

# Comparison of Midwifery Services in India and Sweden

SA Raddi, SR Dandgi

## ABSTRACT

The objective of the paper is to know how India can strengthen midwifery service to reduce maternal mortality based on the lesson learnt from Sweden and India. High maternal mortality in India is due to absence of skilled attendance at the time of delivery and poor postnatal care. Seventy percent Indian population is rural and it is not possible to have doctors for all births. Adopting evidence-based interventions, such as developing a skilled cadre of locally available midwives backed up by efficient referral and emergency obstetric care service like Sweden and India will help to achieve the goal of reducing maternal mortality with the existing resources. Creating the scope for career advancement will help to improve status of midwifery as a profession.

**Keywords:** Maternal mortality ratio, Midwives, Auxiliary nurse midwives.

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## INTRODUCTION

The fact that half a million mothers die in pregnancy and childbirth globally every year. Out of these, 99% are in developing countries and sadly a majority of deaths are due to preventable causes: A result of lack of skilled persons like a midwife or doctors to attend childbirth and provide emergency obstetric care (EmOC) when needed to tackle complications that kill.<sup>1</sup>

India has not yet achieved its goal of reducing maternal mortality inspite of a long history of measures to improve maternal health, mainly due to lack of policies and an absence of focus on evidence-based practices. But efforts were made to establish midwifery practices in India even in British times, midwifery is not recognized as a separate profession by law, society, medical and paramedical professionals even today.<sup>1</sup>

The present maternal health situation in India is similar to the one that prevailed in Sweden during the 18th century.<sup>1</sup>

The nurse to population/patient ratio is low compared to other countries. In 2004, the ratio was 1:2250 in India and 1:100-150 in Europe. Many states in India are facing a shortage of nurses and midwives. As on March 2003, 8,398,620 nurses were registered with the State Nursing Councils. Only 40% of registered nurses are active because there is no system of live register in India, the said figure includes all the nurses who have been trained since 1947.<sup>2</sup>

There are no official job/positions for community health nurses. The auxiliary nurse midwives (ANM) who are community midwives are not trained to use life-saving drugs and procedures in case of an obstetric emergency, although

the government has recently liberalized the drug policy and allowed them to administer the first dose of certain life-saving drugs for birth complications.<sup>1</sup>

There is inadequate number of nurse and midwife leaders at the national and state levels for nursing practice, research, education, management, planning and policy development. Although the nurse is a member of the health team, she/he is never asked to represent the profession in planning and policy formulation for nursing services, education, etc. The nursing chief only looks after the nursing personnel and has no authority to make decisions on pay scales, number of posts, staff development or new interventions.<sup>2</sup>

The original training course for ANMs was for 2 years, which had a midwifery component of 6 months. From 1980, however, the training duration was reduced to 18 months with reduced emphasis on midwifery, specifically the practical component. The nursing courses have a 3 to 6 months posting in the labor rooms of a hospital, but a student nurse does not get any hands-on experience of midwifery. Unlike in Sweden, midwifery training in India does not include management of birth complications. After training, the ANMs are registered with the Nursing Council as there is no separate registering body for midwives.<sup>1</sup>

Training of midwives should be of adequate duration (at least 2 years) with a strong practical component. Competency-based training should be given in both institutional and community set-ups to give midwife the required skills and confidence to manage delivery care in a rural situation. The training should be given under supervision of senior nurse/midwife for normal and abnormal labor and management of basic emergencies.<sup>1</sup>

A regulating body consisting of senior midwives and medical professionals should oversee both sectors. The midwife's role should be expanded to include family planning, menstrual regulation, abortion, STD and HIV counseling, adolescent health, women's reproductive health outside of pregnancy and childbirth, and so on.<sup>1</sup>

