

**UNFPA**

## **UNFPA Maternal Mortality Update 2006**

**Expectation and Delivery:  
Investing in Midwives and Others with Midwifery Skills**

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Expectation and Delivery:

*Investing in Midwives  
and Others with Midwifery Skills*



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## Abbreviations used in the text

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<b>AMDD</b>	Averting Maternal Death and Disability Project, Columbia University
<b>CASA</b>	<i>Centro Para los Adolescentes de San Miguel de Allende (Mexico)</i>
<b>DfID</b>	Department for International Development (UK)
<b>DHS</b>	Demographic and Health Surveys
<b>EmOC</b>	Emergency obstetric care (and see Glossary, p.62)
<b>FCI</b>	Family Care International (FCI)
<b>FIGO</b>	International Federation of Gynaecology and Obstetrics
<b>ICM</b>	International Confederation of Midwives
<b>IMCI</b>	integrated management of childhood illnesses
<b>IMMPACT</b>	Initiative for Maternal Mortality Programme Assessment Aberdeen University, Scotland, UK
<b>MDGs</b>	Millennium Development Goals
<b>MMR</b>	Maternal mortality ratios
<b>MOH</b>	Ministry of health
<b>MOMS</b>	Midwives and others with midwifery skills
<b>MVA</b>	Manual vacuum aspirator
<b>NGO</b>	Non-governmental organization
<b>PAHO</b>	Pan-American Health Organization (WHO)
<b>PHC/FP</b>	Primary health care including family planning
<b>SAARC</b>	South Asian Association for Regional Cooperation
<b>SBA</b>	Skilled birth attendant
<b>SEARO</b>	South-east Asia Regional Office (WHO)
<b>SIDA</b>	Swedish International Development Agency
<b>STIs</b>	Sexually transmitted infections
<b>TBA</b>	Traditional birth attendant
<b>TFR</b>	Total fertility rate
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations Children's fund
<b>USAID</b>	United States Agency for International Development
<b>WHO</b>	World Health Organization

# Preface

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*“More lives could be saved if all women had access to voluntary family planning, ensuring that births are wanted, to skilled attendance at all births and to emergency obstetric care. UNFPA is committed to reducing the high levels of maternal death and disability that exist today”* – Thoraya Ahmed Obaid, Executive Director of UNFPA.

Improving women’s health is the fifth Millennium Development Goal as adopted by heads of states in September 2000. The agreed target is to reduce, by 2015, maternal mortality in developing countries by 75% of the 1990 figure. The target is ambitious and many countries will have to fight hard to reach it. The political commitment was renewed at the September 2005 World Summit and strengthened in 2006 with the additional target of universal access to reproductive health. Therefore, it is imperative to adopt an integrated approach to reproductive health and donors have offered significant assistance for resources to support those activities.

The improvement of women’s health necessitates interventions in areas beyond medical care. Those health outcomes will only improve when the following issues are addressed: gender equality, rights-based programming, and the integration of the various components in the full spectrum of sexual and reproductive health, including adolescent sexual and reproductive health and HIV prevention.

Saving mothers’ lives is widely recognized as an imperative for social and economic development, as well as a human rights imperative. UNFPA affirms that it is the basic right of every woman and baby to have the best available care to enable them to survive pregnancy and childbirth in good health. While the techniques and the strategies to address maternal health are better known and widely accepted, the factor most neglected in the last decade is human resources. Maternal mortality and morbidity cannot be reduced without midwives and other service providers with technical skills; yet the numbers of these skilled providers have not significantly increased and have even started to decrease in some countries, as the result of migration, losses from HIV/AIDS and dissatisfaction with pay and working conditions. At the same time, issues of quality of care remain, particularly where health systems do not play their supportive role.

In response, UNFPA has decided to make the fifth MDG its priority, and has widely promoted the strengthening of health systems with special emphasis on human resources for health, midwifery being an important aspect, along with commodity security and monitoring and evaluation.

This is the fourth issue of the *Maternal Mortality Update* which is published every two years by the Technical Support Division of UNFPA. Like its predecessors, it is intended for all staff, partners and donors as well as the general public, to provide them with the latest information about UNFPA institutional priorities and programmes with regard to maternal mortality and morbidity reduction. Following the initiative of the *Maternal Mortality Update 2004: Delivering into Good Hands*, and as a contribution to the call by WHO in their *World Health Report 2006* on the Health Workforce, this issue focuses on the key staff responsible for maternal health care: midwives and others with midwifery skills. It was prepared in collaboration with the International Confederation of Midwives (ICM).

As in the past, the document is in two parts: Part 1 "Investing in MOMS" reviews the issues around midwives and others with midwifery skills: who they are, what they do and how to scale up professional attendance at all births. This part draws largely from the discussions and recommendations of two international meetings held in 2006, in partnership with ICM and WHO: *the New York Workshop on Midwives* in March and *the Hammamet Forum on Midwifery in the Community* in December. Part 2 "Voices from the Field" is a review of UNFPA initiatives in countries in relation to midwives and midwifery. Countries belonging to all four of UNFPA's geographic divisions have sent their contributions which describe their achievements and constraints in addressing human resources for maternal health, together with evaluation reports when available.

UNFPA hopes that this publication will be useful and serve as a reference for future programmes.

A handwritten signature in black ink, appearing to read 'R. Fernandez Castilla', enclosed within a large, loopy oval shape.

Rogelio Fernandez Castilla,  
Director Technical Support Division, UNFPA



# Acknowledgements

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This publication was initiated and coordinated by Dr Vincent Fauveau, Senior Maternal Health Advisor, Reproductive Health Branch, in collaboration with Dr. Arletty Pinel, Chief of the Branch; The text was prepared by Mrs Della R. Sherratt, Senior International Midwifery Advisor and Trainer, based on her contributions to the two international meetings on midwifery held in 2006 and on the contributions of UNFPA country offices from 15 countries across the world, in particular the midwives at UNFPA: Anneka Knutsson, Ulrika Rehnstrom, Barbro Fritzon, Dorothy Lazaro, Ana Chinombo, Gift Malunga, Janet Jackson and others. The specific contribution of UNFPA's Technical Support Division staff and reviewers is greatly acknowledged, specifically: Sokun Sok, Cambodia, Stephan Wanyeee, Kenya, Delia Barcelona and G Puresvsuren, Mongolia, Peden Pradhan, Nepal, Pamela Stephenson, Pakistan and Luc de Bernis Senior Maternal Health Advisor, Africa.

In addition, UNFPA is grateful for the contributions of Nadine Goodman, Advisor, *Centro para Los Adolescentes de San Miguel de Allende (CASA)*, Nester Moyo, Senior Midwife Teacher and currently Programme Manager, International Confederation of Midwives for information on Zimbabwe Regulations, Fatima Temmar, Trainer in Midwifery School, Rabat, for information on Morocco and Atf Ghérissi, Senior Midwife and Consultant for contributions from Tunisia. Finally, UNFPA is most grateful to all the participants of the **New York Workshop on Scaling-up Midwifery to Contribute to MDGs** and the follow-up **Tunis International Forum on Midwifery in the Community: Lessons Learned**, for the rich discussion and detailed information which helped to clarify many of the issues for the first part of this text.

Thanks to Alex Marshall, the editor, for his patience in reviewing the successive versions of this text.

*This publication is dedicated to the midwives of the world, without whom one could not even think about progressing on the road to maternal mortality reduction,*

*And to the International Confederation of Midwives, their strongest supporter.*



## PART I



# Background

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1

*“Ensuring equitable access to skilled care before, during and after childbirth, especially at the time of birth, acknowledged as a universal human right, is critical for saving the lives of mothers and their newborns. But skilled care requires skilled healthcare providers – a scarce commodity in most low-income countries. Many strategies have been employed to try to reduce the burden of ill-health and disability associated with*

*pregnancy and childbirth – until now few have attempted to replicate the lessons learnt for reducing maternal mortality in both developed and more recent low-income countries – through increasing the capacities of midwives. Yet, skilled care is midwifery care – and the holders of the core competencies in midwifery – are midwives.”* – Background paper to UNFPA midwives’ meeting, March 2006

At the United Nations World Summit in September 2005, heads of government called for integration of universal access to reproductive health into strategies to attain the Millennium Development Goals (MDGs). Heads of governments thus reaffirmed their countries’ commitment to sexual and reproductive health first expressed at the International Conference on Population and Development in 1994.<sup>i</sup> In addition, they made clear in 2006 the links between universal access to reproductive health and the MDGs – improving maternal health (Goal 5); reducing child mortality (Goal 4), promoting gender equality (Goal 3); combating HIV/AIDS and other infectious diseases (Goal 6) and reaching the overarching goal of halving extreme poverty by the year 2015. UNFPA’s mandate is to support countries’ efforts to achieve this agenda.

<sup>i</sup>: In particular the initial commitment to women and men’s reproductive rights and their right to sexual and reproductive health, as outlined in Principle 8 and chapter 7.2 of the Programme of Action, International Conference on Population and Development (ICPD), Cairo, 5-13 September 1994.

Reducing maternal mortality and morbidity is a priority area for UNFPA. UNFPA support for safe motherhood interventions in 89 countries is achieved through a strong network of partners, a wealth of experience and a broad presence at the country level. The organization’s maternal health strategy, which leads its work at country, regional and headquarters levels has three pillars: 1) family planning, to ensure that all pregnancies are wanted; 2) skilled care at all births, to ensure that all woman and newborn have quality care, that complications are recognized, and that action is taken early enough to save lives, and 3) access to quality basic and emergency obstetric care, for management of complications. Skilled care and access to emergency obstetric care are also essential to prevent severe post-partum disabilities such as obstetric fistula, and to ensure the survival and health of newborns. UNFPA-supported programmes emphasize capacity development, including strengthening of human resources, for providing these services. UNFPA is an active member of the new Partnership for Maternal, Newborn and Child Health, launched during the World Summit 2005.

A skilled midwifery workforce is key to safe pregnancy and childbirth and therefore to reaching MDG-5. Recognising this, and in support of the call for a decade of action on human resources for health made by the 2006 World Health Assembly, UNFPA decided to initiate a worldwide initiative to promote the work of midwives and others with midwifery skills (MOMS). UNFPA’s partners include the World Health Organization, UNICEF, the International Confederation of Midwives and others at the global, regional and country levels.

The initiative will respond to the complex challenges of reaching MDGs 4 and 5. Achieving these goals requires health systems to deliver a package of relatively inexpensive interventions to save the lives of mothers and newborns, as outlined in the *2005 World Health Report*.<sup>ii</sup> When fully implemented and accessible by all women, these interventions could save the lives of 75 per cent of the 529,000 women who die each year, according to the World Bank, and prevent around 18 million illnesses that occur as a result of pregnancy and childbirth each year, as well as save the lives of at least half of the 7 million newborns who die every year. As the *Human Resources for Health Report* has shown,<sup>iii</sup> a skilled healthcare provider is vital for these interventions.

Currently it is estimated that no more than 40 per cent of births in the developing world are attended by a skilled healthcare provider, a midwife, or other formally trained healthcare provider with midwifery skills – a skilled birth attendant – and it can be as low as 10 per cent in low-income countries.<sup>iv</sup> In contrast, in high-income countries and in many countries with transitional economies, a skilled birth attendant will assist 90 per cent or more of all births.<sup>v</sup> According to WHO estimates, some of the lowest levels of births by a skilled birth attendant are found in Eastern Africa (34 per cent), South-Central Asia (37.5 per cent) and Western Africa (40 per cent), although a number of South Asian countries have even lower rates. In Bangladesh, Bhutan, Nepal and Timor Leste for example, estimates suggest figures lower than 20 per cent of all births attended by a skilled health provider.<sup>vi</sup> Indeed, such averages mask wide variations within countries.<sup>vii</sup> Most of those with least access to a skilled healthcare provider at birth live in rural and isolated areas, where infrastructure is frequently weak and where physicians, nurses, midwives and others with midwifery skills frequently do not wish to work.

### 1.1 Why a focus on midwives?

The reason for referring to “midwives and others with midwifery skills” or MOMS, is that many people have become confused about the term “skilled birth attendant”.<sup>viii</sup> A skilled birth attendant is a professionally accredited healthcare provider with midwifery skills. A simple definition of “midwifery” would be “what midwives do” and, “midwifery skills” are the skills that midwives possess to be able to function as a midwife. The term “skilled birth attendant” therefore is similar to and encompasses the definition of a midwife, but is a generic term that includes nurses, physicians and others with midwifery skills, as well as specialist obstetricians and gynaecologists. (See Glossary, p. 62)

Without competent healthcare providers, specifically MOMS, in place in sufficient numbers where they are needed, almost all other strategies to reduce maternal mortality and morbidity will fail. Equally, midwives are important for newborn health and child survival. The recent WHO estimates of neonatal and perinatal mortality state: “Of the 3.3 million stillbirths, one in three occur in childbirth and most of these could be prevented if there was a competent skilled health provider monitoring birth and able to take appropriate action.”<sup>ix</sup> Because of the large proportion of neonatal deaths in under-five mortality, it is clear that MOMS are also crucial for achieving MDG 4 on child mortality.<sup>x</sup>

In summary, although not all skilled attendants can be called midwives, all midwives should, when trained properly, possess the necessary skills and abilities to function as

ii: WHO. *World Health Report 2005: Make Every Mother and Child Count*. World Health Organization, Geneva 2005

iii: Human Resources for Health: Overcoming the Challenge. The Report. 1. Joint Learning Initiative, Harvard University Press. available at <http://www.globalhealthtrust.org>

iv: Stanton C, Blanc A, Croft T, Yoonjung C. (2006). Skilled care at birth in the developing world: progress to date and strategies for expanding coverage. *Journal of Biosocial Medicine*. Online access March 8, 2006

v: WHO estimates based on most recent DHS data, available on WHO web site <http://www.who.int>

vi: WHO SEARO. *Improving Maternal, Newborn and Child Health in South-East Asia Region*. World Health Organization Regional Office for South-East Asia, New Delhi, 2005

vii: de Bernis L, Sherratt D.R., AbouZhar C., Van Lerberghe W. Skilled attendants for pregnancy and childbirth *British Medical Bulletin*, Volume 68, 2003

viii: WHO. *Making pregnancy Safer: The Critical Role of the Skilled Attendant. A Joint statement by WHO ICM and FIGO*. World Health Organization, Geneva, 2004

ix: WHO. *Neonatal and Perinatal Mortality - Country, Regional and Global Estimates*. World Health Organization, Geneva, 2006

x: Although skilled care for monitoring and surveillance in pregnancy is equally important for reducing newborn deaths – specifically to detect early poor foetal growth, and to provide sound health education on healthy lifestyles, particularly nutritional advice and strategies for reducing anaemia – most of these needs can be addressed by strengthening midwifery services, especially at the primary care level.

skilled birth attendants. Competence is the product of knowledge, skills and attitude. Further, midwives provide the quality, culturally acceptable care needed to help keep women and newborns safe. Midwives provide safety, in terms both of protection from death and disability and also promotion of health and well being in the fullest sense. In most countries, midwives are by tradition the healthcare workers with the closest contacts in the community and, when properly trained and supported, assist women and their partners with their broader sexual and reproductive health needs.

## 1.2 Reaching all families, especially in rural and poor communities

Investing in professional midwives has made a difference in many countries. Midwives offer a low-technology but high-quality solution to the need for skilled care during pregnancy and birth, with the potential for meeting communities' broader reproductive health needs and contributing to universal primary health care for all. In particular, midwives can be most useful to help ensure that services reach those in greatest need, the poor and hard-to-reach communities, as the history of Sweden has shown.<sup>xi</sup>

Midwives can find local solutions to local barriers to access and utilization of services. In many countries with low maternal mortality ratios, with few exceptions, the history of the development of professional midwifery is rooted in public health initiatives and community-based services; especially for meeting the needs of poor and marginalized women. Even in the United States, where an obstetrician attends most births, evidence shows that early decreases in maternal mortality, especially in New York and Kentucky, were attributable to the use of midwives or nurse-midwives, with a particular focus on poor communities. As a recent review of midwifery in the United States has shown:

*Modern professional midwifery practice in the United States was established to serve poor and vulnerable women and their families. From the founding of the Frontier Nursing Service in the mountains of Kentucky in 1925 through the 1960s, most nurse-midwives worked in underserved communities with high infant and maternal mortality, including Indian reservations, rural southern health departments, and inner-city hospitals. The women they served were vulnerable to poor health and inadequate health care due to low income, lack of access to care, minority race, or immigrant status. Most of the early nurse-midwives followed a mission to serve the poor, and that commitment was reinforced by restrictive state laws, which allowed them to practice only in areas where physicians were in short supply and women could not afford to pay for maternity care.<sup>xii</sup>*

One of the most interesting aspects of this study was that authors looked specifically at the outcomes of midwifery care. They found, in common with studies from other countries, that midwives provided excellent care and made a great contribution to reducing maternal mortality in the communities they served.

Midwives working at the community level have been referred to as the lynchpin in the continuum of care needed to ensure safe motherhood. They link women, families and communities with the formal health service, especially facility-based care for management of obstetric and newborn complications and emergencies.

