Assessing the State of Professional Practice of Midwifery in the Philippines

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RESEARCH ARTICLE

Abstract

Background and Objectives: Midwives have been the country's frontline health care providers in communities. Their role was expanded from largely providing maternal and child care services in the 1920s to provision of basic Primary Health Care services since 1970s. Despite their extensive roles, there has been no comprehensive enquiry on the professional practice of midwifery in the Philippines since it formally started in 1901. This study was conducted to (1) describe the evolution of midwifery education and regulation; (2) describe professional practice of midwifery and the midwives' role in the local health system; (3) identify gaps in the current midwifery practice, and; (4) recommend to improve and standardize the competencies of practicing midwives.
Methodology: The study is qualitative with a grounded theory approach using face-to-face Key Informant Interview (KII), Focus Group Discussion (FGD), and document review. The study, conducted from January to December 2015, purposively sought experts from different fields of midwifery, including midwifery-service providers, birthing home managers from public and private sector, academe, Department of Health (DOH), development partners, the country's three leading midwifery organizations, and the Board of Midwifery (BOM) of the Philippine Professional Regulation Commission (PRC).
Results: Changes in midwifery education, scope of practice and standards were in response to the country's health challenges in maternal and child health. Public midwives were frontline implementors of 57 DOH programs. Despite their vital role and expanded workload, the tenure or plantilla positions of government midwives continued to have the same salary grade promulgated in 2000 while others, although the numbers are unknown, do not have security of tenure. There were no learning and development initiatives designed to enable midwives to become implementors of multiple programs. Regulation of midwifery practice was not cohesive. The standards of practice were program-based and were scattered in different policies.
Recommendation: The study recommends that the DOH, PRC, and midwives' organizations review and revise the scope of midwifery practice in line with global standards, as well as to implement a competency-based career development pathway that is integrated with the regulatory system.

Keywords: *professional practice, midwifery, primary health care*

Introduction

Background

Midwives play a vital role for countries to achieve healthy outcomes for pregnant women and their newborns.

Evidence show that scaling up midwifery, that follows a quality framework for maternal and newborn care integrated within an enabling environment, could be successfully implemented to lower maternal and newborn mortality rates even in resource-constrained conditions [1,2,3]. A Lancet Series about midwifery documented the health system efforts toward maternal and newborn health in Burkina Faso, Cambodia, Indonesia, and Morocco. The case studies illustrated how midwife deployment as a core strategy made "gains in facility birthing in every wealth asset quintile and the proportion of births attended by a midwife, auxiliary midwife, or nurse midwife has increased in the four lowest quintiles in Cambodia, Indonesia, and Morocco or in all five quintiles in Burkina Faso, with sustained and substantial reduction of maternal and newborn mortality [4]."

In the Philippines, midwives have been the country's front-line healthcare service providers even before the devolution in 1991. The midwives have been the backbone of the country's local health service delivery system as primary health providers at the barangay health stations, rural and city health centers, and public and private birthing homes. Despite their extensive roles, there has been no comprehensive enquiry on the status of professional practice of midwifery in the Philippines since 1901 when Public Act 310, regulating the practice of midwifery, was promulgated.

To fill in this gap, this study, 1) described the evolution of midwifery education and regulation, and professional practice of midwifery and the midwives' role in the local health system; 2) identified gaps in the current midwifery practice; and 3) recommended to improve and standardize the competencies of practicing midwives.

Methodology

The study was qualitative with a grounded theory approach using face-to-face Key Informant Interview (KII), Focus Group Discussion (FGD), and document review. The study, conducted from January 2015 to December 2015, purposively sought experts from different fields of midwifery to validate historical accounts, describe the evolution of midwifery education and practice, and elucidate challenges and interventions.

Midwifery-service providers and birthing home managers from public and private sectors, deans of schools of midwifery, and a DOH program manager were among the key informants. Among those interviewed were newly registered midwives deployed to rural areas in Mindanao under the DOH Rural Health Midwives of the Placement Program. Development partners, such as USAID Office of Health, were also interviewed, focusing on their technical support on midwifery practice.

