THE STATE OF THE

WORLD'S MIDWIFERY

2014

A UNIVERSAL PATHWAY. A WOMAN'S RIGHT TO HEALTH

UNFPA

International Confederation of Midwives
Strengthening Midwifery Globally

World Health Organization

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ABBREVIATIONS AND ACRONYMS

AAAQ	availability, accessibility, acceptability and quality
AVD	assisted vaginal delivery
B-EmONC	basic emergency obstetric and newborn care
C-EmONC	comprehensive emergency obstetric and newborn care
CHW	community health worker
CMDP	Community-based Midwifery Diploma Programme
EC	emergency contraception
EmONC	emergency obstetric and newborn care
GIS	geographic information system
GPS	Global Positioning System
HCPAs	health-care professional associations
HRH	human resources for health
ICM	International Confederation of Midwives
ICN	International Council of Nurses
ISCO	International Standard Classification of Occupations
MDG	Millennium Development Goal
MMR	maternal mortality ratio
NMR	neonatal mortality rate
MNH	maternal and newborn health
NGOs	non-governmental organizations
PMNCH	The Partnership for Maternal, Newborn & Child Health
SRMNH	sexual, reproductive, maternal and newborn health
SoWMy	State of the World's Midwifery
STIs	sexually transmitted infections
TBA	traditional birth attendants
UNFPA	United Nations Population Fund
UHC	universal health coverage
WHO	World Health Organization

Cover photos (left to right): Viviane Fortaillier, Viviane Fortaillier, ICM/Liba Taylor, Save the Children

THE STATE OF THE WORLD'S MIDWIFERY **2014**

A UNIVERSAL PATHWAY. A WOMAN'S RIGHT TO HEALTH

Foreword

The world has reached a turning point for women's and children's health. We can now celebrate the fact that maternal, neonatal and child mortality rates are at their lowest levels in history. We are poised for even greater progress thanks to the *Every Woman Every Child* initiative, our progress toward achieving the Millennium Development Goals, as well as the ongoing discussions regarding a set of global sustainable development goals to succeed the Millennium Development Goals after their target completion date of 2015.

This report links two specific areas of focus that I care deeply about: first, maternal and newborn health, and second, the overarching principles and values of the post-2015 development agenda, providing new evidence for decision-makers.

The midwifery workforce, within a supportive health system, can support women and girls to prevent unwanted pregnancies, provide assistance throughout pregnancy and childbirth, and save the lives of babies born too early.

With leadership and resources, the world can prevent the vast majority of avoidable yet tragically common losses of life and address the vicious cycle of impoverishment that ensues.

The *State of the World's Midwifery 2014* documents growing momentum since the first call to action in the 2011 report. Every year, more governments, professional associations and other partners are acting on the evidence that midwifery can dramatically accelerate progress on sexual, reproductive, maternal and newborn health and universal health coverage.

I fully support the Midwifery 2030 vision articulated in this report. This vision is within reach of all countries, at all stages of economic and demographic transition. Its implementation will help governments to deliver on women's right to health, ensure that women and newborn infants obtain the care they need, and contribute to our shared, global ambition to end preventable maternal and newborn deaths.

I commend this report to all those interested in joining the United Nations as we work towards the Midwifery 2030 vision and improve the future of women's and children's health.

Ban Ki-moon
Secretary-General of the United Nations

Executive Summary

The State of the World's Midwifery (SoWMy) 2014: A Universal Pathway. A Woman's Right to Health takes its inspiration from the United Nations Secretary-General's *Every Woman Every Child* initiative and his call to action in September 2013 to do everything possible to achieve the Millennium Development Goals (MDGs) by 2015 and work towards the development and adoption of a post-2015 agenda based on the principle of universality.

SoWMy 2014's main objective, agreed at the 2nd Global Midwifery Symposium held in Kuala Lumpur in May 2013, is to provide an evidence base on the state of the world's midwifery in 2014 that will: support policy dialogue between governments and their partners; accelerate progress on the health MDGs; identify developments in the three years since the *SoWMy 2011* report was published; and inform negotiations for and preparation of the post-2015 development agenda.

SoWMy 2014 focuses on 73 of the 75 low- and middle-income countries that are included in the "Countdown to 2015" reports. More than 92% of all the world's maternal and newborn deaths and stillbirths occur within these 73 countries. However, only 42% of the world's medical, midwifery and nursing personnel are available to women and newborn infants (hereafter 'newborns') in these countries.