However, for many reasons, some to do with the fact that most midwives are women, there has been gross underinvestment, and sometimes none at all, in building a cadre of professional midwives. In too many countries midwives lack status and respect.

xi: Loudon I. Maternal mortality in the past and its relevance to the developing world today. *AJCN* 72(1S): 24iS0246S

xii: Raisler J, Kennedy H. Midwifery Care of Poor and Vulnerable Women, 1925-2003. *J. Midwifery and Women's Health*. 2005; 50 (2): 113-121

Yet, without expert midwives to teach midwifery skills and supervise others, ensuring quality of care will not be possible and efforts to reduce maternal and newborn deaths will fail.

Given the shortage of all healthcare providers globally – not just in low-income countries – there is urgent need to offer countries specific assistance on how best to increase the number of midwives and scale up national midwifery capacity. UNFPA decided to devote the 2006 *Maternal Mortality Update* to this theme. It forms part of UNFPA's contribution to the call for a "Decade of Action on Human Resources for Health," made at the World Health Assembly 2006 and in the 2006 *World Health Report*.

As with previous issues of *Maternal Mortality Update*, the first part of the document gives the outline and rationale for investing in training, supporting and scaling up the capacity of midwives and others with midwifery skills, as well as outlining the major issues, of which training is only one. Part II then offers glimpses, voices from the field, showing what countries are already doing with assistance from UNFPA and its partners, to make skilled midwifery available to more women and their newborns, to save lives and improve health.

*"Strengthening the capacities of midwives needs to be  
at the heart of UNFPA business  
in order to achieve the organization's mandate".*

Thoraya Ahmed Obaid, Executive Director of UNFPA,  
New York, March 2006

# What Is a Midwife and Where Are They?

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## 2

*One of the greatest challenges for a country building midwifery capacity is the confusion that surrounds the term "midwife." There is a great deal of misunderstanding, and even some disagreement, about what a midwife is, what midwives do and who they are; not to mention how many there are, how many more are needed and how best to increase their numbers and skills.*

*Midwives do many things, but first and foremost they do midwifery – they assist women in pregnancy, attend during labour and childbirth and provide important care for mothers and newborns during the postnatal period.*

*In many countries there is need for midwifery to be re-instated as an autonomous profession – a discrete and important area of practice, in which those accredited have an internationally-agreed set of core competencies.*

*What is required is a concerted campaign to affirm the value of midwives and what they do. In addition, there is need of a better way of identifying how many midwives are required and systems for monitoring progress in increasing countries' midwifery capacity. A new indicator, the "ratio of midwives per birth" is proposed.*

### 2.1 Midwifery, the original paradigm

A glance through historical artefacts, writings and research suggests that most civilisations of the world had a tradition of "midwifery" as practiced by "midwives" albeit under another name. This tradition saw midwives as powerful, strong and caring women – women who were afforded respect and status. In Norway and some neighbouring countries the name for midwife is *jordmor* from *jord* = earth, and *mor* = mother. In neighbouring Iceland the name for midwife means "bringer of light", in France she is known as *sage-femme* or "wise-woman". In ancient Greece only high priestesses were permitted to be midwives. In ancient Egypt, according to the biblical story of Moses, midwives were not only routinely called by women to help them at the time of birth, but were strong-minded, ethical and innovative women, not afraid of disobeying Pharaoh's ruling to kill all the male newborns. The Anglo-Saxon word "midwife" means "with-woman".

These positive views of a midwife – as a respected member of the community, sadly are not the case in all countries. For example, the *dai* – the women who traditionally assists women during birth in much of Asia, is usually depicted as old, illiterate and often unclean (physically and culturally) and definitely not viewed with respect, except for their age. Similar locally-specific terms can be found for the traditional, non-formal helper of women at birth in other parts of the world, which carry varying degrees of local respect and public confidence. Research has shown that while these traditional helpers have a key role for working with woman and local families and can contribute to the maternity care team, they often do not possess the skills needed to stabilise women and babies in an emergency and cannot take the place of a professional skilled midwife. What is needed is a return to the early paradigm of midwives as strong and respected women.

## 2.2 Modern medicine led to a decline in midwifery

In many countries, interestingly those that now have a low maternal mortality ratio, midwifery has become a discrete and much-respected profession. However, in some other countries, often as a result of misguided advice from experts, midwifery has been subsumed into other professions – often nursing – or included in the work of other formally-educated multi-purpose health workers. In both cases, the result has been to render midwifery invisible as a defined and discrete practice. In addition, the pre-service programmes of many of these newly-trained multi-purpose health workers included midwifery only as an academic subject. They do not have sufficient exposure to midwifery practice and lack many of the essential midwifery competencies. The same has happened in many nursing programmes.

In a number of countries, midwifery is seen as a specialisation, an additional qualification, but often only for female nurses. Here too there may be a lack of hands-on experience, because the training is frequently conducted in large district or tertiary hospitals where there are many other learners, including medical students who get priority for cases. Because nursing programmes often have no community midwifery components – despite the fact that most births take place in the community – many students lack experience in the management of normal births.

Graduates of these programmes more often than not lack the core competencies essential for a skilled birth attendant.<sup>xiii</sup> In many instances, the lack of practical experience means that the ability to work with understanding and appreciation of the normal processes of pregnancy and childbirth; the traditional “caring” midwifery skills; the capacity to make women feel secure and assist women and their partners with decision-making, and the capacity to work in partnership with women in a meaningful dialogue, are lost.

*What Is a  
Midwife and  
Where Are  
They?*

xiii: WHO. *Making pregnancy safer: the critical role of skilled birth attendant. A Joint Statement by WHO ICM FIGO.* World Health Organization, Geneva. 2004

## 2.3 What is a midwife?

Despite an internationally-agreed definition of a midwife (see Box 1) there is confusion and lack of clarity about who is a midwife. Some make a connection to the fact that most midwives are women: historically, women did most of the work of midwifery, frequently as an act of humanitarian assistance and as need arose. As such, in many countries those “doing midwifery” had little opportunity of becoming organized into an occupational group, still less become a profession.

Given the concern for high rates of death in pregnancy and childbirth, birth is now viewed as a medical event. This inevitably sees “doing midwifery” as calling for the supervision of a physician. In addition, the practice of midwifery has, in some countries, been built on the assumption that all births now take place in an institution, or if not, that they should. The presumed change in the place of giving birth has created a new ideology about childbirth and what midwifery is. Giving birth is no longer viewed as something that women do with the support of midwives, family and their community; but rather has become a medical condition, where the health worker will “supervise” women in labour and “conduct the delivery.” This change of thinking has implications not just for midwives, but for the place of women during childbirth. It renders the woman a passive actor in the whole of the childbearing process. Interestingly, this change in the concept of what midwifery is has occurred in countries where most births still take place at home.

With this change, midwifery has increasingly become seen as a matter of risk identification, surveillance, dealing with emergencies and providing “nursing care”, rather than the traditional partnership with women. The view of a midwife as only a risk identifier and monitor, however, is not the model of midwifery promoted by the International Confederation of Midwives, the professional association that represents the voices of midwives worldwide.

Many argue that the true concept of midwifery sees the midwife assisting and, some would say, empowering the woman in pregnancy, before, during and after labour and birth, in such a way that the woman feels she is in control of the birth process. The midwife provides moral, physical and sometimes spiritual support, as well as information, education and care, to the woman, the woman’s family, her supporters and community members.

In 1972, in an attempt to promote some clarity about what a midwife is and who can be called a midwife, ICM developed an international definition, later endorsed by both WHO and FIGO (International Federation of Gynaecology and Obstetrics). Although the definition has been revised and updated (see Box 1) the basic tenets of what a midwife is and does remain the same – assisting a woman to achieve a healthy pregnancy outcome – which by definition means choosing when to become pregnant – and helping her with self-care to ensure that her own health and the health of her newborn remain intact.

### *Box 1 – International Definition of the Midwife*

A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.

The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife’s own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.

The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women’s health, sexual or reproductive health and childcare.

A midwife may practise in any setting including the home, community, hospitals, clinics or health units.

Adopted by the  
International  
Confederation of  
Midwives Council  
meeting, 19th July, 2005,  
Brisbane, Australia  
and supersedes the  
ICM “Definition of the  
Midwife” 1972 and its  
amendments of 1990

## 2.4 An international model of midwifery

For ICM, midwives work in partnership with women. A midwife assists the woman to achieve a safe and healthy pregnancy and birth experience and helps her to care for herself, her newborn infant and to adjust to the new family dynamic. Ideally, the midwife's role will extend to meeting broader sexual and reproductive health needs. ICM promotes the work of midwifery as encompassing the application of scientific knowledge and sound research, as well as and in parallel to the appreciation and protection of the normality of birth as a natural life-event, including respecting the woman's right to be in control of the whole process. This life-event is seen by midwives to have physical, emotional, social and spiritual meaning to the individual woman, her family and the community. Thus, the predominant view within ICM and its members is that a midwife works not just with an individual woman, but as a vital resource for families and communities. Such work brings with it however a degree of internal stress and can lead to high levels of occupational "burn-out", as an increasing number of studies demonstrate.<sup>xiv, xv, xvi</sup>

## 2.5 Midwifery as a gender issue

As a primarily female workforce, midwives face many difficulties that are different to male health workers. They face difficulties not just because of their sex and the cultural issues around being a woman and taboos associated with this work, especially a female worker functioning outside of the home, but also because of the area they work in, midwifery, which in some countries is not yet recognized as a profession. Yet it is the fact that midwives are women, working "with woman" in partnership, as described above, that is most frequently valued by the women they care for,<sup>xvii</sup> but too often ignored or dismissed by the system most of them work in.

### Box 2 - Midwifery is a philosophy as well as a function

Midwifery has been described on numerous occasions as both an art and a science. The very nature of the work, "being with woman" (the Anglo Saxon literal translation of the word "midwife") often brings midwives into conflict within themselves and within the organizations in which they work. Midwifery - as a philosophy rather than a function - sees midwives as women's advocates and conduits for women's best interests and choices, someone who tries to orchestrate an environment of care in the best interest of women and newborns.

This philosophy can frequently leave midwives frustrated and pressured, as they cope with competing demands of the service and service users; with unsupportive working conditions and excessive caseloads; with personal pressures from home, and with the emotional work of "being with woman", as opposed to being simply present at birth.

The gender dimension of midwifery has been much debated in northern countries, and is now receiving its due attention elsewhere. The consensus is that midwifery is a gender issue and that the lack of investment in midwifery mirrors women's low status and gender inequality in the countries where they work.

## What Is a Midwife and Where Are They?

xiv: Jewkes R, Abrahams N, Mvo Z. Why do Nurses Abuse Patients? Reflections From South African Obstetric Services. *Soc Sci Med* 1998; 47, 11: 1781-179

xv: Walsh D. An ethnographic study of women's experiences of partnership caseload midwifery practice - the professional as friend. *Midwifery*. 1999; 15:167-176

xvi: Sandall J. Midwives' burn out and continuity of care. *British Journal of Midwifery* 1997; 5:106-111

xvii: Nicholls L, Webb C. What makes a good midwife? Implications for midwifery practice. *The Royal College of Midwives. Evidence Based Midwifery* 2006 4(2); 65-70

Sherratt D.R. "Rapid Scale up of Midwives is Vital to Saving Lives of Mothers and Newborns." Background paper for UNFPA workshop 21-23 March 2006, NY. Scaling up the Capacities of Midwives to Reduce Maternal Mortality and Morbidity.

Midwives make decisions and take action that save lives, including making arrangements for referrals: they also develop and implement community mobilization plans. To function well, they need a degree of autonomy. MOMS need to be able to help women and men with their decision-making, and to work with men and male leaders for advocacy, information and education purposes. They are unable to do this effectively if women in general have low status: nor do the women they serve have the power to demand and access care. To build the capacity of their midwifery workforce, countries therefore need to empower women and address gender inequality.

Building a strong professional midwifery cadre can in turn help to address gender inequality. Professional midwives working in the community, close to where women live, respected and treated well by others in the health system, offer girls and women a role model for empowerment. Aspiring to be a midwife, or supporting a daughter's aspiration to become a midwife, can help change families' willingness to support girls' education through secondary school. Women's empowerment and gender equality should be a component of all safe motherhood plans, both to address women's rights and to build midwifery capacity.

## 2.6 What about training midwives?

If there is confusion over who is a midwife and what midwives do, there is even greater confusion and disagreement about how to train midwives. Very few low-income countries have a robust system for collecting accurate, reliable, up-to-date, live data, on their human resources for health; most therefore cannot make good workforce plans.

Globally, very little verified data is available on pre-service education and training of midwives. Even less is known about outcomes of training; few low-income countries have done rigorous evaluations of midwifery programmes.

Like most pre-service education and training programmes for healthcare providers, midwifery programmes are based on historical models of training, much of which lack empirical evidence or rigorous evaluation. Three basic types of training for professional midwives are in use:<sup>xviii</sup>

- Direct-entrant (specialized programme in midwifery ranging from two to five years);
- Post-basic (following nursing training, length from one to two years, average 18 months);
- Combined or integrated within nursing training.

All three types are offered either as academic programmes, based in a university or institution of higher education, or as vocational programmes based in schools of nursing or midwifery, or similar institutions.

Very few low-income countries have designed their midwifery training curricula to meet their specific epidemiological and cultural profiles, to ensure the curriculum is "fit-for-purpose".<sup>xix</sup> Fewer still are based on sound midwifery research, and most lack a public health focus. Some midwifery curricula have no community component at all. Many reports show that hands-on experience is often compromised, especially where training is undertaken in large institutions, and more so where most births take place

xviii: Benoit C, Davis-Floyd R, van Teijlingen ER, Sandeall J, Miller J. Designing Midwives. A Comparison of Educational Models; In Devries R, Benoit C, Van Teijlingen ER, Wrede S (Eds) *Birth by Design Pregnancy, Maternity Care, and Midwifery in North America and Europe*. Routledge, New York, London, 2001

xix: Sherratt D.R. Why women need midwives in Bangladesh. ". In Bere M, Sundari Ravindran T (Eds) *Safe Motherhood Initiatives: Critical Issues*. Reproductive Health Matters/Blackwell Science, London 1999

in the community. Finally, until recently, many midwifery curricula did not offer training in life-saving skills or in critical thinking – a requirement for effective clinical decision-making and action.

This sad picture of midwifery education and training is beginning to change, as more stakeholders begin to realize the value of a skilled professional cadre of midwives. However too many countries, the search for a “quick fix” overrides rational decision-making, and it is likely that improvements will be painfully slow.

## 2.7 How many MOMS are needed?

Despite the lack of rigorous data it is widely recognized that most low-income countries need more and better-trained midwives and others with midwifery skills. WHO estimates that around 700,000 additional midwives are required to provide universal access to skilled care and to meet the reproductive needs of all women, with at least half as many just to take into account estimated attrition rates.<sup>xx</sup> The question in many countries is how best to go about this with the scarce resources at their disposal.

Although the *World Health Report 2006* estimated the numbers required, it did not propose definitive strategies to develop, support and manage this increase. Further, these estimates, based on the minimum interventions agreed by the technical agencies in the field including WHO, UNFPA, UNICEF and others, are mainly for relatively compact populations, and assume that the midwife provides no health services except antenatal, natal and postnatal care. Global averages, like national aggregates, may not be useful in calculating the numbers of MOMS needed. Rather, attention must be given to calculating needs on a sub-national, provincial, or even district-by-district basis. It is essential to estimate how many midwives are needed, and recognize that such estimates will vary because of geographical situations and what services the midwife or other midwifery provider is expected to offer.

Most countries will need at least three different scenarios, with different numbers of midwives for each: 1) highly populated areas, cities and large conurbations; 2) very rural and sparsely populated areas, and 3) intermediate zones in the rest of the country. Each of these scenarios will require a different midwife-to-birth calculation.

Most of the data on numbers of midwives in low-income countries is derived from WHO, and, as acknowledged in the 2006 *World Health Report*, must be viewed with caution, because many countries include midwives as nursing personnel or nurses as midwifery personnel, and do not collect separate data.<sup>xxi</sup> Data often combine nursing and midwifery personnel even in countries where not all nurses have received training in midwifery, or where the nurse never practises midwifery; even if their training had been good, they would soon lose their competence in midwifery.