FGD participants were experts belonging to the Board of Midwifery (BOM) of the Philippine Professional Regulation Commission (PRC), supervisors, policy-makers, and officers of three major midwives' organizations. These organizations were the Integrated Midwives Association in the Philippines, Inc. (IMAP), Philippine League of Government and Private Midwives, Inc. (PLGPMI), and Midwives' Foundation of the Philippines, Inc. (MFPI).

The study also pursued secondary data from various institutions such as the Department of Health (DOH), Professional Regulations Commission (PRC), Commission on Higher Education (CHED), Association of Philippine Schools of Midwifery (APSOM), and various midwives' organizations in order to gain more cohesive narrative on the status of midwifery in the Philippines.

The data analysis was largely inductive in approach.

Results

Evolution of Midwifery Education and Policies

Policies governing the professional practice of midwifery and pre-service education have evolved since its regulation in 1901. These policies, in response to maternal and infant health needs and the wider public health challenges, increased the number of academic years and modified the midwifery scope of practice. This evolution is outlined in Tables 1 and 2, summarizing the policies that were enacted in a span of 106 years.

When these policies took effect, the midwifery education also changed its requirements following the mandates of the law. These changes are summarized in Table 2.

Unfortunately, there were no solid information gathered on midwifery practice from the time that the regulation started in 1901 until 1913 when the first puericulture center was organized.

A group of Filipino doctors established the first puericulture center in 1913 in Manila [3]. Those who wanted to set up puericulture centers in their respective towns got the support from the Third Philippine Legislature, which appropriated P1 million for the protection of early infancy in 1916 [5]. The puericulture centers, mandated to address high infant mortality rates, provided services for children and the unborn. This was part of extensive efforts to address infant mortality which became an index of the general sanitary condition and, thus, of civilization [6]. Unlicensed midwives were hired to provide services at the puericulture centers in resource-poor areas.

The Philippines joined other countries where infant mortality became part of colonial policy discourse in the 1920s. Improving sanitation, hygiene, and infant mortality were part of a central discussion measuring the readiness for an autonomous, Filipino-governed Philippines [5].

Thus, the country's midwifery education, which took off from Dr. Jose F. Fabella, the Philippine Father of Midwifery

Table 1. *Evolution of policies governing midwifery practice*

Year Published or Enacted	Policy	Short Description
December 4, 1901	Public Act 310	Created the Medical Board of Examiners, which regulated both medicine and midwifery professions.
June 20, 1959	Republic Act No. 2382	Medical Act of 1959 separating the regulation of midwifery from medicine
June 18, 1960	Republic Act 2644	Created the Board of Examiners for Midwives, under the direct supervision and control of the President of the Philippines; Set the requirements for an 18-month course in midwifery, requirements for the schools, and the required age at registration for the midwifery examination to be at least 21 years old
April 10, 1992	Republic Act 7392	Philippine Midwifery Act revising Republic Act 2644; Established Board of Midwifery under the direct supervision of the Philippine Regulation Commission; Set the requirements for the academic preparation of midwives; Broadened midwives' functions including community service; Decreased the required age at registration for the midwifery examination to at least 18 years old
2010	DOH Administrative Order on Life-saving drugs 2010-0014	Authorized midwives to provide life-saving drugs such as oxytocin for the prevention and treatment of post-partum hemorrhage, magnesium sulphate (MgSO4) for the management of pre-ecclampsia and eclampsia, prenatal steroids in the case of preterm labor, and antibiotics for infection. This AO also states that “midwives shall be provided with legal assistance, if this becomes necessary in relation to their performance as EmONC providers.”
July 23, 2012	Republic Act 10354, National Policy on Responsible Parenthood, Reproductive Health (RPRH)	With provisions allowing midwives to provide oxytocin, magnesium sulphate, and other life-saving drugs in emergency situations, following the protocols set by DOH, provided that they have been adequately trained for it. The RPRH Law superseded the prohibitions on life-saving drugs explicitly stated in the Midwifery Law
March 21, 2013	Implementing Rules and Regulation of RPRH Act of 2012	