Midwifery is a key element of sexual, reproductive, maternal and newborn health (SRMNH) care and is defined in this report as: the health services and health workforce needed to support and care for women and newborns, including sexual and reproductive health and especially pregnancy, labour and postnatal care. This enables analysis of the diverse ways in which midwifery is delivered by a range of health-care professionals and associate professionals.

SoWMy 2014 has been co-ordinated by the United Nations Population Fund, the International Confederation of Midwives and the World Health Organization on behalf of government representatives and national stakeholders in the 73 countries and 30 global development partners.

It has been widely acknowledged that investing in a proficient, motivated midwifery workforce has a great impact on maternal and newborn health. *(Jhpiego/Kate Holt)*

Tangible progress has been made in improving midwifery in many countries since the *SoWMy 2011* report: 33 of the 73 countries (45%) report vigorous attempts to improve workforce retention in remote areas; 20 countries (28%) have started to increase recruitment and deployment of midwives; 13 countries (18%) have prepared plans to establish regulatory bodies; and 14 (20%) have a new code of practice and/or regulatory framework. Perhaps the most impressive collective step forward is the improvement in workforce data, information and accountability, reported by 52 countries (71%).

The evidence and analysis in *SoWMy 2014* is structured by the four domains that determine whether a health system and its health workforce are providing effective coverage, i.e. whether women are obtaining the care they want and

Not all countries have a dedicated professional cadre focused on supporting women and newborns. *(Mamaye Sierra Leone)*

need in relation to SRMNH services. These four domains are: availability, accessibility, acceptability and quality.

Availability: *SoWMy 2014* provides new estimates of the essential SRMNH services needed by women and newborns. This need for services, in each country, can be converted into the need for the midwifery workforce.

Midwives, when educated and regulated to international standards, have the competencies to deliver 87% of this service need. However, midwives make up only 36% of the reported midwifery workforce: not all countries have a dedicated professional cadre focused on supporting women and newborns. Instead there is diversity in the typologies, roles and composition of health workers contributing to midwifery services, and many of these workers spend less than 100% of their time on SRMNH services.

The new evidence on diversity presented in *SoWMy 2014* can inform policy and planning. Firstly, the availability of the midwifery workforce and the roles they perform cannot be deduced from job titles. Secondly, the full-time equivalent midwifery workforce represents less than two thirds of all workers spending time on SRMNH services. Therefore, any analysis comparing or correlating the midwifery workforce with SRMNH outputs/outcomes should take full-time equivalent staffing as the measure of availability.

The evidence identifies opportunities to: align job titles, roles and responsibilities; strengthen linkages between education and employment: improve efficiency; and assess and reduce high levels of turnover and attrition. In particular, progress is required on the identity, status and salaries of midwives, removing gender discrimination and addressing the lack of political attention to issues which only affect women.

Accessibility: Although nearly all of the 73 countries recognize the importance of financial accessibility and have a policy of offering at least some essential elements of SRMNH care free of charge at the point of access, only 4 provide a national "minimum guaranteed benefits package" for SRMNH that includes all the essential interventions. Gaps in the essential interventions include those known to reduce the four leading causes of maternal mortality: severe bleeding; infections; high blood pressure during pregnancy (pre-eclampsia and eclampsia); and unsafe abortion.

Lack of geographical data on health facilities and midwifery workers precludes reliable assessment of whether all women have access to a health worker when needed. Improving accessibility requires making all urban and rural areas attractive to health workers, and ensuring that all barriers to care, including lack of transportation, essential medicines and health-care workers, are removed.

Acceptability: Most countries have policies in place to deliver SRMNH care in ways that are sensitive to social and cultural needs. However, data on women's perceptions of midwifery care are scarce, and countries acknowledge the need for more robust research on this topic. Contributors to the SoWMy 2014 workshops noted that the issue of acceptability is strongly linked to discrimination and the status of

women generally, both as service users and health workers.

Quality of both care and care providers can be increased by improving the quality of midwifery education, regulation and the role of professional associations. *SoWMy 2014* indicates that although the curricula in most countries are appropriate and up-to-date, pervasive gaps remain in education infrastructure, resources and systems, particularly for direct-entry midwifery programmes.