Despite the global shortage of reliable data, the WHO Regional Office for South East Asia (SEARO) holds one of the most extensive data sets on midwifery outside Europe.<sup>xxii</sup> The data, initially compiled in 1996 as part of a project to develop regional standards of midwifery practice, mapped the midwifery workforce in each country of the region and specifically, the length of midwifery training programmes in all countries in the region. According to the most recent information from the recent WHO/UNFPA/

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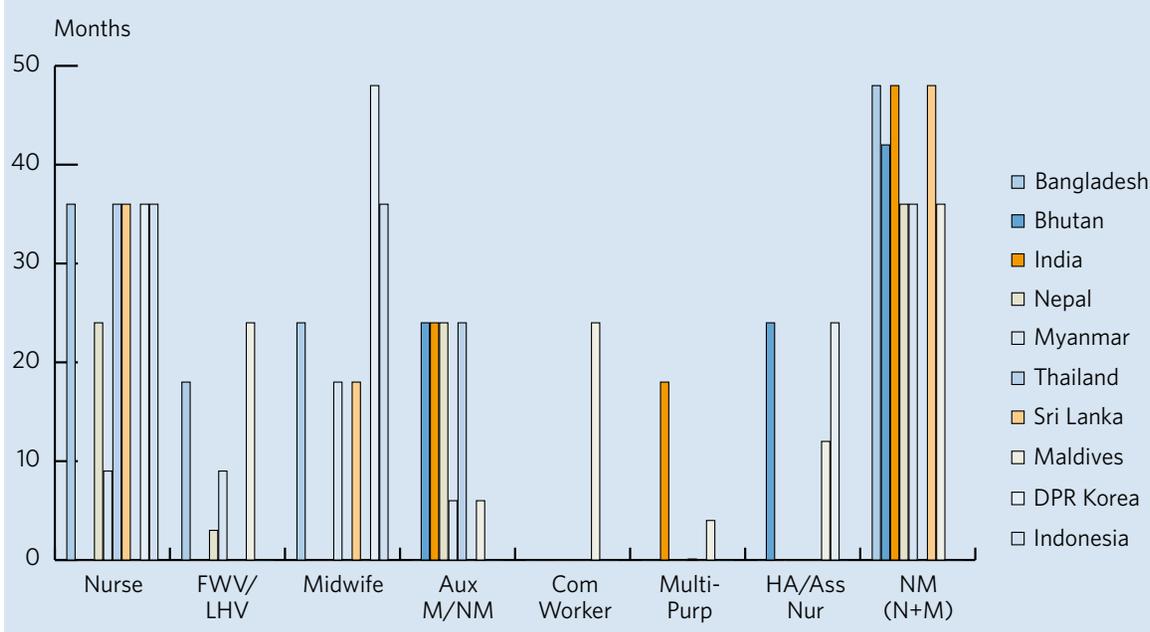
xx: World Health Report 2005 *Make Every Mother and Child Count*. World Health Organization, Geneva 2005 available on WHO web site [www.who.int](http://www.who.int)

xxi: WHO. *Working Together For Health* -World Health Report 2006. World Health Organization, Geneva 2006

xxii: Data collected as part of the development of the Regional Standards of Midwifery Practice project. Data was collected from the Ministry of Health, Professional Associations (where they existed) and from nationally identified centres of excellence providing pre-service education for the different cadres identified as providing midwifery care in each country

ICM bi-regional meeting on accreditation of community skilled birth attendants, held in Rajasthan, India, in December 2005, very little has changed since the mid-1990s.

*Fig 1: Length of training for different cadres of health workers providing maternity care in SEARO countries*



Source SEARO survey 1996

As Figure 1 shows, many different cadres of healthcare worker provide midwifery services across the region. Equally, the length of pre-service programmes, even for those that carry the title “midwife”, also shows great variation, from three months to four years of academic study. Although no other region has conducted a comparable study, anecdotal evidence shows a similar picture in many other parts of the world.

A more detailed look at the SEARO data reveals that the long programmes – in the main those for professional nurses and nurse-midwives – have, with few exceptions, a maximum of six months midwifery content, and often much less. Most graduates of the longer training courses work in hospitals as part of the health team, where some support is available; whereas those providing care in isolated settings in the community – and therefore have least back-up support and so need more skills to stabilize women and newborns with complications, and to manage simple complications within their professional scope – usually have less specific midwifery training, often less than six months. The exceptions are Sri Lanka and Myanmar, which offer 18-month programmes for community midwives; and Thailand, where the midwifery component is 18 months, but which today is integrated into the four-year nursing programme, with an additional six months for those who want to specialize in midwifery. Indonesia did have a one-year midwifery course after nursing, but in 1996 changed to a three-year direct entry diploma. This varied picture in the South-East Asia region can be found in almost all other regions of the world.

## 2.8 Where are the gaps?

Africa and Asia South-East Asia stand out as being in greatest need, given the proportion of births attended by non-skilled attendants and, in Asia, the sheer number of births. Unfortunately, because few countries have a robust database on human resources for health, it is quite difficult to be precise about the numbers of midwives and where the gaps are. Historically, a population base ratio has been used to estimate the number of midwives needed in a given country. The ratio most widely used was devised by a WHO taskforce in Geneva in 1993.<sup>xxiii</sup> The taskforce agreed on a ratio of one midwife to 5,000 population, based on the number of births projected for any one year and a total fertility rate (TFR) of four children per woman. The ratio assumed that one community midwife would be able to care for roughly 200 pregnant women a year, including assisting at their births.

The ratio, as discussed later, has a number of drawbacks. In particular, it does not take account of the skill-mix needed to care for obstetric emergencies, nor the different geographical situations, nor other personal or work demands on the midwife, nor differences in fertility – for example very high fertility countries. What is needed is a new way of estimating how many midwives are really needed; one that considers all these factors and allows different but realistic, context-specific ratios to be set.

## 2.9 A new midwives-to-births indicator

Following the evidence in the Joint Learning Initiative Report on Human Resources for Health<sup>xxiv</sup> that showed the link between maternal mortality reduction and the presence of a formally trained healthcare worker, and given the call for this healthcare worker to be a *skilled attendant*, it may be more useful to calculate the need for midwives based on the number of expected births.

WHO has estimated that one midwife could be expected to provide a full package of care to a woman and her newborn based on a ratio of one midwife to 175 births per year,<sup>xxv</sup> (this ratio works out to roughly the same number of midwives needed as calculated using the 1:5,000 midwife-to-population figure,<sup>xxvi</sup> but is more accurate because it allows for variation in the fertility of the population from a TFR of 2 to a TFR of 8). However, the ratio of one midwife to 175 births is calculated based on a fairly compact population, where the midwife is employed full-time to provide only midwifery care, and where the bare minimum care is required – not taking into account that some of the women she sees will require additional care or referral.

Naturally therefore, the midwife-to-births ratio needs to be adjusted where midwives work in more dispersed communities and have to travel more, and where midwives provide additional services such as childhood immunization, IMCI (integrated management of childhood illnesses) or where there are many women with complications requiring additional visits or treatments, such as where there is a high incidence of anaemia, poor nutrition or other factors that will lead to poor foetal growth. In these cases a ratio of around 1:125 may be more realistic: where midwives work in low or sparsely populated rural areas the midwife-to-births ratio may need to be as low as 1:50-70 (one midwife for 50-70 births) as found in a recent review of midwifery in Cambodia for example.<sup>xxvii</sup> Ratios in the region of 20 births per midwife can also be used to alert programme managers to the need for strategies for maintaining midwifery

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xxiii: WHO. Human Resources Development for Maternal and Newborn Health at the Health Centre referral level. Report of a joint FHE/HRH Task Force Meeting 1993, 25-29 October. World Health Organization, Geneva 1993

xxiv: *Human Resources for Health: Overcoming the Challenge*. The Report. 1. Joint Learning Initiative, Harvard University Press. available at <http://www.globalhealthtrust.org>

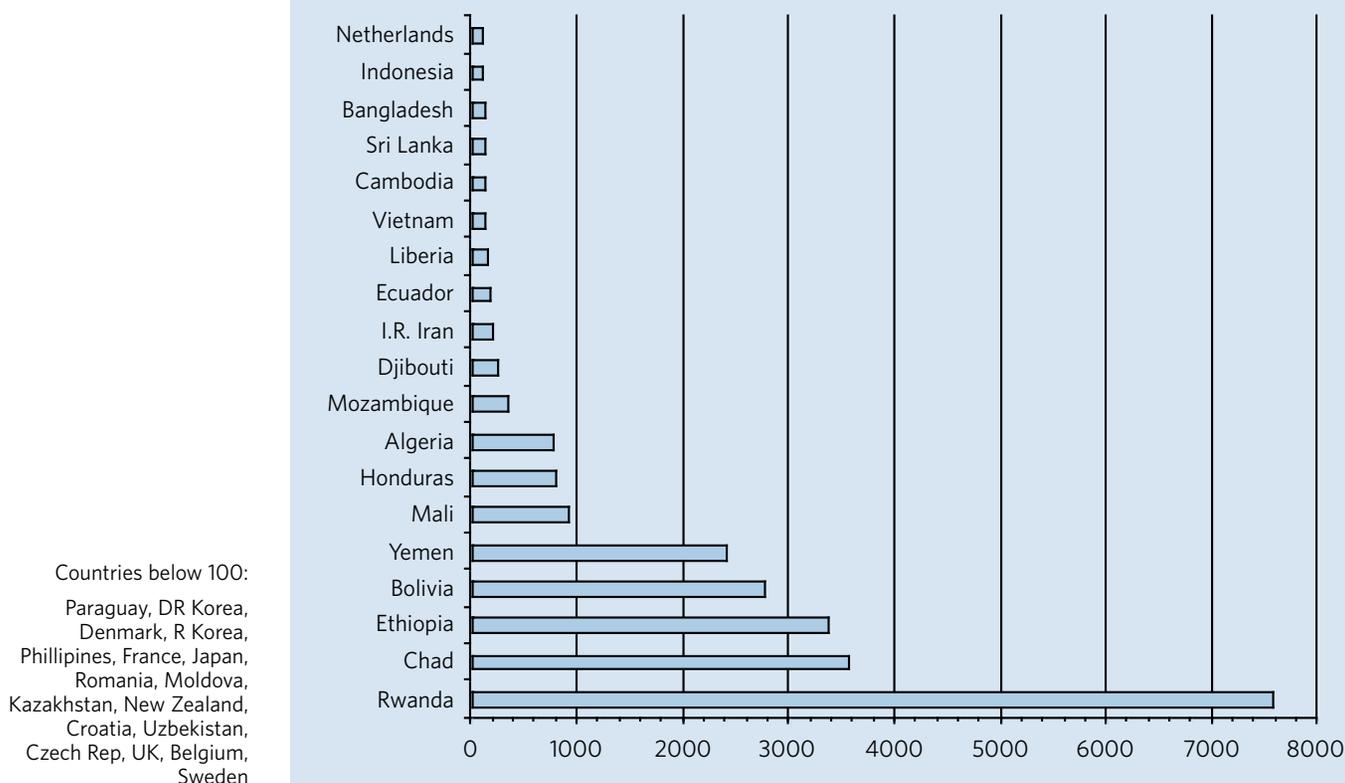
xxv: WHO *The World Health Report 2005: Make Every Woman and Child Count*. World Health Organization, Geneva, 2005.

xxvi: The population-based estimate of 1:5,000 is based on a total fertility rate of 4. The population-based estimates are only useful for broad national assessment. They do not help identify actual staffing needs at the grass roots level. Neither are they helpful in countries with high fertility levels or where service delivery is based in the community, or through mobile and/or outreach models.

xxvii: Sherratt DR, White P, Chang C. A *Comprehensive Review of Midwifery in Cambodia*. Final Report prepared for MoH, Phnom Penh, 6th October 2006

skills; for example by rotating midwives working in low birth settings into larger referral facilities for short periods of on-the-job in-service training.

Fig 2: Midwife to birth ratio in selected countries



Applying the midwife-to-birth indicator to the data available on the number of midwives and estimated births, it can be seen that there is an inverse correlation between the numbers of midwives to births and the maternal mortality ratio (see Figure 2).

The graph should be interpreted with caution, since the figures are taken from the 2006 *World Health Report* and, as already mentioned, carry with them a reminder that the data for numbers of midwives may well not be accurate. However, cross-checking with data from country reports and ICM, these are the countries with the most reliable data on numbers of midwives who meet the ICM definition. Also, it should be noted that the industrialized countries include in their data all midwives, even those that may be in practice out of the country, as well as those working in policymaking, management, research and academia. The ratio of midwives to births would be substantially different if the data included only midwives in clinical practice.

Attempts are being made at the international level to encourage countries to disaggregate their data. This may well become easier as countries begin to recognize the importance for the provision of quality care of accreditation of skills and periodic updating. It is now well accepted that all healthcare professionals, including midwives, should possess a licence to practice, or some form of verifiable accreditation of their skills, and should be periodically renewed. Such a mechanism would allow countries to estimate their workforce numbers and skills base more effectively, permitting evidence-

based workforce planning. Currently a great deal of workforce planning, especially for midwives, relies on guesstimates and only rarely on a profile of the existing workforce and a systematic needs analysis.

Although most low-income countries will not achieve the very low midwife-to-birth ratios of the richer western countries, this new midwife-to-births indicator can help them plot progress towards adequate numbers and coverage of MOMS. In combination with the proportion of births by a skilled attendant, the midwife-to-birth (either expected or live births) indicator will highlight human resource priorities at country and sub-national level. It will also help to indicate uneven distribution, and whether problems are related to distribution or numbers.

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# Meeting the Midwife Challenge – the Need for Speedy Scaling-Up

## 3

*“At this defining moment in history, we must be ambitious. Our action must be as urgent as the need, and on the same scale.”*

– Kofi Annan, In Larger Freedom. Secretary General’s Report, UN, New York, 2005

*Creating understanding about what is a midwife, what midwives do, the barriers that prevent them becoming a professional*

*group, including the gender dimension of their work, are vital. Above all, strengthening professional identity and leadership is at the heart of ensuring access to a competent midwife who will provide skilled care before, during and after childbirth, and help save the millions of lives lost or blighted as a result of this most basic function – reproduction of the human race.*

To ensure that culturally appropriate yet scientific solutions are applied to the development, scale-up and practice of midwifery, calls for a holistic framework to address the current deficiencies, first, in numbers and quality; and second, in midwifery leadership, activism and research. Without addressing the full spectrum of need, it will not be possible to build a strong, flexible, functioning system, capable of producing a midwifery workforce adequate not only for current needs, but for the needs of generations to come.

The key to building this workforce is to define the basic standards with which all midwives must comply. These standards should define not just the scope of midwifery practice, but the educational entry criteria for both pre-service and continuing midwifery training, as well as the core competencies required for all midwives. Such standards, or professional codes of conduct, are critical for good governance of the profession and for protection of the public. Among the distinguishing marks of a profession is the

### *Box 3 – International Confederation of Midwives – Core Competencies of the Midwife*

In an attempt to answer the question “What knowledge, skills and behaviours are required of a midwife for safe practice in any setting?” and to provide an evidence-based answer to the question “What do midwives do?” ICM undertook a modified Delphi study from 1995 to 1999, involving 39 different countries in all regions of the world. Many low-income countries participated in this study.

The results identified 214 different competencies, clustered under six basic care sections or domains:

1. General care – the ability to offer culturally sensitive and ethical care;
2. Pre-pregnancy care and family planning;
3. Care and counselling during pregnancy;
4. Care during labour and birth;
5. Care of postnatal women;
6. Newborn and child care.

The full list, including additional competencies, can be found on the ICM Web site, <http://www.internationalmidwives.org>

ability to control both entry to and the practice of the profession. Good governance equally protects the public from sub-standard and bad practice, and provides a means of recourse if a patient feels unhappy with the care provided, or has been harmed by a member of the professional group. It is the role of the national midwifery boards or councils to establish and uphold rules and regulations that govern the profession, as well as the scope of professional practice.

ICM have identified a set of 214 core competencies that a midwife must possess to help a woman stay safe and healthy through pregnancy and birth and to help her to ensure the health of her baby and the rest of her family. These core competencies, developed through a rigorous Delphi study, form the basis for a global consensus on what a midwife should be able to do (see Box 3). Further, the ICM core competencies are in line with the competencies required of a skilled attendant at birth.

These core competencies may stand as a global description of what constitutes basic midwifery practice. Work is now being undertaken to identify which are truly essential for saving lives of women and babies. Preliminary work by PAHO in the Americas, and results from Indonesia and Pakistan, show that some 22-26 of these competencies are essential for saving lives; the rest contribute to health promotion and protection and therefore have an indirect life-saving element.

### *3.1 Regulation and professional autonomy*

As new initiatives for providing and funding skilled care for women and newborn begin to be established, attention is needed to the regulation of the workforce, especially where there is a rising number of midwives in the private sector, whether in their own private practice, in clinics or birthing centres, or in larger private maternity facilities.

Professional regulation is the means by which order, consistency and control are brought to a profession and its practice.<sup>xxviii</sup> The purpose of professional regulation of midwifery practice is to enhance national efforts to reduce maternal and newborn deaths, improve women's reproductive health and ensure safe motherhood (see Box 4).

This is best achieved by ensuring that the regulation system is based on effective legislation, but regulations should be reviewed and revised from time to time to make sure that they remain pertinent to the changing needs of the country, as in Zimbabwe, (see Box 5).

xxviii: Affara FA, Madden Styles M. *Nursing Regulation Guidebook: From Principle to Power*. International Confederation of Nurses, Geneva, 1993.