Table 2. *Evolution of midwifery education*

Year	Short Description of the Midwifery Education
1922	Dr. Jose Fabella established the first School of Midwifery. The nine-month midwifery course required the students to take obstetrical nursing, anatomy and physiology, dietetics and housekeeping, infant hygiene and feeding, bacteriology, hygiene and sanitation, and to render 1,400 hours of clinical practicum. Optional courses in English, dental hygiene, and social diseases were offered.
1960	Following the enactment of Republic Act 2644, midwifery became an 18-month course. The course subjects expanded to include introduction to general anatomy and physiology, principles of bacteriology, obstetrics, midwifery procedures including hygiene and care of patients' environment, delivery room technique, nursery technique, infant care and feeding, nutrition, domiciliary midwifery, community hygiene and first aid.
1965	Dr. Jose Fabella School of Midwifery had its first nurse-midwife graduates.
1992	Following the enactment of Republic Act 7392, Diploma of Midwifery was established and its length of study required 2 years + 1 summer term.
1995	Board of Midwifery Resolution No. 100, Series of 1993, required further training on family planning, suturing of perineal lacerations, IV insertions and mandating applicants for Midwifery Licensure Examinations to submit documentary evidence for having performed suturing of 5 perineal lacerations and 5 cases of IV insertions.
2007	CHED released CMO #33 Series of 2007 aimed at producing competent midwifery graduates; It spells out Policies and Standards for Midwifery Education, providing for the requirements, curriculum and standards for both Diploma in Midwifery and Bachelor of Science in Midwifery

and the first Secretary of Health and Social Work, became part of a nationwide campaign to reduce the country's high infant mortality rate [7].

On November 9, 1920, Dr. Fabella founded the Maternity and Children's Hospital in Manila. Two years later in 1922, he established the School of Midwifery attached to the hospital to (1) train young women in midwifery to gradually supplant unlicensed midwives who became unpopular and were blamed for untimely maternal and newborn death, and to (2) improve health services and education on maternal and child care [7].

The School of Midwifery in Manila started in 1922, two years after he founded the Maternity and Children's Hospital. It opened in Cebu in 1922 and had 14 students. In 1923, it opened in Bacolod, Negros Occidental and had 20 students. These schools were enthusiastically received [7].

After having its first ten 10 graduates, the Dr. Fabella's School of Midwifery redefined its objectives - to train students in modern techniques of attending to normal deliveries, and; to give practical education to mothers on the modern procedure of delivery including pre- and post-natal care and care of the babies [8].

Almost all students in Manila were supported by their families. Charitable organizations such as the puericulture center, local women's club, and the municipal government financed the students' midwifery education in Bacolod and Cebu in exchange for a return service in their hometown's puericulture center of at least a year [5].

Fast-forward to 1960, Republic Act 2644 defined the boundaries of the practice of midwifery as performing "…services requiring an understanding of the principles and applications of procedures and techniques applicable to the care of normal child-bearing women from the beginning of pregnancy until the end of puericulture and the care of their normal infants during the neonatal period…"

When the country implemented Primary Health Care in the '70s, their role was expanded from largely providing maternal and child care services to providing basic community health services.

In 1992, RA 7392 or the Philippine Midwifery Act further legalized this expanded practice of midwifery as:

"…performing or rendering services requiring an understanding of the principles and application of procedures and techniques in the supervision and care of women during pregnancy, labor and puerperium management of normal deliveries, including the performance of internal examination during labor except when patient is with antenatal bleeding; health education of the patient, family, and community; primary health care services in the community, including nutrition and family planning in carrying out the written order of physicians with regard to antenatal, intra-natal and postnatal care of the normal pregnant mother in giving immunization, including oral and parenteral dispensing of oxytocin drug after delivery of placenta, suturing perineal lacerations to control bleeding, to give intravenous fluid during obstetrical emergencies provided they have been trained for that purpose; and may inject Vitamin K to the newborn…"

In 2007, the Commission for Higher Education (CHED) released CMO #33, delineating Policies and Standards for Midwifery Education aimed at producing competent midwifery graduates. To keep up with the demands for improving outcome-based education as well as quality care, this memorandum provides for the requirements, curriculum and standards for 2-year Diploma in Midwifery, 2-year Bridge Program in Midwifery, and Bachelor of Science in Midwifery (BSM).