Nearly all of the 73 countries have a regulatory infrastructure for midwifery, with prescribed standards for midwifery education, including in the private sector. Quality of care would be further strengthened by licensing/re-licensing systems that

KEY MESSAGES

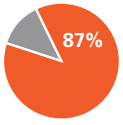
The report shows that:

1 The 73 Countdown countries included in the report account for more than **92% OF GLOBAL MATERNAL AND NEWBORN DEATHS AND STILLBIRTHS** but have only **42% OF THE WORLD'S MEDICAL, MIDWIFERY AND NURSING PERSONNEL.** Within these countries, workforce deficits are often most acute in areas where maternal and newborn mortality rates are highest.

2 **ONLY 4 OF THE 73 COUNTRIES** have a midwifery workforce that is able to meet the universal need for the 46 essential interventions for sexual, reproductive, maternal and newborn health.

3 Countries are endeavouring to expand and deliver equitable midwifery services, but **COMPREHENSIVE, DISAGGREGATED DATA** for determining the availability, accessibility, acceptability and quality of the midwifery workforce **ARE NOT AVAILABLE.**

4 Midwives who are educated and regulated to international standards can provide **87% OF THE ESSENTIAL CARE** needed for women and newborns.



5 In order for midwives to work effectively, **FACILITIES NEED TO BE EQUIPPED TO OFFER THE APPROPRIATE SERVICES**, including for emergencies (safe blood, caesarean sections, newborn resuscitation).

6 Accurate data on the midwifery workforce enable countries to plan effectively. This requires **A MINIMUM OF 10 PIECES OF INFORMATION THAT ALL COUNTRIES SHOULD COLLECT:** headcount, percentage time spent on SRMNH, roles, age distribution, retirement age, length of education, enrolments into, attrition and graduation from education, and voluntary attrition from the workforce.

7 Legislation, regulation and licensing of midwifery allow midwives to provide the high-quality care they are educated to deliver and thus protects women's health. High-quality midwifery care for women and newborns saves lives and **CONTRIBUTES TO HEALTHY FAMILIES AND MORE PRODUCTIVE COMMUNITIES.**

8 The returns on investment are a "best buy":

- Investing in midwifery education, with deployment to community-based services, could yield a **16-FOLD RETURN ON INVESTMENT** in terms of lives saved and costs of caesarean sections avoided, and is **A "BEST BUY" IN PRIMARY HEALTH CARE.**

- Investing in midwives frees doctors, nurses and other health cadres to focus on other health needs, and contributes to achieving a grand convergence: reducing infections, **ENDING PREVENTABLE MATERNAL MORTALITY** and **ENDING PREVENTABLE NEWBORN DEATHS.**

require the midwifery workforce to demonstrate continuing professional development.

The ultimate goal of professional associations is to foster a dynamic, collaborative, fit-for-purpose, practice-ready team of health-care professionals who are responsive to the needs of women and children. Although almost all countries have at least one professional association for midwives, nurse-midwives or auxiliary midwives, their role in quality improvement could be strengthened if they were enabled to contribute to policy discussions and key decisions affecting midwifery services.

There are substantial gaps in effective coverage in both the availability and quality dimensions. Reducing these gaps requires the collection and better use of workforce data and leadership to prioritize midwifery and release resources to support workforce and service planning. The minimum 10 data elements required for health workforce planning are: headcount, percentage time spent on SRMNH, roles, age distribution, retirement age, length of education, enrolments into, attrition and graduation from education, and voluntary attrition from the workforce.

Midwifery2030: Quality midwifery care is central to achieving national and global priorities and securing the rights of women and newborns. *SoWMy 2014* has developed *Midwifery2030* as a pathway for policy and planning. Starting from the premises that pregnant women are healthy unless complications, or signs thereof, occur, and that midwifery care provides preventive and supportive care with access to emergency care when needed, it promotes woman-centred and midwife-led models of care, which have been shown to generate greater benefits and cost savings than medicalized models of care.

Midwifery2030 focuses on increasing the availability, accessibility, acceptability and quality of health services and health services and health providers to achieve the three components of universal health coverage (UHC): reaching a greater proportion of women of reproductive age (increasing coverage); extending the basic and essential health package (increasing services); while protecting against financial hardship (increasing financial protection). Central to this are an enabling policy environment that supports effective midwifery education, regulation and association development, and an enabling practice environment that provides access to effective consultation with and referral to the next level of SRMNH services. This should be underpinned by effective management of the workforce, including professional development and career pathways.

Implementing the recommendations of *Midwifery2030* can lead to significant returns on investment. A value for money assessment in Bangladesh reviewing the education and future deployment of 500 community-based midwives ranked positively for economy, efficiency

Midwives can offer woman-centred and supportive care that goes beyond childbirth. *(World Vision/ Sopheak Kong)*