#### *Box 4 – Purpose of Professional Regulation of Midwifery*

- To protect the public from unsafe practices;
- To ensure (as far as possible) quality of services;
- To inform the public of what they can expect;
- To help develop the profession
- To ensure accountability and responsibility

### *Box 5 – Midwifery Regulation for Improving Quality of Care: the Zimbabwean Experience*

Until the year 2000 Zimbabwean midwives were functioning under regulations drafted in 1970, though women's needs had changed and many aspects of midwifery practice were not covered. When a Zimbabwean midwife won the Marie Goubran Award (awarded by International Confederation of Midwives) the country's midwives set to out to revise the regulations. Many lessons have been learned from Zimbabwe's experience:

- 1) **Without regulation, the boundaries of the midwife's scope of practice were blurred.** This left the midwife practitioner at risk of functioning outside her scope of practice and carrying out procedures for which she had not been prepared. The quality of practice became tainted as people did whatever they thought was necessary, whether it was midwifery or not. When legal issues arose, the midwife had neither support nor protection.
- 2) **Without a clear scope of practice, nobody knew what a midwife was or did.** The country required practitioners in the rural areas where the need was greatest. Midwives and nurses were deployed to fill any practice gaps where there were no physicians, and midwives found their scope of practice vastly expanded. However there was no mechanism to check whether midwives or nurses were appropriately educated for this expanded role. The emergence of multipurpose cadres to carry out what would normally be midwives' work only added to the confusion. An identity crisis ensued among all three groups; quality of care declined; women lost confidence in midwives and midwifery care, and there was frequent negative publicity about midwives. Physicians and ob/gyns lost respect and support for midwives, as the term became associated with a rather amorphous practitioner who could do anything at any time.
- 3) **Once regulations were in place**
  - Scope of practice was distinct. Any additional responsibility became the subject of additional training.
  - Monitoring and supervision became easier. Supervisors knew what to expect and what to discourage. Intra-group discipline became possible.
  - Education needs became distinct. Education was tailored to the scope of practice, the needs of women and the demands of the state. Even university education became possible once what a midwife knew and what additional education she needed were clear.
  - Quality of care improved (before it was reduced again by HIV and AIDS).
  - With a clear scope of practice, it became easier to ask for better pay and conditions.

The next requirement was a council to regulate the practice of midwifery by midwives. There was a protracted struggle to convince policy makers and other care providers that midwives needed to be distinct from the all-encompassing, physician-led Health Professions Council which classified nurses and midwives as "allied professions". Zimbabwe now has a Nursing and Midwifery Council regulating the practice of midwives and nurses.

Midwives are now advocating for a separate midwifery council to sharpen the line between midwifery and nursing, for the benefit of both professions, and for women and children. Before this can happen, health care colleagues' attitudes must change so that they can see midwifery as a profession in its own right.

But regulation has definitely cleared up most of the confusion about what is meant by midwifery skills and who are midwives. Regulations have illustrated the need for more well-prepared midwives with a robust education programme. In addition, in-service issues are much clearer, given the current needs of the population and the curriculum content. Regulation has also gone a long way towards easing competition and conflict between midwives and nurses, and between midwives and physicians. Because they are now sure of their identity, midwives in Zimbabwe have started working with women's groups and religious organisations to improve the health of women and children.

### *3.2 Professional associations and regulations*

The relationship among standards, regulation and accreditation causes great confusion, including on occasion among professionals themselves.

Professional **regulation** provides the mandate that establishes and maintains the profession and lays down the rules or criteria governing the profession, ensuring that monitoring, often referred to as supervision, and evaluation of the profession will be carried out. Regulation enables sanctions for non-compliance and the removal of individuals who do not conform to professional standards. Good legislation supports good regulation, which in turn supports good professional practice.

**Standards** provide members of the regulatory body with a measuring stick to ensure that agreed criteria have been met.

**Accreditation** is the process verifying that the protocols and procedures outlined in the regulations have been carried out to the required standard, and declaring that the agreed criteria have been met.

Professional associations are key to effective, working regulations. Professional organizations advocate for professional standards and in many instances, act as both the partner and the conscience of the regulators.

For example, professional associations:

- Act as gatekeepers to the profession.
- Ensure enforcement of regulations and provide sanctions for non-compliance.
- Provide intra-group discipline, control and monitoring.
- Advocate for women and for the profession at the same time.
- Apply pressure on governments, especially in low-income countries, to create an enabling environment for effective midwifery practice.

Many low-income countries have weak infrastructure for supervision and regulation of all healthcare professions, especially their midwifery workforce. While many countries

are introducing a number of quality assurance and improvement initiatives, most of these are facility-based. There are few initiatives for community-based practitioners; yet in many low-income countries, midwives and others with midwifery skills, working mainly in the community, form the bulk of the midwifery workforce.

It is unlikely that ministries of health will be able to take on the supervision and regulation of the increased midwifery workforce needed to achieve the targets for births by skilled attendants, especially in rural, hard-to-reach and vulnerable communities. It is essential for the government to establish effective legislation and regulation to ensure that supervision and monitoring is established and functioning well. Partnership with professional associations will be required to ensure an effective regulation and licensing system.

Ensuring quality of service, especially when they are provided by professionals who work in isolation or small groups in community-based settings – and also in the burgeoning private sector – is likely to be a concern to most countries. The only way to ensure quality of care in these settings is to ensure compliance with nationally- and professionally-agreed standards. However, to ensure quality, regulatory systems must include strong mechanisms to ensure that the standards are being met. This calls for, not just a professional regulating body – usually a midwifery council or separate midwifery committee within a multi-profession regulatory body or council – but also a professional association. The professional association, being concerned with the development of the profession of midwifery, can offer professional advice on the development of standards. Both professional bodies and associations therefore have an important role to play in the assurance of quality care, and plans for building midwifery capacity should address the need for both.

### *3.3 UNFPA's first global midwifery workshop*

In 2006 UNFPA, with WHO, ICM and other partners, launched an intensive country support initiative to strengthen the scaling-up of midwifery. The initiative recognizes the pivotal role of midwives in providing quality women-centred maternity care. It is an attempt to grapple with the complexity of scaling up both the number and the quality of skilled birth attendants and help meet communities' broader reproductive healthcare needs. It has the highest level of support from all organizations

The initiative began in March 2006 with a global workshop with midwives, the first worldwide initiative on the subject (see Box 6). Launching the initiative, UNFPA's Executive Director, Thoraya Ahmed Obaid, said, "Addressing the shortage of midwives through education, training and deployment to underserved areas would bring us much closer to achieving the Millennium Development Goal of improving maternal health."

### *Box 6 – Scaling-up Midwives and Midwifery Training to Accelerate Maternal Mortality Reduction – New York, March 21-23 2006*

UNFPA sponsored the workshop, in collaboration with WHO Department of Human Resources, ICM and the Community of Practice Steering Group for Nursing and Midwifery (a special project of the WHO Collaborating Centres for Nursing and Midwifery).

To respond to the global agenda on shortages of human resources for health and, recognizing that urgent efforts were required to achieve the goals that heads of governments and UNFPA had reaffirmed at the UN Global Summit September 2005, UNFPA and its partners brought together midwives from a variety of settings, including low-income countries, industrialised countries and midwifery advisors working at the international level, to explore ways of increasing the capacity of midwives to save the lives and improve the health of mothers and newborns.

Together with key UNFPA staff, including UNFPA country teams and with UNFPA partners, the midwives discussed the major barriers facing the development of midwifery skills in low-income and transitional-economy countries. The midwives not only shared their views and experiences, but suggested strategies to enable them to contribute more effectively to national efforts.

On the last day of the workshop, participants explored and proposed possible solutions and ways that UNFPA could contribute to the agenda, especially in countries with high rates of maternal mortality.

*Meeting  
the Midwife  
Challenge  
– the Need  
for Speedy  
Scaling-Up*

The Workshop Report is available on the UNFPA Web site at <http://www.unfpa.org>

During a one-day follow-up meeting to discuss the implications of this new agenda for their workplans, UNFPA staff agreed there was urgent need to define the way forward and define the role of UNFPA in supporting this ambitious international agenda. UNFPA's outline strategy is in Annex 1. Further joint efforts are being planned with WHO, ICM and others to continue the work begun during this landmark workshop. The work will focus on country and regional activities and on strengthening country teams to provide in-country technical expertise and advice.

### *3.4 Midwifery in the community workshop*

As a follow-up to this first workshop, an International Forum was held in Hammamet, Tunisia, in collaboration with WHO, ICM, The Partnership for Maternal Newborn and Child Health, and sponsored by many national and international donors, including the Swedish International Development agency (SIDA); the Initiative for Maternal Mortality Programme Assessment (IMMPACT) based at Aberdeen University, Scotland, UK; Family Care International (FCI) and many others.

The theme of the workshop was “Midwifery in the community: lessons learned”. The theme was chosen in response to the many concerns raised at the first meeting regarding standards, minimum length of training required, and other issues, as more and more countries decide to establish community-midwifery programmes. The Forum

also considered how to monitor and evaluate such programmes and how to draw on the lessons learned by low-income countries which had already used community-based midwives. More information on this Forum and its outcome, including recommendations, can be found on the UNFPA website

### *3.5 Scaling up midwifery requires a different approach*

The New York workshop confirmed the barriers regarding building midwifery capacity at country level, to which many others have alluded (see Box 7). However, it became clear for the first time that the lack of gender equity underlying most of these barriers needs recognition and acknowledgment, if the voices of midwives are to be heard.

Scaling up the numbers and quality of midwives requires countries to adopt a fundamentally different approach to midwifery, an approach built on a midwifery model of care using a “midwifery framework”, similar to that developed by ICM (see Box 8). The midwifery framework requires that midwives collaborate with others, in particular with the community, with a reasonable degree of autonomy and flexibility. To achieve this will require changes both to the way that midwives are educated and to their supervision, as well as increasing the opportunities for continuing education.

#### *Box 7 - Barriers to Midwifery Capacity Development*

- Confusion about what is meant by midwifery skills and who are midwives and others with midwifery skills (MOMS), capable of contributing to saving lives of mothers and babies.
- Lack of numbers, and in most cases quality, of midwives. In many countries the midwifery training is of poor quality and starved of investment. Many studies find clinical as well as theoretical aspects of pre-service midwifery programmes to be out of date.
- Lack of funding for pre-service, in-service and continuing training, and for employment of midwives. Many midwives seek employment elsewhere because their salaries are so low.
- Competition and conflicts between physicians and nurses; physicians and midwives, and nurses and midwives, with midwives trying to secure professional space.
- Lack of incentives and lack of human resources policies and plans. There is also need for support for the basics: housing, light, water and topping-up of salaries.
- Finally, midwives, and sometimes groups and associations representing midwives, too often work in isolation. Greater efforts are needed to strengthen the relationships between midwives and women. Where midwives work with women and women’s groups, the midwifery profession is usually stronger.

*From the Final Report on the Workshop on Scaling up the Capacities of Midwives to Reduce Maternal Mortality and Morbidity – Strategies for UNFPA to Contribute to the Global Agenda. New York, 21-23 March 2006.*

## Box 8 – The Midwifery Framework

The skills required for midwives to support and protect women, and to seek justice and equity for all include being able to:

1. Assist women's access to appropriate care and services by
  - A. Advocating for free access to maternity care for all women;
  - B. Advocating for local services close to where women live or appropriate transport systems;
  - C. Ensuring all women know where to go for pregnancy-related care, how to use local services, and how to plan for pregnancy and birth.
2. Assist women to overcome barriers to health including advocating for removal of gender inequality by
  - A. Working with and listening to women.
  - B. Advocating for changing attitudes, such as those known to be harmful to women, including opposition to sexual and reproductive health care and gender equity in health care. (However, midwives should remember that changing attitudes and tradition takes a long time and requires assistance from others in the community such as politicians, community leaders, and the media. Women as individuals cannot change attitudes; they need advocates who will assist and sometimes intercede with family, community or the State on their behalf. Most often this is achieved through action by women's groups and NGOs.)
  - C. Providing advice to the community and employers about the dangers of heavy work and women's need for healthy environments.
  - D. Providing nutritional advice to children and adolescents in and out of school, as well as targeting family members, especially whomever is in charge of food in the family.
  - E. Providing age-appropriate education and advice to all sectors of the community, including children and adolescents in and out of school, on reproductive health, including advice on sexually transmitted infections, HIV/AIDS and family planning.
3. Assist women to negotiate for high-quality maternity care by
  - A. Building bridges with communities and others in the health team, to determine the best place for each individual woman to give birth.
  - B. Advocating and assisting women with education, advice, counselling and support, to overcome harmful traditional barriers without transgressing cultural norms
  - C. Developing "woman-friendly" approaches to service provision, including ensuring services are available at the appropriate time and place, taking into account the special needs of pregnant women.
4. Establish and maintain standards of good practice. Where resources are few, this will require great creativity:
  - A. Reflect on practice. (Use research networks to identify good midwifery practice; involve women, their family and other colleagues in this reflection.)
  - B. Ensure pre-service and refresher training as appropriate, in particular life-saving skills. (Research demonstrates that not all obstetric emergencies can be predicted, so all midwives need to have these skills.)

*Meeting  
the Midwife  
Challenge  
– the Need  
for Speedy  
Scaling-Up*

- c. Keep both knowledge and practice up to date, using peer support networks. (Case study reviews and professional and inter-professional meetings are particularly useful.)
- d. Keep good records.
- e. Be flexible and innovative.
- f. Work collaboratively with other health workers including medical colleagues and community workers.

Implementing the midwifery framework will require assistance from other health colleagues, national and local governments, the local community, local leaders, professional groups and local pressure groups, as well as midwives' own peers and the national midwifery association.

### *3.6 Strategies for rapid scale-up of midwives – lessons learned*

The reason that WHO or anyone else cannot say with any certainty how to go about rapid scaling-up of midwives is not hard to find: there has been very little investment in case studies from which to draw evidence about good practice.

There are however some common findings about what has and has not worked, which can inform national strategies for building midwifery capacity. For example, a case study in Indonesia has shown that training young, inexperienced girls in a short, poorly-focused midwifery programme and putting them to work on their own – especially outside their own community – with no back-up or supervision, does not work in the long-term. It does not produce skilled midwives with the capacity to save lives.

Investment in training midwives from local communities is often very useful, but is ineffective without a strategic approach to capacity building. For example, Sudan has been unable to invest in midwifery teachers and leaders (mainly because of internal problems) and its midwifery leadership is weak. Despite opening its first midwifery school in the late 1920's, Sudan has not provided the academic support to help midwifery develop on a professional footing, nor is midwifery seen as equal to nursing. Lack of leadership has inhibited development of the midwifery curriculum, and graduates leave the programme with limited life-saving capacity and skills in newborn care. This lack of capacity means that midwives from the north are unable to assist with reconstruction and development in the south of the country.

Another widely propagated but ineffective strategy is increasing the roles and responsibilities of midwives without adjusting the training or workload expectations which might permit midwives to take on new roles, maintain professional identity, and incorporate additional work into their daily work plans without compromising midwifery care. This merely turns midwives into multi-purpose workers.

Sri Lanka and Malaysia, to name only two, have shown that midwives can be used effectively to deliver a wider package of healthcare in the community. Sri Lanka acknowledged them with the title of "public health midwives" and protected the midwifery function in the community. Midwifery in Sri Lanka has sadly lost some of its status in recent years: early investments in midwifery have not been maintained as the place of birth has moved from home to a hospital facility. Today Sri Lanka's

maternity facilities are suffering because they lack the skilled and highly motivated midwifery workforce to staff maternity areas. Quality of maternity care is becoming hard to maintain. The same can be seen in Egypt, where, despite an impressive reduction in maternal mortality achieved by a holistic approach, including upgrading the skills of all available human resources,<sup>xxix</sup> midwifery has not yet achieved the status of a profession. As in western countries, many Egyptian women are now beginning to complain about increasing use of technologies and interventions in many of the larger maternity hospitals, and are calling for more humanistic care.

## *Meeting the Midwife Challenge – the Need for Speedy Scaling-Up*

Lessons are also available about what has worked in the past, drawing on experience in countries such as Argentina, Chile, Malaysia, Sri Lanka, Thailand, Tunisia, Democratic Republic of Congo, Zimbabwe, and some western countries. (See Box 9) There appear to be a few general conditions for the development and sustainability of midwifery capacity:

xxix: MoHP, *Egypt National Maternal Mortality Study 2000*. Directorate of Maternal and Child Health, Ministry of Health and Population, Egypt, 2001

### *Box 9 – Lessons from Countries Which Have Reduced Maternal Mortality Using Midwives*

These lessons show a consistent theme, as outlined by others (See footnote 7) – *the need for quality midwifery care to be readily available and well used by all women and families*. These lessons fall into five broad strategies

**Strategy 1: Taking a sustained public health approach.** All countries with long-standing low MMR made maternal mortality reduction a national public health issue.

**Strategy 2: Collaboration between midwives and obstetricians (specialized physicians with obstetric skills).** Where the relationship between the medical profession and midwives was collaborative and mutually respectful, MMR fell more rapidly than where relations were more contentious. Both midwives and obstetricians are required for a safe pregnancy outcome – a healthy mother and baby.

**Strategy 3: Professionalize midwifery and phased movement to institutional births.** Countries which have been able to reduce their MMR in more recent years, such as Malaysia, Sri Lanka and Thailand, all invested in the quality and numbers of midwives. They made midwifery a respectful and attractive profession by regulating entry and practice and professionalizing the midwifery workforce.

Although all three countries also invested heavily in provision of hospital births, all have seen a steady and progressive move toward all births taking place in institutions, rather than a sudden and rapid movement. The move to institutional births began as the community developed trust in the formal healthcare system, having had initial care from a trusted community midwife, and continued as infrastructure improved and other economic investments were made.

*Strategy 4: Political and civil society support.* Successful moves to low MMR all enjoyed broad political and civil support, coupled with the efforts of national leaders or opinion makers – though sometimes only a small number.

*Strategy 5: Working in partnership with traditional birth attendants (TBAs) and refocusing their role.* Most countries which reduced maternal mortality introduced professional midwives, while at the same time working with TBAs to help them reposition their role and become advocates for skilled care at birth. They did not criminalize TBAs.