The Diploma of Midwifery, a direct entry course after high school, has 118 units of general education, core, and professional courses, and at least 1,275 hours of clinical practicum. CHED maintained at the time of study that the Diploma in Midwifery was still recognized even if there were initiatives to implement the BSM curriculum.

The Bridge Program in Midwifery was jointly developed by the CHED, the DOH and midwifery schools to "fill the gap between the competencies of the graduates of the Diploma in Midwifery and Bachelor of Science in Midwifery (BSM)." This is an optional 2-year course for graduates of Diploma of Midwifery who are licensed midwives, allowing them to be conferred with the BSM degree after finishing the bridge program.

These innovations advanced the midwifery education to become competency-based with the DOH as the trailblazer. The DOH has 100 scholars for the two-year Diploma midwifery course in 2014. When the scholars graduate from the two-year course in 2016, they will continue to the third and fourth level, completing the four-year BSM by 2018. The DOH was the first institution to implement the BSM.

Table 3 compares the competencies of the graduate of the Diploma and Degree (BSM) Programs for Midwifery.

Table 3. *Competencies of the Graduate of Diploma for Midwifery and BSM*

Diploma Course in Midwifery	Bachelor of Science in Midwifery
1. Provide the necessary supervision, care and advise to low-risk women during pregnancy, labor and puerperium. Specifically, they should be able to: ● Obtain pertinent history; ● Perform physical assessment including vital signs taking; ● Do simple laboratory examinations such as hemoglobin determination and urine test for sugar and albumin; ● Assess the progress of labor; ● Perform relevant midwifery procedures; ● Provide life-saving measures during obstetrical emergencies such as administering IV fluids and cardiopulmonary resuscitation; ● Detect abnormal conditions of the mother and/or newborn; and ● Facilitate referrals as necessary. 2. Perform primary health care services within the community. Specifically, they should be able to: ● Implement government health programs following proper protocols ● Administer first aid measures as needed ● Give appropriate health teachings to individuals, families and the community ● Supervise barangay health workers; and ● Manage a barangay health station	1. Provide the necessary supervision, care and advise to woman with a high-risk pregnancy in the absence of a specialist. 2. Correctly interpret diagnostic examinations related to midwifery care and act accordingly. 3. Execute life-saving obstetrical management during the emergency cases. 4. Assist in a cesarean section procedure as a scrub/ circulating assistant. 5. Provide post-cesarean section care 6. Provide basic and comprehensive family planning services. 7. Administer appropriate drugs according to proper protocol. 8. Manage a Midwifery educational Program and Reproductive Health Care Facility/Program. 9. Conduct classes in Midwifery courses. 10. Prepare a project/research proposal.

Direct entry to the 4-year BSM from secondary education or high school has not yet been implemented at the time of study. CHED planned to start this direct entry to BSM in 2018. It requires 188 units of general education, core and professional courses, and a total of 2,346 hours of Clinical Practicum.

Considering these expected competencies, the graduates of the Diploma of Midwifery and the BSM can have different career pathways, as exemplified in Table 4.

According to CHED, the development of the competency-based BSM, whose curriculum subscribes to Outcome-Based Education (OBE), was a product of collaboration among different stakeholders in the midwifery profession from the academe, professional organizations, industry, hospital associations, PRC, and DOH's Health Human Resource Development Bureau (HHRDB).

Regulating the Professional Practice of Midwifery

Corollary to the expansion of the professional practice of midwifery was the challenge of regulating it. There were four separate institutions that regulated the practice.

The PRC's Board of Midwifery (BOM) traditionally regulated midwifery practice. The BOM, at the time of study, was composed

Table 4. *Specific professions or careers after graduation*

Graduate of Diploma in Midwifery can be:	Graduate of Bachelor of Science in Midwifery can be:
● Staff Midwife ● Domiciliary Midwife ● Rural Health Midwife ● Clinical Instructor	● Faculty/trainer ● Supervisor ● Principal ● Health Facility Administrator ● Researcher ● Entrepreneur/Clinic owner/Manager ● Health Program Manager