Existing situation of nursing and midwifery in India regarding nursing services, nursing education, nursing management, evidence-based nursing research and regulation are reviewed in a paper by Dilip Kumar (2005). While focusing on the management of nursing and midwifery services, the paper quotes 'Nurses and midwives are not well accepted or recognized as leaders or administrators. Nursing management skills, leadership, lobbying and negotiating skills are poor.'<sup>2</sup>

In response to the demand of the Delhi Nurses' Union, the Government of India has sanctioned 5 nursing posts at the national level. It quotes the major nursing issues that need to be addressed as:<sup>2</sup>

- Insufficient contribution of nurses and midwives to health care development due to few positions for nurses and midwives at the state and national levels; inadequate nursing

- leadership and strategic management; inappropriate nurse to <sup>2</sup>population/patient ratio;
- Poor quality of nursing and midwifery care due to inadequate number of nursing positions as per the recommended staffing norms; migration issues; insufficient number of nurses with Bachelors' and Masters' degree and in clinical specialties;
  - Limited competency of nurses and midwives due to unclear roles and responsibilities of nurses and midwives; ineffective clinical preparation and supervision during training;
  - Inadequate standards and guidelines for nursing practice and also ineffective regulation of nursing and midwifery practice;
  - Inadequate infrastructure for nursing and midwifery practice;
  - Inadequate motivation to provide effective care;
  - Poor quality of nursing education to produce qualified graduates for service due to inadequate national nursing and midwifery education plan and development; limited involvement of nurses and midwives at the policy level; shortage of qualified nurse educators; inadequate infrastructure for nursing education; and
  - Limited role and authority of the INC in nursing development due to limited roles prescribed in the Indian Nursing Council Act, 1947; inconsistency in the Indian Nursing Council and State Nursing Council Acts; insufficient information systems in nursing and midwifery services; and shortage of staff at the INC and State Nursing Councils.<sup>2</sup>

Sweden was among the first countries to achieve a low maternal mortality ratio (MMR) by 1900, compared to the United Kingdom and United States. The decline in maternal mortality was more in the 19th century and early 20th century – before the discovery of modern technology, such as surgery, blood transfusion and antibiotics. The overall reduction in MMR in Sweden was from 900 deaths per 100,000 live births in 1750 to only six deaths per 100,000 live births in 1980; the rate is now only 1 to 2 per 100,000 live births.<sup>1</sup>

Sweden was one of the first European countries to establish a reliable vital registration system as early as 1750. In 1749 the office of the Registrar General was founded which compiled national statistics, such as census and causes of death. Reasonably reliable data is available in Sweden on maternal mortality from the 17th century onward, which helped measure progress in reducing the maternal mortality ratio (MMR).<sup>1</sup>

Sweden is a vast country with a sparse population making the availability of doctors to rural populations difficult in the past; hence, a midwifery-based maternal care system was developed. In the early 18th century, the government declared that midwives undergo 2-year training and pass the Collegium Medicum (equivalent of the Medical Council) examination. By the late 19th century, midwifery became a legitimate profession – separate from nursing.<sup>1</sup>

Strong, healthy and respectable women were selected and trained to become midwives. The maternal mortality in Sweden

declined from 400 to 100 as the deliveries by trained midwives increased from 30 to 70% between 1861 and 1894.<sup>1</sup>

The early reduction in maternal mortality in Sweden was mainly because of teamwork of physicians and highly competent midwives. This fact is reflected in a remark by an American physician, 'Scandinavian midwives are proud of being associated with important community work and whose profession is recognized by medical men as an important factor in the art of obstetrics, with which they have no quarrel'. He attributed the lower mortality rates in Sweden to a carefully supervised system of instruction and practice of midwifery.<sup>1</sup>

In Sweden normal deliveries in the 18th and 19th century were done by midwives under supervision of doctors. This midwife-doctor cooperation was facilitated by the population distribution where 90% of the population was in rural areas and without doctors, but had locally accessible trained midwives. Most of the home deliveries were undertaken by midwives who also performed instrumental delivery in the absence of doctors.<sup>1</sup>