First, there must be a reasonable working system for regulating training and practice. Such regulation is vital for the community to trust midwives and to attract sufficient recruits to the profession. Second, building career pathways, so that midwives can reach senior positions, including at the policy level, and strengthening professional standards and ethics – for which a strong professional association is needed – does a great deal to build up the image and respect afforded to midwives. This helps change the image of midwifery and increase recruitment to the profession.

Examples can be seen in Indonesia, where there has been an exponential growth in private midwifery academies in recent years and where places on midwifery programmes are highly contested and attract high tuition fees. That applicants will pay large sums of money for training testifies to the success of marketing midwifery and of official permission for private midwifery practice – though the expansion of private academies and allowing salaried public-sector midwives to work in private practice present some problems.

Countries with very low maternal mortality ratios (MMR), mostly western industrialised countries, achieved these reductions well before the advent of modern technologies; almost all were well on the way to low MMR by the beginning of the 20th century. When MMR began to fall, some had similar income levels and conditions to those in low-income countries today – Sweden in particular, with 90 per cent of its population in rural areas, had serious geographic problems and weak infrastructure.

All these countries took a public health approach to providing universal access to skilled care, some more successfully than others, and over different time spans. In general, relatively well-trained professional midwives, working at the community level offering primary health care, provided most of the skilled care. These midwives had strong linkages to medical facilities, to which they referred women with complications or women with underlying medical problems.

### *3.7 Midwifery-led care must be available to women in all countries*

Midwives are important in helping individual women to remain healthy during pregnancy, birth and the important period after birth; and in helping to ensure survival of newborns. By helping women and newborns stay alive and healthy, midwives help secure the future health of both woman and child. In doing so, midwives contribute to the health of families and the nation, assist countries to reach their social and economic development targets.

Although the roles and duties of the midwife will vary from country to country, there is a unifying central focus, referred to (from the original meaning of midwife) as being “with woman”. There is an additional element of unity in the provision of a basic package of maternity care and services to mothers and newborns. Ideally midwives should deliver this package with the collaboration and support of other healthcare providers, though this is often not the case, as in the day in the life of a Malawian midwife described in part II.

When offered the choice, women prefer to seek care at the time of birth from a properly trained professional midwife. In countries such as Canada and New Zealand, it was advocacy by women with politicians and the wider society that pressurised governments, sometimes against opposition from other healthcare professions, to make midwifery care available to all women. Studies from Australia, Canada, Sweden and the United Kingdom, among others, show that not only do many women rate midwifery care highly, but often prefer and will seek out midwifery care, as the growing popularity and support for midwifery-led units show.

The desire for professional and women-friendly carers is not, as some have suggested, unique to rich countries. For example, in a recent UNFPA-supported study in Cambodia, women expressed interest in greater access to a professional midwife,<sup>xxx</sup> and many other country studies show similar results. Nepal, for example, has a very popular midwifery-led birthing unit that has shown excellent birth outcomes for over ten years. Other countries have similar facilities.

xxx: MoH/UNFPA.  
*Obstacles to deliveries by  
Trained Health Providers to  
Cambodian Rural Women.*  
UNFPA, Phnom Penh,  
February 2006

There is also a clear need to put midwifery on a firm professional basis. Midwifery providers must be well-educated and there must be effective mechanisms for accreditation and regulation of the profession and professionals.

Advocacy is required for a better understanding of what a midwife is and what midwives can and should do. Their right to practise certain life-saving skills is crucial for women and babies. Professional identity is needed for the community to recognize what the midwife is and does, as well as for the midwife’s own motivation, self-esteem and good performance.

It is neither essential nor feasible in most low-economy countries for all midwives to be educated to tertiary (baccalaureate) standard; but for sustainability there must be some, those who will become the leaders, policy-makers, educators and researchers. A core group of midwives with advanced education are needed in leadership positions, to find culturally-appropriate solutions and overcome barriers, and to develop a midwifery model specific to local conditions.

For a well-educated midwifery workforce, the delivery of education must change - not only better application of current educational approaches, based on principles of adult learning, but new and innovative models of education. Education should be built on best practice as demonstrated by research; and it should equally be women-friendly taking into account cultural factors in women’s lives and practices surrounding pregnancy and birth. One such model, known as the CASA Model, has been successfully used in Mexico. (See Box 10)

### *Box 10 – The CASA Model of Midwifery Training*

The CASA (*Centro Para los Adolescentes de San Miguel de Allende*) School of Midwifery is the only government-accredited school of midwifery in Mexico and still keeps its focus on traditional practices, women's empowerment and protecting normal birth. Students learn traditional midwifery practices as well as modern midwifery. They develop their clinical skills by apprenticing with traditional midwives, as well as working in the school's own maternity hospital, where the impressively low rate of 9 per cent for caesarean sections testifies to the hospital's ethos of keeping birth normal.

CASA's merging of cultural traditions and modern midwifery might be one way to improve the capacity of midwives and increase the numbers trained without losing a focus on women and the value of traditional knowledge and ways of knowing. It could also help to maintain cultural traditions that assist not only with keeping childbirth a normal event, but maintaining the significance of birth for the community.

Taking local women with a history and family connection to midwifery and, providing them with high-quality, culturally-appropriate education focussing closely on skills development will also help to increase midwifery coverage to the rural populations. Midwifery recruits who are well established and settled in the community are more likely to stay and practice their skills locally.

For further information on the CASA school of midwifery and the CASA midwifery project, see <http://www.casa.org.mx/midwife.html>

Finally, both history and recent successes show that, with high-level political support, midwifery can flourish in any country, regardless of its socio-economic status or structural development. Midwives can contribute not only to lower maternal and newborn deaths and morbidity, but also to better health overall, especially for poor, vulnerable and hard-to-reach communities.

## Final Word: Training Alone Will Not Be Enough

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# 4

*The education of midwives, both pre-service and in-service, must be addressed if there is to be a rapid expansion and scale-up of numbers of midwives and quality of midwifery care. However, training is not the only issue. Regulation, accreditation, proper delegation of authority and supportive supervision of midwives are equally important, as is ensuring that midwives have appropriate employment protection, remuneration and incentives, for which building motivation is perhaps the most crucial. The motivation to be “with woman” during pregnancy and birth requires more than just a set of skills.*

In most countries, efforts to address the quality of midwifery care focus on healthcare providers already in the system: but increasing coverage and utilization calls for a comprehensive human resource policy addressing overall numbers; recruitment, training, deployment and retention, as well as the legislative and policy framework in which MOMS function. Greater emphasis must be given at an early stage to building in better monitoring and evaluation systems to ensure that lessons learned are taken into account before massive and potentially expensive scale-up begins.

One of the major challenges for many low-income countries is how best to organise and deliver quality pre-service education. Sadly, external pressures over the past two decades have caused many midwifery schools to close or be amalgamated into nursing schools. As a result there has been a steady decline in the competence of the midwifery workforce, coupled with an increasing number of multipurpose and partially-skilled midwifery providers.

The reluctance of governments, especially in low-income countries, to fund long training programmes, such as post-basic midwifery programmes after nursing graduation, is understandable. However, amalgamating midwifery into pre-service nursing training may not be the answer, given more complex technologies, the increase in chronic diseases, and the impact of new diseases such as HIV/AIDS and related illnesses, all of which also have to be accommodated in nursing programmes. Neither is it cost-effective to invest in short midwifery programmes, unless, like Bangladesh, it is for a specific and brief time, or as part of a long-term plan to train more midwives, as in Tunisia and a number of other countries (for more on Tunisia and Bangladesh, see part II). Without attention to quality in pre-service education for midwives the shortage of skilled practitioners will continue. Trainees will continue to graduate without the necessary technical skills, professional attitudes or the ability to respond to the needs of women and newborns in critical situations.

Poor-quality pre-service education programmes also affect the community's perceptions of graduates, and make people less willing to make use of the services provided. There are examples of women and their families refusing to use local services, jeopardizing the lives of both women and babies by travelling many miles to another service point.

Finally, as some countries such as Indonesia are now finding, making up for the shortcomings of pre-service midwifery programmes *ex post facto* can be costly and time-consuming. Improvement of pre-service education, however, calls for investment in preparing midwife-educators and making midwifery an attractive and valued profession.

Until they raise the status of midwifery, countries will be hard pressed to attract either the numbers or the calibre of entrants to the profession. Retention will continue to be a problem, with the most able leaving the profession rather than staying to become teachers, supervisors, policymakers and managers.

xxxi: WHO. *Mother-Baby Package: Implementing safe motherhood in countries.* Maternal Health and Safe Motherhood Programme, Division of Family Health, World Health Organization, Geneva, 1994

As noted in the WHO Mother-Baby Package, "Training alone will not ensure the provision of effective quality care". The attitude of the workers is also vital."<sup>xxxi</sup> Without attention to the motivation and attitudes of health workers; their remuneration, workloads and work-patterns, and career structures, whatever services are provided may not be effective. The evidence is that a user's perception of quality, measured by provider performance - specifically their attitudes and if they treat service-users well - may have a greater influence on uptake of services than access or client costs.<sup>xxxii</sup>

xxxii: Andaleeb S.S. Service quality perceptions and patient satisfaction: a study of hospitals in a developing country. *Social Science & Medicine* 2001; 52:1359-1370

While many safe motherhood programmes are led by very competent public health or medical professionals, few have the relevant, specialist up-to-date technical knowledge and skills in midwifery, and therefore cannot make informed decisions on types of training and training efforts. It is possible that this lies behind the failure of many training efforts to produce sustainable results.

Training programmes rarely include sufficient attention to the factors that impact on provider performance: salary and other forms of remuneration; career enhancements; housing; education grants for children; delegation of authority, legal protection, legal right and training to practise life-saving skills, and devolution of responsibility. In particular most programmes have not given attention to enhancing the position and status of professional midwives, nor to building a professional identity capable of further advocacy and offering peers support and self-regulation.

Countries need their own competent and knowledgeable midwives to advise and make decisions on the best models to follow. Most countries will probably need to employ a holistic framework that addresses the need for first, highly educated teachers; second, clinical midwives for supervision, research and policy; and finally, skilled community-based clinical midwives. All are required to create a vibrant and self-sustaining midwifery body.

There is some hope that much more will be achieved over the next few years. Many more countries - with the assistance and support of UN agencies such as UNFPA and its partners, including the NGO sector - are recognizing the importance and benefits of developing their own midwifery workforce. As they begin to invest in midwives and others with midwifery skills, they can expect accelerated progress in reducing maternal and newborn deaths, and the many disabilities which are too often still associated with pregnancy and birth.

*The legal right and training to practise life-saving skills; devolution of responsibility; and in particular enhancing the position and status of midwives and building a professional identity that can then advocate for further strengthening of midwifery practice and offer peers support and self-regulation, are crucial to the building of a competent and sufficient midwifery workforce.*





## PART II

### Voices from the Field



# UNFPA supports human resource development to save the lives and protect the health of mothers and babies

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*"At this defining moment in history, we must be ambitious. Our action must be as urgent as the need, and on the same scale."*

- Kofi Annan, Secretary General's Report, *In Larger Freedom*, 2005

*"Putting in place the health workforce needed for scaling up reproductive, maternal, newborn and child health services is an urgent task, and we believe that the support of health professional organizations will be crucial."*

- Thoraya Ahmed Obaid, Executive Director of UNFPA.

The year 2006 was important for UNFPA. At the World Summit meeting of September 2005, the international community acknowledged that universal coverage of reproductive health services was essential for achieving the ambitious Millennium Development Goals (MDGs). The World Summit further acknowledged that universal skilled attendance at birth could be achieved only with appropriate skilled health workers with midwifery skills. This would require concerted, innovative and ambitious efforts, with each partner contributing according to their comparative advantage.

Recognizing that increasing the numbers and improving the skills of midwives and others with midwifery skills (MOMS) would save the lives of 5 million women between now and 2015, prevent 80 million illnesses from pregnancy or childbirth and save the lives of countless newborns, UNFPA with its partners WHO and the International Confederation of Midwives (ICM) launched a new global initiative to scale-up midwifery capacity at country level. The initiative directly supports UNFPA's three-point strategy for maternal mortality reduction, which calls for increased access to family planning and to emergency obstetric and neonatal care (EmONC), and acknowledges the right of all pregnant women to skilled care at birth. Skilled care calls for skilled healthcare providers, who are, as the *World Health Report 2006* makes clear, in short supply in most countries with high maternal mortality.

In acknowledging the complexities of providing a skilled pair of hands for delivery of EmONC, prevention of obstetric fistula and other obstetric complications and for the delivery of skilled care at birth (all topics of previous *Maternal Mortality Updates*), the global initiative calls for improving the status of midwifery and increasing the numbers of midwives and others with midwifery skills (MOMS), especially at the community level. The initiative seeks to assist countries to focus on practical, low-cost but high-quality solutions, to ensure that all women have skilled care at birth.

## *The MOMS Initiative*

The midwives and others with midwifery skills (MOMS) initiative was launched by UNFPA with its partners WHO, UNICEF and the International Confederation of Midwives (ICM) at a workshop in New York in March 2006. This workshop, the first for UNFPA on the subject of human resources, brought together midwives from developing

and industrialized countries and midwifery advisors working at the international level, to discuss with key UNFPA staff and UNFPA partners, the major barriers facing the development of midwifery skills in low-income and transitional-economy countries, and propose possible solutions.

The barriers are well known. What was new was the recognition that their basis lies in gender inequality. As a primarily female workforce, midwives face different difficulties from male health workers; not just because of their sex and the cultural issues around being a woman, but also because the area they work in, midwifery, is not yet recognized in some countries as a profession. Yet it is the fact that they are women, working “with woman” in a modality of partnership, that is valued most frequently by the women they care for, but is too often ignored or dismissed by the system they work in.

Following the success of the March workshop, UNFPA with its partners WHO and ICM organized the first international Forum on Midwifery in the Community in Hammamet, Tunisia, in December 2006.<sup>xxxiii</sup> The workshop ended with a call to governments, regulatory bodies, professional health care organizations, educators, and communities worldwide for urgent and intensified action to ensure the provision of midwifery services in the community. (Box 11)

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supports  
human resource  
development to  
save the lives  
and protect  
the health of  
mothers and  
babies*

xxxiii: The Forum was held with support from Swedish International Development Cooperation (Sida), the Government of Luxembourg, the Government of Tunisia, the Initiative for Maternal Mortality Programme Assessment (IMMPACT) based at Aberdeen University, Scotland, UK, the Averting Maternal Death and Disability Programme at Columbia University (AMDD), Family Care International (FCI) and the Partnership for Maternal, Child and Newborn Health (PMCNH).

### *Box 11 – Hammamet Call to Action*

The Forum, held in Hammamet, Tunisia, in December 2006, gathered international agencies and organizations, midwives, nurses, physicians, health policy makers, professional associations, regulatory bodies and researchers from 23 countries around the world where maternal and neonatal mortality and morbidity remain unacceptably high. Having reviewed progress and constraints over the 20 years since the launch of the Safe Motherhood Global Initiative, participants concluded that intensified action is needed at global, regional and national levels to train and support the additional numbers of midwives needed to work in contact with communities.

Action is needed in six key areas:

- Policies to ensure equitable access to midwifery services;
- Policies and regulatory systems to improve the number, deployment, status and conditions of work of midwives and others with midwifery skills;
- Competency-based education and training in midwifery skills;
- Peer and supportive supervision of providers in the field;
- An enabling environment to support effective healthcare delivery, including infrastructure, communication, emergency transportation, adequate funding, equipment and supplies;
- Permanent monitoring and periodic evaluation.

The outputs of the Forum are being used to develop guidance for countries wishing to scale up their midwifery capacities and will map the recommendations of the participants in these critical areas.

Given the gravity of the shortage, almost all UNFPA country teams are supporting countries' efforts to strengthen human resources in this area, often with technical support from UNFPA's country support teams and its many partners. What follows is a brief overview of some of these activities. UNFPA's mandate includes strengthening all the human resources needed to ensure the reproductive health of all men and women: women's empowerment and increasing access to health services for women, in particular to save the lives of women in and around childbirth is a major feature of this work. The examples in this year's *Maternal Mortality Update* particularly focus on strengthening midwifery capacity.





## Midwives' Voices from the Field



# Africa

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## 1

xxxiv: Chintu M, Susu B, Role of the Midwife in Maternal Health Care In Nash BT, Mati JKG, Kasonde JM (eds) *Contemporary Issues in Maternal Health Care in Africa*. 1994; Harwood Academics, Australia

Africa has the greatest need for increase in midwifery capacity, the result of decades of under-investment and lack of professional autonomy for midwifery providers. With the exception of some parts of Northern Africa, most countries recognize midwifery as a discrete area of professional practice, but usually only within nursing or as a specialization after basic nursing education. One of the few exceptions is Congo, which has had one of the few direct-entry schools of midwifery since 1969;<sup>xxxiv</sup> but the Francophone countries generally present the greatest challenge in the region. They lack in particular up-to-date, evidence-based information and guidelines, including teaching materials, readily available in local languages.

Africa's endemic deep poverty, the impact of HIV/AIDS, and conflict in many countries complicate the midwifery situation. Poverty deprives families of even basic midwifery care, especially in rural areas. HIV/AIDS threatens a whole generation of adolescents and young women and calls for urgent action. Many skilled midwives have left, to escape war or civil unrest. Many countries lack standards for midwifery education and practice as a basis for developing not only quality education programmes but also supervision and monitoring. These are the great challenges.