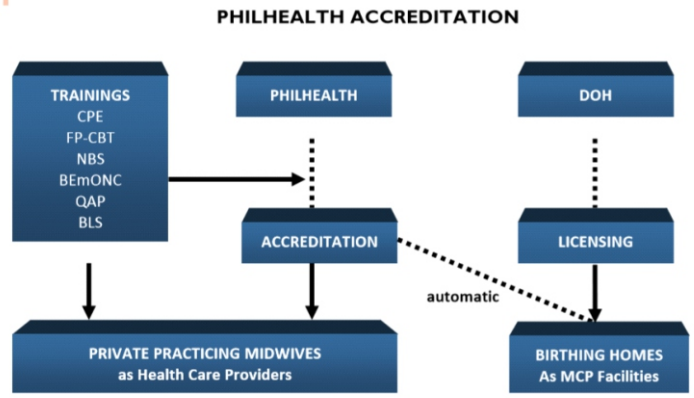
of an obstetrician as the Chairperson, 2 midwives, and a nurse-midwife. There was a general sentiment among study participants that the BOM be composed and headed by midwives. BOM was supposed to enforce provisions of the Midwifery Law, conduct yearly licensure examinations, administer oaths, perform investigations, and oversee conditions affecting the practice.

Local Government Units (LGUs) also issued policy instruments regulating the private practice of midwifery to increase the access, coverage, and improve the quality of maternal and neonatal care [9].

The National Health Insurance Corporation (NHIP), or more popularly known as PhilHealth regulated midwifery practice through accreditation with incentives. Midwives and their birthing homes got accredited as Maternal and Newborn Care Package providers. PhilHealth's accreditation, though voluntary in nature, was deemed necessary not only for the monetary gain it brought in but the required facility upgrade, competency development among providers, and bundle of services for both mother and newborn. PhilHealth's payment to midwives and birthing homes for services rendered to its members focused on antenatal care of low-risk pregnancies, facility-based deliveries covering Normal Spontaneous Delivery (NSD), essential intra-partum newborn care, post-partum, and provision of modern artificial and long-acting family planning (IUD, interval) [10].

As of April 2015, there were 2,247 PhilHealth accredited midwives nationwide. This was a huge leap from the 824 accredited midwives in 2012. The data then were not disaggregated into publicly or privately practicing midwives or both.

This number of PhilHealth-accredited midwives may change with the implementation of DOH licensing of birthing homes.



Source: Expanding the Contribution of Private Practicing Midwives (PPMs)

Figure 1. *PhilHealth accreditation process*

The requirements for PhilHealth accreditation would be harmonized with the requirements of DOH License to Operate (LTO). In summary, birthing homes have to pass the DOH –LTO, as one of the bases for automatic PhilHealth accreditation. Figure 1 depicts the PhilHealth accreditation process in 2015.

The DOH, to a certain extent, regulated the practice of midwifery based on its formulated standards of practice and licensing of birthing homes.

The standards of practice that guided midwives in their daily conduct of service provision were program-based, and were scattered in different policies, manual of operations of different programs.

Professional Practice of Midwifery

Overall, the PRC database listed a total of 168,995 registered midwives licensed as of August 10, 2015.

Interviews and focus group discussions with key stakeholders from CHED, APSOM, PRC, and DOH revealed that the PRC database of licensed midwives did not necessarily connote that they were actively practicing as midwives in-country.

There were no solid and updated evidences showing that midwives have gone abroad to work as midwives. This is because they did not register themselves as midwives when they went abroad to work. Anecdotes shared by the respondents of this study said that they knew midwives who worked abroad not as midwives but as household helpers.

The only available data on the migration of midwives from 1998 to 2008 are shown in Table 5.

Table 5. *Trend in migration of midwives, 1998-2008 [11].*

Year	Temporary migration	Permanent migration
1998	113	48
1999	149	27
2000	66	58
2001	55	44
2002	81	42
2003	172	58
2004	275	60
2005	252	60
2006	230	53
2007	367	53
2008	423	51

Source: WHO. Philippines Health Systems Review,2011

Midwife migration ranged from 1% to 10% when the data on migration were cross-tabulated with the available data on the actual number of midwifery graduates from 2001 to 2005. The results are shown in Table 6.