Under supervision of the head midwife or trained sister, the student midwife was required to deliver 100 to 125 women during the training period, which gave high degree of skills and confidence to conduct childbirth. For instrumental deliveries, a local medical officer supervised the midwife. Until the age of 50, midwives were required to undertake regular review courses. From its inception, the midwifery system has been under the firm control of the state and medical profession. The strict regulation came at the beginning of a midwife's career, but she was independent once she was trained and satisfied the examiners who were also doctors.<sup>1</sup>

Community midwifery in Sweden was based on regular review and close supervision. The midwives were required to report to general practitioners through a detailed diary. The report provided information about all the deliveries attended, interventions done, reasons for interventions, follow-up including temperature chart of woman, outcome of the mother and child and so on. The report was signed by the county physician and registered at the national health bureau. The Swedish midwifery association exercised control over the professional conduct of midwives. The standardized protocols for management of birth complications were strictly enforced. Thus, over the last 300 years, Sweden created a system of high quality training, deployment and supervision of highly skilled midwives which lead to a decline in MMR.<sup>1</sup>

The Health and Family Welfare Department, Government of India has proposed a ₹ 2,900 crore scheme to meet the acute shortage and the skewed distribution of nurses across Indian states. Inaugurating the centenary celebrations of Trained Nurses Association of India (TNAI), the Union Minister for Health and Family Welfare Dr Anbumani Ramadoss said that the new scheme aims at creating human resources of nurses under the Development of Nursing Services. According to the Ministry of Health and Family Welfare, a large number of nursing personnel are required under the National Rural Health Mission (NRHM) to serve at primary health centers across the country. While the Ministry is working toward strengthening

and improving the quality of the training, the government has also chalked out plans for setting up additional institutions under NRHM.<sup>3</sup>

Based on the Planning Commission Task Force report that highlights the acute shortage of Nurses in the country, the Ministry has identified 230 districts that do not have adequate institutions for training nursing staff. As part of the strategic framework for nursing during 11th 5-year plan, the Ministry is looking at setting up 24 centers of excellence at an overall investment of 480 crore. Dr Ramadoss also informed that the Ministry plans to spend ₹ 725 crore to set up 145 ANM schools and further ₹ 1370 crore for establishment of 137 GNM schools in the 230 districts, that lack any nursing training institutes. The Ministry has also chalked out plans to spend nearly ₹ 34 crore for strengthening the existing 17 state Nursing Councils and Nursing Cells in Directorate of Health Services at the state level. The Minister also announced an investment of ₹ 90 crore for setting up six Colleges of Nursing in Rajasthan, Bihar, Chhattisgarh, Madhya Pradesh, Odisha and Uttar Pradesh.<sup>3</sup>

An additional ₹ 200 crore has also been earmarked for four Regional Institutes of Nursing in the four metros—Chennai, Mumbai, Kolkata and Delhi - he said. Government Bureau Click to get the daily dose of news on good governance in the Government. Dr Anbumani Ramadoss, met Mr Goran Hagglund, Minister for Health and Social Affairs of Sweden on 20 November, 2008 at Stockholm (Sweden). During his meeting with the Swedish Minister, the ongoing programs under the Swedish International Development Agency (SIDA) assistance in India were discussed. With reference to developing interinstitutional collaboration between institutions in India and Sweden, for improving midwifery and maternal health services in India.<sup>3</sup>

Dr Ramadoss thanked the Swedish Government for collaborating with the Indian Institute of Management (IIM), TNAI, Academy of Nursing Studies (ANS) Hyderabad, White Ribbon Alliance of India (WRAI), and the Society of Midwives of India (SOMI). He appreciated the idea of imparting training as a part of the institutional strengthening, to various officers from Central and State Governments dealing with maternal health and midwives from nursing schools and colleges in Sweden. The Swedish partners are the Karolinska Institute and the Swedish Midwifery Association.<sup>3</sup>

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