaining their written informed consent, and assuring the participants of the confidentiality of the information provided and of the voluntary nature of participation and their right to withdraw from any stage of the study at their discretion and adhering to the principles of loyalty in copyright quotes. This study was approved by the Research Ethics Committee of Shahid Beheshti University of Medical Sciences (Code: IR.SBMU.PHNM.1395.515). Written informed consent was obtained from all participants.

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Conflict of Interest

The authors declare that they have no competing interests.

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