Table 6. *Percentage of temporary and permanent migration, 2001-2005*

Year	Midwifery Graduates	Percentage of Temporary Migration	Percentage of Permanent Migration
2001	1,856	3%	2%
2002	2,002	4%	2%
2003	2,264	8%	3%
2004	2,831	10%	2%
2005	4,160	6%	1%

Public Sector Midwives

Based on the DOH-HHRDB data, as of June 2015, there were 17,294 midwives in the government sector. This is below the projected number of 20,603 midwives needed in the public health sector in 2015, based on Philippine Human Resources for Health Master Plan 2005-2030 [12].

Please refer to Tables 7-9 for some of their characteristics.

Table 7. *Distribution of selected health providers according to age*

Age Category	Midwife
< 25	144
25 – 34	1,212
35 – 44	4,840
45 – 54	4,110
55 – 64	5,082
65 and Above	1,293
No Info	613
TOTAL	17,294

Source: hhrdbjob.doh.gov.ph/ndhrhis

Table 8. *Distribution of selected health providers according to sex*

Sex	Midwife
Female	17,128
Male	161
No Info	5
TOTAL	17,294

Source: hhrdbjob.doh.gov.ph/ndhrhis

Table 9. *Distribution of selected health providers according to overall service type*

Service Type	Midwife
Administrative	8,027
Direct	9,267
TOTAL	17,294

Source: hhrdbjob.doh.gov.ph/ndhrhis

Public Health Midwives' Work Load

The study participants agreed that a midwife in the Philippine context was mainly responsible for three focal areas of practice. Primarily, a midwife should work with a team of competent service providers, women of reproductive age, and their families (1) in the provision of appropriate and optimum care, support, information, services on maintaining health during pre-pregnancy, pregnancy, labor, intra-partum and post-partum, using protocols, guidelines that are appropriate to the midwife's competencies based on scientific and universally accepted standards of care as set by the government; (2) in ensuring the health of mothers, newborns, infants, children, and teen-agers; (3) in detecting risks, danger signs, symptoms and if such are found, immediately refer them to and access quality services from the nearest, appropriate, next level of care within or outside the Service Delivery Network or SDN [13,14].

A midwife should record, maintain and manage accurate, verifiable information on the support, care, information, and services she provided to clients, be it individual, families or communities, ensure privacy and confidentiality of such information.

A midwife may practice in any setting including birthing homes, community, hospitals, clinics or health units.

All midwives interviewed for this study agreed that based on law and their training, their main duty is to ensure that both mother and her unborn or newborn child are both healthy.

Policy-wise, the country's Maternal, Newborn, Child Health and Nutrition (MNCHN) Strategy shared the same objective - to rapidly reduce maternal and neonatal mortality through effective population-wide provision and use of integrated MNCHN services as appropriate to any locality in the Philippines. The MNCHN Strategy envisions improvements in the local health system to ensure that (1) every pregnancy is planned, wanted, and supported; (2) every pregnancy is adequately managed throughout its course; (3) every delivery is facility-based and managed by skilled birth attendants, and; (4) every mother and newborn utilize proper post-partum and postnatal care [15].

Midwives, being the frontline provider at the barangay level, have the core responsibilities to ensure that these four major intermediate results are realized.

Unfortunately, these are not the only core responsibilities of midwives.

Midwives, especially in the local government units (LGUs), were the frontline implementers of the DOH's health programs that increased to 57 at the time of the study in 2015, covering family health to control and prevention of communicable and non-communicable diseases.

FGDs with midwives-educators from Naga (Bicol Region), NCR, Iloilo (Western Visayas Region) and Mindanao corroborated the government midwives' narrative that they have gone out beyond their focus and expertise because of the numerous programs they needed to implement. Although they were grateful for the new knowledge, they were worried that they were failing in doing their main tasks.

Under the nurse's supervision, the midwife assumed critical, multiple roles such as service provider, counsellor, administrator, team leader and supervisor of Community Health Volunteers, record and drug manager across different programs. To further provide details, the midwives' specific tasks in three DOH vertical programs are listed in Table 10.