UNFPA and its partners are committed to the Road Map for Maternal and Newborn Health, mostly developed in African countries, of which the production of skilled midwifery providers is an important component. With assistance from UNFPA, many countries are taking similar action to **Burkina Faso**, where auxiliary nurse-midwives who have received a two-year training provide most of the first-level midwifery care (Burkina Faso decided not to allow TBAs to conduct childbirths and to work with TBAs to redefine their role). With UNFPA support, governments and training institutions are developing systems to supervise, support and educate health workers at all levels, especially at community level. In most systems higher levels of care supervise lower levels, supported by a multi-profession expert team at the hospital level.

UNFPA is supporting the efforts of WHO and others to develop Africa-wide regional standards for midwifery education and practice, as a basis for countries to develop strategies for strengthening midwifery capacity and improve quality of care. The standards will also be useful for conducting needs assessments and for accreditation purposes. In 2005 and 2006, UNFPA participated in WHO regional workshops which laid down a set of regional core competencies for midwives and midwifery-accredited health workers. These core competencies, based on those developed by ICM, will make it easier to share resources, in particular education and training materials, share lessons learned and promote technical cooperation among countries.

UNFPA's current programme of work across the region involves collaboration with many different partners and covers a wide variety of activities, from supporting a maternal morbidity audit in **Uganda** to the development of midwifery curricula in **Sudan**, as the examples from a selected number of UNFPA priority countries demonstrate.

## 1.1 *Making midwifery care more accessible to poor and rural communities*

Many low-income countries in Africa are following the example of Burkina Faso, Kenya and Mozambique. Kenya is currently working on a pilot project to increase access and reduce costs of skilled care to families in greatest need. Kenya has a long history of midwifery and has been training midwives for many years, and has widened the scope of practice for midwives; for example, with appropriate training and competence, midwives are permitted to practice manual vacuum aspiration for management of incomplete abortion. Despite this long tradition, most midwives in Kenya still work in a hospital or clinic setting.

With UNFPA support, Kenya's MOH is piloting community or home-based midwifery in two districts. The aim of the project is to reduce maternal and perinatal morbidity and mortality by improving the quality of normal pregnancy, delivery and postnatal care for women in the community. Specific objectives for this pilot project include:

- Improve access to skilled care within the socio-cultural context;
- Increase reproductive health knowledge among women, their male partners and the community at large;
- Assist women to make individual birth-preparedness plans;
- Provide more antenatal, childbirth and postpartum support to mothers and newborns, continuing up to six weeks after birth;
- Reduce costs for women during the pregnancy, childbirth and postpartum period.

Recruitment and training began in 2006. UNFPA is supporting training; delivery kits; MVA kits; mobile phones for midwives' use, and monitoring and supervision.

UNFPA and the Averting Maternal Death and Disability Project (AMDD) are supporting Mozambique to increase the role of midwives in addressing HIV/AIDS in young women, and to reduce maternal and neonatal mortality. Despite significant improvements in national health indicators, Mozambique's health system does not reach all the population, the great majority of whom still live in rural areas. MOH aims to build on successes at district level, notably in the province of Sofala, which has reduced maternal mortality by increasing the effectiveness of facilities' response to emergencies. Sofala strengthened rural hospitals and health centres, improved transportation, communication and referral systems and developed human resources, in particular by supportive supervision for staff, many of whom are maternal and child health nurses with midwifery skills. UNFPA staff and others are convinced that this supportive supervision, along with stronger logistical support for supplies equipment and drugs, better record-keeping and regular monitoring and evaluations account for Sofala's success.

High levels of HIV/AIDS, and the large numbers of young women who become pregnant each year, threaten to undo this progress. Estimates suggest 60 per cent of all pregnant women are below 20 years of age. The MOH is hoping, with the support of UNFPA, other UN agencies and Save the Children Norway, to start a project focussing on HIV/AIDS, in which midwives will help educate communities, specifically young women, on preventing unwanted pregnancy, protecting themselves from HIV infection and reducing gender based violence. In addition, midwives and nurses with midwifery skills will offer practical help for the care of infants and women living with HIV/AIDS and for the prevention of mother-to-child transmission. UNFPA's technical support

has been greatly enhanced by a Swedish professional midwife who is working closely with her Mozambique national counterparts. The Swedish International Development Agency (SIDA), which generously provided support for her services, is supporting Bolivia and Bangladesh in the same way. After an evaluation SIDA hopes to extend this collaboration.

To help increase Mozambique's capacity for midwifery education and training UNFPA has distributed, with WHO, the *Safe Motherhood Midwifery Modules* in Portuguese (*Manual para Professores de Enfermagem Obstetrica*). These are now available in Maputo, Beira, and Nampula, and it is hoped that more will be distributed in 2007. Small discussion sessions have introduced the Modules to midwifery tutors and showed them how to use the materials in their teaching programme.

UNFPA has also supported the midwifery organisation APARMO (*Associação de Parteiras de Mozambique*) which will soon become a member of ICM. Finally, UNFPA is supporting MOH plans to review midwifery curricula, using the WHO/ICM *Strengthening Midwifery Toolkit*. UNFPA are advocating with stakeholders to demonstrate the potential of a well-trained midwife as a source of health information, specifically in regard to safe motherhood.

## 1.2 Addressing migration of skilled midwifery providers

Malawi has the capacity to produce its own trained midwives, but is still struggling to provide skilled care at birth. Malawi's maternal mortality is one of the highest in the world. UN estimates for 2000 indicated a figure of 1800 deaths per 100,000 live births, though government statistics have officially put it at 984 per 100,000 (DHS, 2004).<sup>xxxv</sup> Regardless of the actual figure, the situation for women in pregnancy and childbirth is very poor and does not appear to be getting any better. Malawi's constraints to ensure quality skilled attendance, despite a relatively high proportion of births in facilities, is traceable to the high rate of migration of healthcare professionals – particularly trained midwives – one of the highest in the region. A poor working environment and remuneration package also makes keeping women in the profession increasingly difficult. The working life of a midwife in Malawi is arduous, and attractive only to those with a true vocation, as a glimpse of a typical day clearly demonstrates (see Box 12).

xxxv: Malawi  
Demographic Health  
Survey, 2004

### *Box 12 – A Day in the Life of a Malawian Midwife*

A typical Malawian midwife is female and married. She starts her day at 5:30 a.m. First she lights a fire using charcoal or wood, unless she lives in town, where she may use a cooker or an electric hotplate. She makes sure her husband and children have had their baths and breakfast before they leave for work and school. In between all these activities she prepares herself for work.

She has to be at her duty station at the hospital 5 or 10 minutes before her shift starts at 7:30 a.m. If she is lucky she may have quarters in the hospital compound, but most midwives have to walk for 30 to 45 minutes or use local transport, if they can afford it.

In a busy maternity unit there should be two midwives on a shift, but it is not uncommon for one midwife to work the whole day by herself. She is expected to care for not less than 30 clients a day: admit patients; perform thorough physical examinations; monitor women in labour; conduct deliveries, and manage third stage and immediate care of the newborn. In case of a caesarean section she goes to theatre to receive the baby. She may conduct 10 or more deliveries in a shift.

It is also her responsibility to care for high-risk clients, such as those with pre-eclampsia and eclampsia. Ideally an obstetrician is supposed to conduct, or at least be present for, all high-risk deliveries. In Malawi, such assistance is a luxury, which means the midwife takes on full responsibility. She must command a number of skills; management of a breech or multiple-gestation birth, for example, or vacuum extraction in case of miscarriage, or dealing with complications such as the removal of retained placenta. There are times when she has not even the basic resources at her disposal and has to improvise, so that women and their newborns can count on at least some care.

At 5 p.m. the midwife hands over to her night duty colleague. She arrives home at 6 p.m., to be met by expectant children and because most midwives in Malawi are women, an eager husband. The same household chores she went through in the morning await her again at the end of her day. And for her unremitting efforts and for taking responsibility for so many lives, on average the Malawian midwife receives \$US100 per month.

Despite all these setbacks, Malawi's midwives continue to discharge their duties, tirelessly and diligently. They consider themselves to be in a noble calling, with a professional and moral responsibility to help mothers and their families. But it is no surprise that some midwives have been persuaded to migrate to other countries, where pay and conditions are better and the working environment more favourable.

The country's initiatives for safe motherhood and newborn health therefore include initiatives to encourage more trained midwives to stay in Malawi. UNFPA and its partners in Malawi, notably DfID, are working with the ministry of health on a comprehensive human resource plan. UNFPA is also assisting with expanding training institutions, so that they can increase enrolment of nurse/midwife trainees and other health care providers. Standards are required for this expansion, and for work to scale-up the community empowerment programme on reproductive health.

### *1.3 Establishing standards to improve quality of care*

Failure in quality of care is a major contributor to maternal death and severe morbidity. A recent assessment of maternal and neonatal health services in Zimbabwe by the ministry of health and child welfare, WHO, UNICEF and UNFPA, showed that in 2004, 50 per cent of the primary health facilities had no midwife in post.<sup>xxxvi</sup> The shortfall is greatest in rural areas. It is unlikely that the situation improved in 2006.

xxxvi: Assessment of Maternal and Neonatal Health Services in Zimbabwe. MOCHW, UNICEF, UNFPA, WHO, 2005

This is a very serious concern, given the central importance in Zimbabwe of having a healthcare professional with midwifery skills at the primary care facility. The community depends on the midwife to deliver quality services; to educate people about the many delays that can result in maternal death, and for early recognition, treatment and referral of complications.

The assessment also found that even where staff were in place, many obstacles prevented them from giving care, and especially making the interventions that could save lives. Many essential life-saving drugs were lacking; there were no accurate records and no transport for referral to higher-level care. UNFPA has been supporting training in midwifery for existing staff as well as improving the skills of working midwives to ensure they have the capacity to provide essential life-saving care. Revision of the regulatory framework under which midwives and nurses used to work has helped this work a great deal.

As the national assessment notes, however, training alone is not sufficient. Many health workers lack good standards and evidence-based protocols, even proper job descriptions. The country is fortunate in having a relatively strong basis of professional midwifery on which to build. UNFPA will collaborate with the professional associations of midwives, obstetricians and gynaecologists, and other professional groups.

Many low-income countries in the Asia Pacific region do not have a specialist cadre labelled “midwife”. In most of the countries, midwifery content is included in nursing programmes. As in other regions, some countries have a programme for nurses wishing to specialise in midwifery. The few countries that do offer a direct-entry programme usually offer it to girls who do not meet the entry requirement for nursing. These programmes are usually between a year and 18 months in duration. They often do not pay enough attention to critical thinking and decision-making, nor to life-saving skills – even though the training is primarily intended for midwives working at the community level, where they will often be the lone healthcare provider with little or no support or back-up. UNFPA and its partners are working hard with the respective ministries of health to help address these deficiencies. UNFPA also recognises that, at least in the immediate future, community-based midwives and others with midwifery skills will be required to take services to rural communities, where most people live.

**Bangladesh, Nepal and India** have multi-purpose midwifery-trained workers rather than community-based midwives as such – the auxiliary nurse-midwife, or in Bangladesh the family welfare visitor, and before that the lady health visitor. Most of these multi-purpose auxiliary healthcare workers have 18 months pre-service education and training, but, as with the programmes for nurses, the midwifery content is often very limited. For example, Nepal had only 14 weeks midwifery in the auxiliary nurse-midwife programme.<sup>xxxvii</sup> With support from all the health partners, including UNFPA, Nepal is now strengthening this programme. Pakistan on the other hand is just beginning to introduce a new community midwifery programme with assistance from UNFPA and other partners.

xxxvii: WHO/SEARO HR  
Safe Motherhood Needs  
Assessment For Nepal,  
December 2004  
Pakistan

Also in Nepal, UNFPA are partners in a national plan to introduce both a one-year specialization in midwifery for nurses, as well as a longer (three-year) direct-entry programme, for women who want to become midwives working primarily in the community. To ensure sufficient and appropriate hands-on practice and caseloads for all the students, Nepal is investing in midwifery-led birthing units. Such birthing units have proven popular and are well used by women.

In South-East Asia, for example **Cambodia, Laos, Vietnam and Yemen**, the midwifery education situation is equally poor. Here too there are efforts to address the problem. In Cambodia for example, UNFPA and its partners have supported the Ministry of Health in a comprehensive review of midwifery. Among low-income countries in the region, **Indonesia** has had the most publicity for its production of midwives.

Regulation and accreditation is a major issue in many countries across South and East Asia, where in the majority of cases there are very weak or no regulatory systems for midwifery providers, especially at the community level where most births still take place. In **Afghanistan** UNFPA is working closely to establish midwifery regulation and education, and support the new midwifery association.

Other initiatives supported by UNFPA include the development and implementation of policy dialogue and change, as in India, which now permits auxiliary nurse midwives,

the main community midwifery providers, to practice selected obstetric life-saving skills. India has also embarked on a very small pilot project to train professional nurse-midwife practitioners, able to function in both hospital and community settings. This programme does not yet have national approval or support and nurse-midwife practitioners are found in only a few of India's states.

To encourage regional dialogue and experience sharing, UNFPA has supported a number of region-wide activities, beginning with a workshop on skilled birth attendants in Islamabad, Pakistan in 2004 (see Box 13). The country technical services team for South and West Asia have also provided technical briefing to the Secretariat of SAARC (the South Asian Association for Regional Cooperation) on advocacy for investments in skilled birth attendants. UNFPA and its partners are taking energetic action to provide technical assistance and practical help for many countries in the region, as the following stories demonstrate.

### *Box 13 – Sharing Experience in Scaling-up Midwifery Capacity*

In 2004, the UNFPA country technical services team for South and West Asia organized a meeting in Islamabad, Pakistan, to discuss the issue of skilled birth attendants. Consensus was reached on the skills expected for community-level birth attendants who assist women who give birth in the family home: home births account for 50 per cent of the births in most countries in the region. The meeting concluded that with proper training and supportive supervision, midwives and others with midwifery skills working at the community level can contribute to national efforts for reducing maternal and newborn mortality and morbidity. The keys were proper training, stronger regulation and an accreditation system. The meeting also agreed that efforts to strengthen access to EmOC services must go hand in hand with strengthening basic maternity care at the community level, to facilitate better decision-making by families and avoid the delays in seeking treatment that cause most of the maternal deaths in the region.

In 2005, as a follow-up to the Islamabad workshop, WHO Regional Office for South and East Asia organized a further inter-regional workshop to consider what was required for strengthening regulation and accreditation of community-based midwives and others with midwifery skills. The workshop called for the regional standards for education and training of community-based midwifery providers, and regional advocacy for proper regulatory and accreditation systems. Agreeing that an accreditation system was essential to assure quality of care, participants requested technical support for follow-up workshops at country level to help develop their own frameworks, following regional guidelines. Participants called for UNFPA and WHO to advocate for midwifery legislation articulating the right of all women to a skilled and accredited midwifery provider. They felt that unless women knew they had a right to skilled care, increasing demand and use of midwifery services would be difficult in countries where women's empowerment was still a problem.

## 2.1 *Increasing Rural Communities' Access to Midwifery*

**Bangladesh** remains one of the few countries where life expectancy at birth is lower for females than males. While fertility and child mortality have fallen, maternal mortality and morbidity have only marginally declined, with the latest available figure derived from a large country-wide sample being still at 320 per 100,000 live births, which directly contributes to a high neonatal mortality rate.

With its vast population of 140 million, Bangladesh needs different approaches to overcome the big gap between the number of available midwives and the number required to ensure all women and newborns have skilled care at birth. Several categories of trained health personnel provide midwifery services, including nurses and family welfare visitors, but few offer care for home births. A number of country evaluations have found that most health workers lack essential midwifery skills, especially those related to saving lives. Although Government health facilities are available at all levels including the union (group of villages) level, more than 90 per cent of births are still conducted at home by traditional birth attendants or relatives, with no access to a skilled birth attendant. These helpers are not trained to recognize or respond to risk factors during pregnancy and delivery.

Bangladesh is training community-based skilled birth attendants to address this issue, with the support of WHO (which conducted the initial needs assessment) and UNFPA. The pilot programme has evolved into a joint national training programme by the Government of Bangladesh, supported by WHO and UNFPA. Pakistan is taking similar steps to increase the number of community midwives, as part of a comprehensive package of interventions including improving communication and transport systems.

## 2.2 *What is a community-based skilled birth attendant?*

The community-based skilled birth attendant is an accredited health care worker who must have had a minimum of 10 years basic schooling, be trained as a family welfare assistant or female health assistant and successfully complete a course of training. Community-based skilled birth attendants are proficient in all the core midwifery skills and competences needed to manage normal (uncomplicated) pregnancies and childbirth; to provide care for mothers and newborns in the immediate postnatal period, and to identify and refer complications after providing first-aid management to mother and newborn.

After revision in 2005, the course now encompasses a six-month basic course, a work-experience period with a defined set of targets and cases to be completed that will prepare them for an additional course of three months. Both the basic six-month and the additional three-month courses consist of competency-based modules employing adult learning approaches. On completion, community-based skilled birth attendants are certified and registered by the Bangladesh Nursing Council. UNFPA and WHO are strengthening the council's capacity to regulate and support the new cadre. (See Box 14)

## *Box 14 – Everyday Stories from Bangladesh*

The two short excerpts below are transcribed from stories told by a community-based SBA and a family welfare visitor (FWV). They give a vivid picture of midwifery work in Bangladesh.