Table 10. *Midwives' multiple tasks in three DOH programs*

Programs	Midwives' Tasks
Maternal, Newborn, Child and Nutrition (MNCHN) [15,16]	• Lead the Community Health Volunteers who are expected to contribute in improving utilization of services by women and their families. Their work included master listing pregnant women and women of reproductive age; assess health risks of women and their families and refer high risk pregnancies to appropriate providers; assist families in the preparation of health plans; provide information on available services; good health practices including financing options; provide community level care and services during the pre-pregnancy, pregnancy, delivery and post-partum period; organize outreach services especially for remote areas; organize transportation and communication systems within the community; report maternal and neonatal deaths; follow-up clients for family planning, nutrition and maternal and child care; facilitate discussions of relevant community health issues, like those affecting women and children. • Be part of the itinerant team of providers doing outreach services for long-acting and permanent family planning methods such as Intra-Uterine Device (IUD), Bilateral Tubal Ligation through Mini-Laparotomy, Local Anesthesia (BTL-MLLA), Non-Scalpel Vasectomy (NSV); be part of the Basic Emergency Obstetric and Newborn Care or BEmONC team (composed of a doctor, nurse, midwife trained on BEmONC); provide lifesaving interventions within the intent of Administrative Order 2010-0014 on lifesaving drugs; provide family planning services; assist mothers during delivery at the appropriate birthing facilities; provide post-partum care. • Perform administrative functions such as conducting regular (e.g. weekly) meetings with the Community Health Volunteers; report barangay level health plans to the Municipal or City Health Office (M/CHO); receive and store supplies.
National Tuberculosis Program [17]	• Identify presumptive patients • Ensure proper collection and transport of sputum specimen • Refer clients to physician and nurse for clinical evaluation and initiation of treatment • Provide continuous health education to patients • Supervise intake of anti-TB drugs • Track and report defaulters within 2 days • Refer patients with adverse reactions to physician for evaluation and management • Supervise and mentor treatment partners as well as other community health volunteers • Maintain and update NTP treatment cards, and other program records • Accomplish quarterly report on drug and supply inventory and requirement of the dots facility
Field Health Service Information System (FHSIS), [18]	• Accomplish and manage the Individual Treatment Record (ITR) and seven (7) Target Client List (TCL). These are the TCL for(a) Prenatal Care, (b) Post-Partum Care, (c) Under 1 Year-Old Children, (d) Family Planning, (e) Sick Children, (f) NTP TB Register, and (g) National Leprosy Control Program Form 2-Central Registration Form • Record all relevant data unto the Summary Table composed of Health Program Accomplishment and Morbidity Diseases • Accomplish and maintain Monthly Consolidation Table, Monthly Program and Morbidity Reports, annual Barangay Health Station (BHS) report form • Transmit all these accomplished reporting tools to the Public Health Nurse (PHN) of the Rural or City Health Office

Yet, despite these multi-faceted tasks, there has been no capability development on program management designed for midwives in general.

Notwithstanding their experiences, trainings and huge expansion of their job descriptions in the implementation of 57 DOH programs, the *plantilla* positions of midwives were the same as promulgated in the year 2000 [19].

There were midwives hired as Job Order (JO) employees. A midwife interviewed for this study related her mother's experience. Her mother used to work as a Rural Health Midwife (RHM) for sixteen years in the same rural LGU where she was assigned Her mother was a JO until death, with a salary amounting to PhP6, 000 per month if she did not incur any absences.

Government employees hired as JO have lower wages than those with regular *plantilla* posts. They only receive payment for the days that they worked with no security of tenure nor benefits.

Another midwife interviewed for this study assumed the tasks of a provincial midwife supervisor, overseeing midwives assigned in different localities throughout the province. Yet, she had a position and salary grade of a nursing attendant without transport allowance.

Private Practice of Midwifery

Privately practicing midwives supplemented and complemented public sector midwives [20]. Their practice was more focused on providing quality ante-natal, intrapartum and post-partum care, facility-based delivery, and family planning services.

Although interviewees exposed the challenges in monitoring quality of care provided by midwives in private birthing homes, private practice of midwifery has become a lucrative model in the Philippines. Midwives would own, manage, and practice in private birthing homes which when DOH-licensed and Philhealth-accredited, proved to be financially sustainable, gaining from PhilHealth's Maternal Care Package and Newborn Care Package.

Unfortunately, despite their role in maternal and child health provision in the Philippines, there were no consolidated records on the number of midwives practicing in the private sector at the time of the study. There were no extensive studies on the quality of care they provided as well as their contributions to local and national performance in maternal and child care.

Conclusion

Central to the evolution of midwifery education and practice in the Philippines since the 1920s was the midwives' role in improving maternal, neonatal, and infant health. However, the professional practice of midwifery, especially in the public sector has evolved beyond their education, training, and competencies based on the mandates by the law. Their tasks span across 57 public health programs that newly graduate midwives felt they were not adequately trained for the jobs they were expected to do.

Despite the midwives' critical role in our local health system, there was limited progressive career pathway for them and no systematic competency development related to health systems, program management, and policy. There were midwives with expanded responsibilities but their *plantilla* posts and salaries were not commensurate to the tasks they perform. Worse, there were LGUs that hired them as Job Order employees without the security of tenure.

Supervision and monitoring of midwifery practice were weak. It was not solely because nobody was tasked to do it. The reasons were multifaceted and system-wide ranging from lack of appropriate tools, competence on supportive supervision, and a compartmentalized/programmatic approach to service provision, subsequently limiting their capability to implement continuous quality improvement initiatives at the community level.

Although there were several institutions regulating the practice of midwifery, there were no collaborative efforts among them to harmonize regulation of midwives practicing in public and private sectors.

The dominant model for midwives was to seek public sector employment in response to an increasing unmet needs for maternal and neonatal care. However, with the LGUs' limited resources to provide for a competitive salary and career development, opportunities for private practice among already licensed midwives beckoned. This would further aggravate the already limited number of midwives providing public health community services to an increasing number of population, most especially among those socially and geographically disadvantaged.

The PRC had the number and listing of registered midwives. However, there was no database of currently

licensed public and private midwives practicing in the Philippines. There was no consolidated database of public and private midwives trained on different maternal, neonatal, and infant health care. Neither was there a consolidated database of BSM graduates and their places of practice. This information could help analyse areas with poor access and coverage of maternal and child health care.

In summary, the country's midwives were not working in an optimum, enabling environment. However, the study could not fully describe this environment nationwide since the study was conducted in selected places. It could not determine the number of midwives hired by LGUs as JOs, with job expansions, tasks, and functions that were beyond their *plantilla* posts and salary grade because these were beyond the scope of this study. The study did not include health systems description.

Recommendation

With an increasing population and increasing demand for maternal and newborn health care, public health sector must increase its number of competent midwives, equitably distribute them where there is greater need, and implement strategies for their retention, career development and competency enhancement.

There are structural changes that need to happen. Foremost of which is the review and revision of the scope of midwifery practice that is congruent with ASEAN's highest standards.

Information about midwives practicing both in public and private sectors in the Philippines has to be generated. These data must include their training, job status (permanent or as job order personnel), public or private sector employment, gender, place of assignment.

The competencies of midwives have to be systematically kept up through a competency-based certification, harmonized with the regulatory and career development systems. The DOH must move forward to implement a certification program to support midwives' career paths, standardize competencies of midwives working in rural and urban communities in both public and private sectors in the country.

For midwives to be able to provide services addressing the MNCHN (Maternal, Neonatal, Child Health and Nutrition) and the needs of families especially the poor and in hard-to-reach areas or in resource-limited circumstances, there has to be an outcome-based standardized system for achieving, maintaining, and upgrading midwives' competences with commensurate salaries and benefits. This will enable midwives to dispense services aligned with globally recognized standards integrated with the health service delivery system across the continuum of care.

There has to be a decentralized system for assessing midwives' competencies starting from the regional and provincial levels. Also, to ensure continued competency building after every assessment, this certification program must be coupled with a systematic learning and development intervention package for midwives, available and accessible at the regional and provincial levels.

Above all, to support these initiatives, national and local governance structures need to establish an enabling environment recognizing the scope of midwifery practice and the supporting mechanisms for the professional practice of midwifery. This will mean focusing their work based on their competencies and global standards of care.

All of these require evidence-based policy.

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