### *A day in the life of a community-based skilled birth attendant (SBA)*

"I work as an SBA in the rural and remote community of Bangladesh. In my daily work I have to walk and cross many rivers. I do a lot of different things in my job. Sometimes I work in the vaccination programme, in the ORS [oral rehydration solution] programme, but mostly I work with maternal health. That is what I enjoy most. When I conducted my first delivery by my own hand I felt it was the most exciting event in my life. One of my main tasks is also to organize uttan boitok [a small courtyard session to teach families about birth preparedness, nutrition and other pregnancy related matters] and counsel the women and the mothers-in-law. I ask them at these meetings to call me when their labour starts. I am working around the clock. People can call me anytime. I would like to share one of my experiences at work.

"One morning in June at 4 a.m., a patient's husband came to call me. When I reached their house I took her history and they told me that her pains had started at 11 p.m. I examined her and the cervix was fully dilated, but the presenting part of the foetus was very high up: I could not reach it with my hand. The abdomen was big. The foetal movements and the foetal heart sound were normal. After waiting for some time I found that there was no progress in labour. I explained to the family that it is an obstructed labour and referred them to the district hospital. I told them that it was not possible to conduct this kind of delivery at home, that it would create problems for the mum and the baby. Initially they did not agree to take her to the hospital. After long discussions I was able to motivate the family to take her [to the hospital]. The consultant examined the patient. She said that she immediately needed a caesarean section. The family agreed to it. Through the c-section a healthy baby weighing 4.5 Kg was delivered. In the aim of saving the lives of the mother and the baby, we are the first line of defence. So I think I am the most fortunate person to have this job."

### *A family welfare visitor with midwifery skills tells her story*

*Family welfare visitors are posted in the health and family welfare centre where some of the referred cases from the SBAs will come. They will also attend deliveries at home on request. This is the story of a family welfare visitor who got her special midwifery training in 2004.*

"I usually attend about 14-15 deliveries a month and four or five take place at home. When people come to me for ante-natal care I always advise them that I am trained and that I am available to help them both in the clinic and at home during labour.

"One day when I was working in the family welfare centre there was this patient who I had given ante-natal care. She was pregnant for the first time and full term.

Her labour had started and they had tried with a TBA [traditional birth attendant] at home. When the TBA examined her she could feel the baby's fingers. She took the patient all the way to the family welfare centre. I was scared when I received the patient because there are no facilities for caesarean section in the clinic. I examined her and found that the cervix was fully dilated and the waters were clear. I also found the hand along with the head. There was no time to refer the patient. I also understood from my examination that it was a case of twins. I told the family about this. I was scared and I waited, but I put an intravenous drip with 1 ampoule of oxytocin on a slow pace. The first baby was delivered in cephalic presentation. After seven minutes the second baby was also born with the head first. The babies were big. The first one weighed 2750g and the second 2500g. There was no bleeding but I was afraid because the placenta was so big and I was worried about post-partum haemorrhage. I gave her two ampoules of oxytocin intra-muscularly and she was fine. I was happy everything went well but I feel I need more training on newborn care and resuscitation."

In **Pakistan**, UNFPA is supporting efforts to make services more widely available and more responsive to the needs of mothers and newborns, especially in rural areas. For example, UNFPA is providing assistance for the new 18-month community midwife programme (see Box 15). In addition to technical and logistical support, including refresher training for district midwife teachers and the refurbishment of many of the schools of midwifery, UNFPA is supporting refresher training for staff; capacity-building in facilities that manage maternal and neonatal complications, and increased referral capacity.

1. **UNFPA supports refresher training:** UNFPA and its health partners have provided refresher training for working midwives. In the UNFPA-assisted districts the emphasis has been on training midwives by district tutors at the district headquarters hospital.
2. **Promoting Interventions for Safe Motherhood project:** The project will assist the Government of Pakistan in midwifery skills training for selected community-based workers from the national programme on PHC/FP. Midwives already working in the project areas will be provided refresher training and inducted into the national programme on PHC/FP. The catchment area would be a rural population of 2000-5000, depending on the geography of the area. The project will expand in the focus districts as the national programme expands. In addition, the project will assist in community sensitization on maternal health; help develop a referral system for basic and comprehensive EmOC, help train necessary staff and strengthen schools of midwifery in the focus districts.
3. **Human resources support and focused innovations:** To meet the acute shortage of skilled human resources and permit round-the-clock basic and comprehensive EmOC service delivery, UNFPA is providing in-service training and salaries at first and second level health care facilities for gynaecologists, anaesthetists, women medical officers, nursing staff and lady health workers. This support is being gradually replaced by government efforts. Postgraduate trainees were rotated on a

monthly basis from tertiary hospitals to district headquarters hospitals for training in comprehensive EmOC service delivery and skill enhancement.

4. **Improving communication systems to save more mothers and babies:** lady health workers are trained to identify danger signs of pregnancy and refer complicated cases to health facility. Effective communication system is being established between lady health workers and health facilities to improve referral system and utilization of maternal, neonatal and child health services. Negotiation is in progress with phone companies to provide mobile and landline phones to LHWs for free connectivity during referral of patients to health facilities. Commercial use of the phones by the public will be a source of income for lady health workers.
5. **Revival of village health committees:** Each lady health worker has a village health committee and a women's social group in her catchment area. To enhance participation and ownership by the communities, lady health workers have been encouraged to conduct monthly meetings of village health committees to discuss maternal and neonatal health problems and suggest solutions. The team from the nearby health facility participates in the meeting and conducts a free medical camp on the community's doorstep. This activity has encouraged the participation of the community in maternal and neonatal health interventions and increased service utilization at the health facility.
6. **UNFPA support for wireless ambulance system:** Hospitals' ambulances were repaired to allow transportation of patients from community to health facility and from first-level health facility to referral facility. District governments funded wireless systems in the ambulances.

### *Box 15 – UNFPA Supports the Community Midwifery Curriculum in Pakistan*

After extensive consultations the Pakistan Nursing Council and UNFPA developed a new community midwifery curriculum in 2005. UNFPA, with the International Confederation of Midwives and John Snow Inc., also assisted the Council with development of a training manual, to be translated into Urdu and Sindhi. UNFPA supported training for 48 district midwife trainers from 10 UNFPA-focused districts, the strengthening of district community midwifery schools and training centres, and the creation of midwifery training resource centres.

### *2.3 The need for advocacy and high-level support for midwives*

Many countries in the region do not have experience of professional midwifery, calling for advocacy about its value for reducing maternal mortality. UNFPA country teams have been active on the issue, especially with policy-makers and politicians, as in Cambodia, as well as with the general public, as in Bangladesh (see Box 16).

### *Box 16 – Celebrating the International Day of the Midwife*

Bangladesh celebrated the International Day of the Midwife (5th May) for the first time in 2006. The Bangladesh Nursing Association and the Bangladesh Nursing Council, supported by UNFPA, arranged awareness raising rallies in the cities of Dhaka and Comilla, followed by a half-day seminar which resulted in the formation of a working group for midwifery issues.

**Cambodia** reintroduced training of midwives only in 1999 as the country emerged from one of the most devastating periods in its history. The many years of war and turmoil, and the cessation of midwife training for six years, left Cambodia with a huge gap in its midwifery workforce. Only three in 10 pregnant women have access to a midwife or other healthcare professional with midwifery skills during childbirth, and nine out of ten births still take place in the home. In some rural parts of the country figures for births attended by a midwife or skilled healthcare provider are even lower.

Not surprisingly, with this low level of coverage, maternal mortality in Cambodia remains one of the highest in the region, at 437 per 100,000 live births. Crude estimates suggest that midwifery coverage for 80 per cent of births would require more than 1,000 additional midwives. A specially-designed one-year programme began in 2005, which will produce nearly 200 new midwives each year; but it is feared that even this is well below what is required. A third of Cambodia's midwives will reach retirement age in the next five years, making meeting national requirements even more difficult.

Cambodia has given high priority to improving reproductive, maternal and child health and to increasing the availability of midwives. These priorities are clearly highlighted in the Cambodian Millennium Development Goals and the National Strategic Development Plan 2006-2010. The goals were reinforced during a two-day national midwifery forum co-sponsored by the government and UNFPA in December 2005, which brought together policy-makers, midwives including the Cambodia Midwives Association, and development partners, to consider what can be done to improve the situation of midwifery in Cambodia. The forum spurred action and commitment to addressing the national shortage of midwives, including agreement to conduct a comprehensive review of midwifery.

The review, conducted between July and September 2006, suggested action to address midwifery coverage; competencies of midwives; recruitment, retention and deployment issues including incentives, and strategies for making midwifery more attractive. The review, supported financially by UNFPA, had the backing and support of not just all the health partners, but other sectors, including the ministry for education, youth and sport and the civil service secretariat. The Review provided a focus for consensus and collaborative action to ensure reproductive health care for all women and newborns.

UNFPA's work around gender, to improve the status of women, to ensure quality birth spacing services and to protect adolescent reproductive health, will all support an increase in midwifery capacity and coverage. Work on adolescent reproductive health is particularly important, given the numbers of young people who will soon enter their reproductive years. The huge number of adolescents threatens to compromise the government's efforts to provide healthcare for its entire people. Delaying onset

of marriage and first pregnancy will be crucial, to give the MOH time to increase the numbers of midwives and service delivery points. The UNFPA country office is already working with MOH and the Cambodia Midwives Association to hold a follow-up national midwifery forum, to consider recommendations from the 2005 forum and the findings and proposals of the comprehensive review.

#### *2.4 Midwives delivering quality integrated reproductive health services*

In **Mongolia**, as in Nepal, UNFPA and its partners are assisting the ministry of health to update and further improve midwives' integrated reproductive health skills. The services that midwives provide include antenatal care; family planning counselling and services; handling of partogram; maintaining infection prevention procedures; assistance for the doctor in the management of obstetric complications and care during childbirth; newborn resuscitation and breastfeeding. In addition they maintain medical records related to maternal and newborn care.

In both Mongolia and Nepal, as in many countries in the region, in the absence of the doctor the midwife should be able to manage childbirth, including stabilizing and managing the referral of women or babies with complications.

In **Mongolia** between 1997 and 2006 UNFPA assisted with the assessment of training needs of midwives; development of training modules on essential and emergency obstetrics care, and training of trainers and local training for midwives. The training curriculum included family planning; updates on obstetric practices; infection prevention and syndromic management of STIs. More than 90 per cent of midwives in UNFPA-supported districts have been trained. Reproductive health clinical guidelines adapted to the Mongolian context were provided to all midwives.

In 2005 the Health Science University of Mongolia and UNFPA jointly assessed the undergraduate reproductive health core curriculum. Some of the main findings were:

- Insufficient training manuals and textbooks;
- Continuing use of a textbook translated from Russian and focused on curative rather than preventive care;
- Need to provide training institutions with training supplies for clinical skill development;
- Too many students at the hospital at the same time, affecting the quality of training and overburdening medical facilities

With technical assistance from UNFPA and experts from New South Wales University, the Health Science University of Mongolia developed a new reproductive health undergraduate training core curriculum which nursing schools now use in routine training sessions.

In 2006, the UNFPA regional support office in the western region of Mongolia conducted an assessment of the training needs of midwives in Khovd Province, one of the UNFPA focus provinces. Major findings were:

- 76 per cent of reproductive health services at *soums* (county) level rely on midwives.

- Although the project trained midwives in reproductive health, they needed both refresher and more practical hands-on training.
- Midwives need to get involved in experience sharing and exchange programmes and have great interest to learn from each other.

Although the assessment found that more midwives should be involved in experience sharing, midwives have since as early as 1994 been involved in Mongolian Federation of Obstetrics and Gynaecology seminars. For example the Association of Obstetrics and Gynaecology 2005 Pre-congress on “Improving Women’s Health–Learning by Sharing Experiences” in Ulaanbaatar included 150 obstetricians and midwives from all 21 provinces and nine districts. During the pre meeting the Federation established an educational trust fund with a seed grant of \$US4000 to develop strategies to promote midwifery practice in Mongolia. A midwifery association has now been established in several provinces and the capital city.

In **Nepal** UNFPA has worked with the ministry of population and health to develop a comprehensive strategic plan for the supply of skilled midwifery providers. In support of the national safe motherhood policy 1998, UNFPA Nepal continues to support basic and refresher training to auxiliary nurse-midwives and maternal and child health workers, to build their capacity in midwifery skills. These are the only front-line health workers at community level and in remote areas trained to assist women during birth. They can provide rural women with reproductive health care services, including care for normal pregnancy and childbirth and obstetric first aid. They are trained to recognize complications, stabilize the case and make referrals to the appropriate health facility.

To equip these different health workers to provide care at birth, whether at home or at a community level facility, a specially-designed EmOC kit is given to each trainee on completion of the competency-based refresher training.

As part of its contribution to skilled birth attendant policy development, UNFPA Nepal took the lead in reaching consensus on a definition of the SBA for Nepal. This definition recognized that the central competencies needed to assist women and newborns, especially during the critical time around birth, are those of a midwife. Since Nepal does not have a specialist cadre of midwife, UNFPA assisted in the development of an SBA policy, which has in turn contributed to the development of human resource strategy for the safe motherhood programme, designed to increase midwifery skills and capacities nationwide.

In 2006, UNFPA Nepal began a number of activities to implement this strategy:

1. **Accreditation of SBAs:** UNFPA is standardising the accreditation of SBA in collaboration with the Government, the Nursing Council of Nepal and major stakeholders. A workshop at the end of 2006 developed a national road map for implementation of the national SBA Policy.
2. **Contribution to development of master health training plan:** In line with Nepal’s health sector reform programme implementation plan, the National Health Training Centre is developing a five-year master training plan (which also includes an a master training plan for increasing the skills of healthcare providers to function as skilled birth attendants) with UNFPA’s financial and technical support.

3. **Contribution to revision of curriculum of midwives:** UNFPA has provided technical assistance to revise and update the pre-service training curriculum of nurses in midwifery skills, and helped review and comment on the new four-year pre-service curriculum for community midwives.
4. **Contribution to establishment and upgrading of EmOC:** UNFPA has made contributed to establishing and operationalizing basic emergency obstetric care sites in selected provincial health centres.
5. **Operationalization of maternity waiting homes:** 28 homes constructed in UNFPA's last country programme cycle are being operationalized in selected districts.
6. **Contribution to birth preparedness:** UNFPA supported the government in piloting a specially designed birth preparedness package for pregnant women, their families and the community, to prepare them for safe delivery.

UNFPA contributed in many other ways in 2006 to ensuring that more women and newborns were able to receive skilled midwifery care, including referral and emergency care when needed. In particular, UNFPA has assisted MOH to establish an emergency obstetric care fund; provide cycle ambulances, and advocate in selected districts for more women to give birth in an institution. In addition, UNFPA has provided bicycles for skilled healthcare providers, which has increased the proportion of home births they can attend. They can reach women's homes more quickly which improves care overall, but also gives more time to detect complications, provide obstetric first aid, stabilize the woman and refer her to the appropriate health facility.

Although the greatest needs are in Africa and Asia, the same issues are found in almost all other countries, even the industrialised countries with low maternal mortality. For the Arab states and neighbouring countries in the Mediterranean and for most of Eastern Europe and Central Asia, the major efforts are increasing quality of midwifery care, as **Egypt, Morocco and Tunisia** have done in recent times. In most of these countries midwives have little status and midwifery is a branch of nursing, although this is changing slowly in countries such as Morocco. Many of the Central Asian republics have midwives with specialized training and functions. Many of the Mediterranean, Eastern European and Central Asian countries that UNFPA works with, except **Sudan**, do not have specially-trained midwives or midwifery programmes. In these countries improving the quality of midwifery care is part of more general programmes.

In some of these countries most women give birth in an institution, and many more births are supervised by physicians. This tends to relegate midwives to the status of maternity nurses, assistants to physicians. In a number of countries, especially in Eastern Europe, there are still large communities of professional midwives who are trying to stop what is seen as the systematic downgrading of midwives. In other countries civil unrest presents obstacles to improving the quality of maternal and newborn healthcare.

### *3.1 Responding to healthcare reforms*

**Morocco, Egypt and Tunisia** among several other countries in the region have invested in training midwives and others with midwifery skills to improve the quality of maternity care, especially the management of obstetric complications.

Moroccan midwives have three years of training without specific focus on community midwifery. Very few are posted in remote health centres because they are isolated, without communication, accommodation, social integration, or support from the medical establishment. The government, with UNFPA support, has begun to address these problems through clinical and community support visits. The visits, by district teams and managed by the district, strengthen midwives' social (empowerment, integration), clinical (competency and self confidence) and managerial (capacitating) functions. A manual has been developed on the basis of experience so far.

Morocco is also building on experience in maternity waiting homes and community-based insurance schemes. Much of this work is a result of an in-depth reform of human resources by MOH, with the support of donors and UN partners including UNFPA. This reform, responding to ever-growing demand, has particularly involved health professionals concerned with maternal and neonatal mortality and morbidity reduction, as well as reproductive health.

Reform of midwifery training, planned since 1994, has addressed issues observed since Independence: too few midwives; too limited training; too little practical, competency-based training, and confusion between tasks and qualifications. The results are encouraging:

- Twenty-five training institutes have been opened in all parts of the country; 1000 new nurses a year have received midwifery training. There are also 250 direct entry (non-nurse) midwives.
- New posts have been created in peripheral facilities, particularly in rural areas, mostly for female nurses and midwives.
- New regulations specify that basic training for midwifery should begin no less than three years after end of secondary school.
- Improved pedagogic methods and a permanent feedback system between students and teachers are in place.
- Curricula have been revised to adapt to ever-changing techniques and knowledge.
- New modules have been added to the curriculum on family planning, neonatal care, EmOC, and gender.
- UNFPA-funded research and surveys are gathering feedback from new graduates posted in rural districts on their conditions of life and work.

Tunisia's impressive improvements in maternal mortality over the last three decades also owe much to government efforts to extend maternal health services to all women and families, offering the best quality of care possible, creating a clear referral mechanism for women with high risk pregnancies, and developing mobile outreach services for rural communities. Training for all healthcare providers, including midwives, has been central to all these efforts; with the continuing support of UNFPA they will continue to provide high-quality care.

Despite this progress, recognition of the midwife as a professional is still in its early stages. As a quick glance at the history shows (see Box 17), midwifery training in Tunisia began not with a direct entry model, but with express training to nurses. As nurses came to appreciate what was required to be a competent professional midwife and evaluations showed its shortcomings, this initial training was lengthened to a three-year programme, in keeping with other countries in Northern Africa and Europe.

Although the position of the midwife is still being debated, and she has as yet little recognition as members of autonomous profession, midwifery is growing in stature year by year, with a critical role in national strategies for preventive and curative health care. To help this process, the midwifery curriculum needs updating, mostly to develop critical thinking to secure a more active and effective place for midwives in the policy dialogue. This would strengthen the privileged position the midwife has always had in Tunisia. In addition to their position as the exclusive provider of perinatal services, midwives are now involved and being proactive in advising and counselling women for newly introduced components of reproductive health such as breast cancer screening and menopause. The midwife has much to offer as a listener and coach for young people in the various aspects of sexual and reproductive health.

### Box 17 – History of Midwifery Training in Tunisia

- 1956 – basic training for midwifery, as a short training (six months) for obstetrical nurses;
- 1967 – length of training extended to three years;
- 1979 – designation of *High Technician in Health* and definition of status, outlining the role of the midwife;
- 1985 – elaboration of a professional profile;
- 1987 – reform of the midwifery curriculum.

Over five decades, the demographic structure has changed, from a very young population with more than 50 per cent under 15 to a more balanced age profile, with more men and women in their reproductive years. This has brought the demand for new midwifery services. National policy recognizes this and continues to invest in midwives to keep them up to date and become more intellectually involved in national policymaking. Midwives are now more able to give adequate answers to requests for more and better information on sexual and reproductive health. As such they are not only better able to contribute to national objectives in reproductive health, including reducing maternal and neonatal mortality and morbidity, but are becoming an autonomous, responsible and challenging profession.

### 3.2 Increasing access through community midwifery

The Sudan has a long history of training midwives, in particular young local women, to work in the community. In the 1920's Sudan opened specialist schools of midwifery, mainly through the efforts of physicians concerned with the appalling rate of maternal death. The initial programme was a pioneer in its time, in that it took local girls, many of them daughters of TBAs, and gave them formal training. However, the programme did not lead to a strong professional cadre of midwives, and in 2006 midwives do not enjoy the same status as nurses, although it is a well-respected occupation in the community, especially in rural areas.

Families will allow their daughters to train as midwives, and a new 18-month curriculum has been designed specifically to take account of the poor educational level of women in the country. However, lack of investment and many years of civil unrest have made it impossible to move midwifery to a professional standing and there has been little attention to creating an enabling environment for community midwives. UNFPA and its partners are working to redress some of these shortfalls and, following the peace agreement, to re-establish midwifery in the South.

The long years of internal disagreements between North and South have left South Sudan with very few trained midwives and almost no training centres. UNFPA has for many years supported efforts to increase the training capacity for midwifery in Sudan. Since 2005 these efforts have addressed the midwifery situation in the South, so that women and newborns can have access to skilled care, especially at and around the time of birth.

The comprehensive peace agreement signed in 2005 marked the beginning of a new era. Under the rubric of "One country, two systems" The Government of National Unity

and the Government of Southern Sudan have begun, with the aid of the international community, a joint effort to reverse the effects of decades of conflict and build a sustainable peace. Currently data collection in Southern Sudan is weak and there are few reliable reproductive health indicators. The provision of health services depend on the efforts of the few NGOs able to function in the country and are far from adequate.

Estimates suggest that only 16 per cent of all pregnant women have access to antenatal care, although the figure is rising. Most births take place in the home with care provided by a well meaning but insufficiently skilled local TBA. Absence of skilled care, coupled with the inadequate infrastructure, not surprisingly results in a very high MMR. Estimates suggest around one in nine women die from complications of pregnancy or childbirth.

To address this situation UNFPA Sudan commissioned the African Medical and Research Foundation (AMREF) to undertake a rapid reproductive health needs assessment, specifically to map the available environment for conducting midwifery training in Southern Sudan. A consultative workshop in May 2005 explored options for developing a training programme for midwives at the community level. A diverse group of health partners, including the Sudan Secretariat of Health, WHO, UNFPA and other health partners including the NGO community agreed upon a way to introduce training for midwives at the community level. The health partners are using the recommendations of this workshop to develop an action plan.

### *3.3 Supporting professional midwifery in Yemen*

UNFPA supported the establishment of the National Yemeni Midwives' Association, in collaboration with USAID, to enable them to advocate for better education and service provision, and to provide the self-regulatory systems necessary to improve quality of care. The project supported the first general assembly meeting, training for board members and health awareness activities, and established an income-generating reproductive health/family planning clinic.

The National Yemeni Midwives' Association will assist in the selection of midwives for training, curriculum revision, and development of a code of ethics for midwifery practice.

### *3.4 Training community midwives*

Between 1998 and 2004 the Ministry of Public Health and Population in collaboration with UNFPA office and funded by the Royal Netherlands Embassy, trained 1282 community midwives, upgraded *murshidat* (primary health workers), and trained trainers. A committee from the targeted rural area selected the candidates and participated in all aspects of the training, encouraging a feeling of community responsibility and ownership. The community contributed the students' housing and food to supplement stipends provided by the project. This involvement ensured good communication between trainees and the community, with follow-up and on-going training and support to ensure continuity of training.

Community training of midwives differs from traditional training at an institute, emphasizing behaviour change communication about reproductive health/family

planning, nutrition and hygiene; and on-the-job training in the community, with home deliveries and house visits. Two trainers live in the hostel with the trainees for the whole two-year training period. The project brought reproductive health services to some communities for the first time, and midwife-attended births increased. Selecting and training within communities maintained the trainees' connections with community and family, and increased the likelihood that they would continue to serve. School directors in the community reported that families were allowing their daughters to continue formal schooling so that they might be selected for midwife training. The project has generated demand for similar midwifery training in other communities.

*Arab States,  
Europe and  
Central Asia*

# Latin America and the Caribbean

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## 4

xxxviii: PAHO/WHO.  
Profiling Midwifery  
Services in the Americas.  
Models of Childbirth Care:  
a literature review. PAHO,  
Washington DC, 2004

In Latin America, the picture for midwifery is very different from other parts of the world. Very few countries in Latin America have a history of midwifery specialization; births in a health facility are under the control and supervision of a medical physician, or specialist gynaecologist/obstetrician with a nurse assisting the physician. **Chile** and **Argentina** are two exceptions, although **Bolivia**, **Peru**, **Nicaragua** and **Haiti** are beginning new programmes with UNFPA assistance.<sup>xxxviii</sup> **Mexico** is also working on improving access to quality midwifery care. The government recently approved an innovative midwifery programme aimed at indigenous women: although operational in only one area at present, the programme is proving very popular and has had positive evaluations.

Unlike many of their close neighbours, many Caribbean countries do have professionally-accredited midwives and there is a strong history of midwifery. Although midwifery care and many midwifery programmes today fall under the remit of nursing services, many Caribbean countries are seeing a renaissance in midwifery. For example, **Trinidad and Tobago** has a strong professional association of midwives, despite being relatively new members of ICM. Trinidad and Tobago hosted the ICM Americas Regional Conference for Midwives in 2004 and welcomed many midwives from around the world. The **Dominican Republic** is struggling to revise the content of its curriculum for the nurse-midwife programme to meet national needs for improving the quality of maternity care.

In Latin America as in other regions, lack of professional autonomy and the rise in medical interventions stand in the way of recruitment to midwifery programmes and a higher profile for midwifery in general. UNFPA, with WHO and other partners, including the American College of Nurse Midwives and educational institutions in the United States, are helping schools of nursing and schools of midwifery across Latin America develop midwifery specialization programmes. Chilean midwives, known as *Matronas*, enjoy a relatively high reputation; but there are very few efforts in Latin America to follow the Chile model of direct-entry midwifery. The Chilean midwifery programme dates back to the 1930's. It has a heavy focus on community midwifery and is five years in length, including a period of internship. UNFPA is providing technical support for similar programmes in Bolivia, Peru and Haiti which will emulate some of these features.

### 4.1 *Making midwifery accessible to rural and indigenous populations*

Among the most important issues for increasing midwifery capacity in Latin American and the Caribbean are making midwifery more accessible and acceptable to rural and indigenous populations, who are traditionally isolated from formal healthcare and do not find modern institutional birthing culturally acceptable.

Although there are only a few countries in Latin America with accredited professional midwives, a number of countries have non-accredited, non-formal training programmes for midwifery practitioners. Most of these programmes are offered by NGOs and are not recognized by the MOH. They do not lead to formal State recognition or confer a legal right to practise midwifery.

**Mexico** however is striving to reverse this by introducing professional midwifery. The Ministry of Health and Ministry of Education have approved a new and innovative programme of midwifery, which merges the midwifery practices of traditional birth attendants (known as and referred to as traditional midwives) with modern midwifery practice including life-saving skills. The programme was started in 1996 by *Centro para Los Adolescentes de San Miguel de Allende (CASA)*, see Box 10) which had been providing training and education to traditional midwives since 1985 together with general community-based education and efforts for women's empowerment.

Recent evaluations of this programme have shown very positive results; when in 2005 the Federal Health Ministry gave one of its top awards to a rural health clinic for exemplary teamwork, the midwife in the team was a CASA graduate.

The unique merging of cultural traditions as practised by CASA could be one way to improve the capacity of midwives and increase numbers of midwives trained, without losing the focus on women, and at the same time preserve traditional knowledge and ways of knowing. It could also help to maintain long-held cultural traditions that help to keep childbirth a normal event, of importance in a community. Taking local women with a history and family connection to midwifery and providing them with high-quality, culturally-appropriate education that has a heavy focus on skills development will also help to increase midwifery coverage among rural populations. Midwifery recruits who are well established and settled in the community are more likely to stay and practise their skills locally.

#### 4.2 Raising the profile of midwifery and increasing professional autonomy

In **Bolivia**, on average only 56 per cent of births are assisted by a skilled birth attendant and in the rural areas only 34 per cent.<sup>xxxix</sup> UNFPA is currently working with WHO and other partners on a pilot project to institutionalize career training in midwifery in the university system of Bolivia. The aim is ultimately to increase both demand and access to a skilled provider. The proposal is to develop a career pathway for midwives in Bolivia by introducing a Bachelor of Midwifery degree. The programme will pay particular attention to socio-cultural aspects of birth and to culturally appropriate, women-centred care. Many women in Bolivia say that respectful treatment and care is crucial for them, and the condescending attitude of providers is the major factor in deciding not to use existing maternal health services.<sup>xl</sup>

xxxix: Bolivia, *Post-census Survey on Maternal Mortality*, 2000

Many decision makers in Bolivia would have preferred a much-abbreviated fast-track system for developing midwives. However, after the *World Health Report 2005* and a positive approach by UNFPA, aided by one of the three Swedish midwives sponsored by the Swedish International Development Agency, they accepted that a formal programme was the only way to make midwifery in Bolivia a respected career.

xl: Ministry of Health and Sports, *Guide for the Development of an Intercultural Approach within the Attention of Maternal Health*, La Paz 2005.

The first steps in this project, along with general advocacy to make the proposal known to everyone in Bolivia, is to prepare the curriculum and to train midwifery teachers. Authorities from the universities, Nurses' College and MOH with assistance from UNFPA, PAHO and midwifery experts from Peru and Chile, will develop an intensive, culturally-sensitive programme for midwifery teachers. Part of this training will be undertaken in Peru and Chile, given that these two countries have some of the strongest and most longstanding midwifery programmes in the region.

# Glossary of Terms

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Midwifery (French <i>la pratique de sage-femme</i> ; Spanish <i>partería</i> ; Arabic <i>kebela</i> )	The scope of professional midwives' practice. The art and science of assisting a woman before during and after labour and birth
Midwife ( <i>Sage-femme</i> ; <i>Matrona</i> )	An accredited (qualified) healthcare practitioner who assists women in pregnancy, throughout labour and childbirth and cares for women and babies in postnatal period. She has an important promotive and preventative function in broader reproductive health, health advocacy, empowerment of women and neonatal health. (See Annex 6 and International Definition of a Midwife: <a href="http://www.internationalmidwives.org">http://www.internationalmidwives.org</a> )
In the community ( <i>Dans la communauté</i> ; <i>En la comunidad</i> )	Level of health system close to where families live, e.g. government, private or NGO health post or clinic, or the family home (sometimes referred to as primary health care level)
Midwifery workforce ( <i>Les professionnels compétents dans la pratique de sage-femme</i> ; <i>Personal calificado de partería</i> )	Healthcare workers whose primary functions include health care to women in pregnancy and throughout labour and birth, and to mothers and babies in the postnatal period.
Midwifery workforce ( <i>Les professionnels compétents dans la pratique de sage-femme</i> ; <i>Personal calificado de partería</i> )	Total workforce needed for maternity care. The category includes midwives and others with midwifery skills; obstetric and surgical staff; paediatric (neonatal) physicians and nurses; laboratory technicians, radiologists and other specialists.
Maternity support workers ( <i>Les agents communautaires de santé maternelle</i> ; <i>Asistentes de maternidad</i> )	Healthcare workers, community workers and others, including traditional healers and others, who work and have links with the midwifery workforce. They play an important role in supporting women's and newborns' access to skilled care for safe pregnancy and childbirth, including postnatal and neonatal healthcare.

<p>Emergency obstetric care (EmOC), basic and comprehensive (<i>Les soins obstétricaux d'urgence (SOU) de base et complets; Cuidados Obstétricos de Emergencia (COEm) basicos y ampliados</i>)</p>	<p>Consists of eight signal functions: Basic: Parenteral administration of antibiotics oxytocics and anticonvulsants; manual removal of the placenta; manual vacuum aspiration; vacuum extraction; plus stabilization of woman for referral, pre-referral care and referral. Comprehensive: all the above plus surgery (caesarean) and safe blood transfusion.</p>
<p>Emergency obstetric and neonatal care (EmONC) (<i>Les soins obstétricaux et néonataux d'urgence [SONU]; Cuidados obstetricos y neonatologicos de emergencia [CONEm]</i>)</p>	<p>Consists of nine signal functions: Basic: Parenteral administration of antibiotics, oxytocics and anticonvulsants; manual removal of the placenta; manual vacuum aspiration; vacuum extraction; neonatal resuscitation; plus stabilization of woman and newborn for referral, pre-referral care and referral. Comprehensive: all the above plus caesarean surgery and safe blood transfusion</p>
<p>Skilled care for pregnancy and birth (<i>Soins obstétricaux qualifiés; Atención calificada durante el embarazo y el parto</i>)</p>	<p>“Skilled care” denotes a skilled attendant assisting pregnancy and birth in an enabling environment, supported by a functional referral system.</p>
<p>Competency</p>	<p>The knowledge, skills, attitudes and experience required for individuals to perform their jobs correctly and properly.</p>
<p>Skills</p>	<p>Abilities learned through training or acquired by experience to perform specific actions or tasks. Usually associated with individual tasks or techniques, particularly requiring the use of the hands or body.</p>
<p>Core competencies</p>	<p>An area of specialized expertise such as midwifery made up of a combination of complementary skills and knowledge bases (i.e. more than one knowledge base) embedded in that group's, team's or professional cadre's expertise. Descriptions of core competencies are found in the joint ICM/WHO Manual.</p>

MDG-5

The fifth of the Millennium Development Goals adopted by world leaders at the Millennium Summit at the United Nations in the year 2000, with the aim of halving extreme poverty by 2015. The goal is to reduce the maternal mortality ratio by three-quarters of its 1990 value.



# Websites

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UNFPA: [www.unfpa.org](http://www.unfpa.org)

WHO: [www.who.int/reproductive-health/](http://www.who.int/reproductive-health/)  
[www.who.int/makingpregnancysafer](http://www.who.int/makingpregnancysafer)  
[www.paho.org](http://www.paho.org)

UNICEF: [www.unicef.org](http://www.unicef.org)

International Confederation of Midwives: [www.internationalmidwives.org](http://www.internationalmidwives.org)

Family Care International: [www.familycareintl.org](http://www.familycareintl.org)

AMDD: [www.amddprogram.org](http://www.amddprogram.org)

IMMPACT: [www.impact-international.org](http://www.impact-international.org)



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