Strengthening quality midwifery education for Universal Health Coverage 2030

A transformative approach to improving quality of care

DRAFT FOR CONSULTATION
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Strengthening quality inter-professional midwifery education for UHC 2030.

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Foreword

To come
Acknowledgements

To come
1. Introduction

“Midwifery education is the bedrock for equipping midwives with appropriate competencies to provide a high standard of safe, evidence-based care.”

Bharj et al., Midwifery, 201x

1.1 Strengthened midwifery education improves outcomes for women and newborns

Quality midwifery education is critical to achieving global commitments to improve the lives of all women and newborns everywhere.

Universal coverage of midwifery care provided by midwives who are educated to international standards, licensed, regulated and fully integrated into the health system and working in a team with medical and public health colleagues1 “could avert a total of 83% of all maternal deaths, stillbirths, and neonatal deaths”2.

The HoHoe Midwifery Training school, Ghana. Students practice first on rubber dolls that “react” to certain actions by the students.
Reaching beyond the prevention of maternal and newborn deaths, **good quality midwifery care improves over 50 other outcomes**. This includes increasing breastfeeding rates, better access to family planning, identification and treatment of sexually transmitted diseases including HIV, as well as the prevention of malaria and tuberculosis (TB), screening for cervical cancer, provision of safe abortion care where legal, and post-abortion care where not legal.

Providing the best quality care for women and their newborns requires excellent teamwork to prevent and manage complications should they arise, this must be based on interprofessional learning and collaboration between midwives, nurses, doctors and others to maximize the skills of all.

Women and newborns are the most vulnerable in conflicts, natural disasters and humanitarian health emergencies. Well-educated midwives living in the affected communities are best placed to prepare for and respond to health emergencies, providing immediate, life-saving care to all women and newborns.

Importantly, the universal provision of quality midwifery care upholds the rights of women, newborns and their families no matter the circumstances.

"...the human right to health is meaningless without good quality care because health systems cannot improve health without it."

### 1.2 Poor quality of care is slowing improved rates in mortality and morbidity

Although progress was made in increasing access to facilities and reducing maternal and newborn mortality and morbidity during the era of the Millennium Development Goals, rates of maternal and neonatal mortality have not declined in recent years as much as expected.

The Lancet Global Health Commission on Quality Care 2018 highlights that access to a facility is not enough to reduce mortality; the quality of care at the facility matters. What also matters is that health workers are educated and regulated, so that they have the right skills, knowledge and behaviour to practice effectively.

### 1.3 Investing in midwifery education is transformative and cost-effective

There has been a startling lack of investment in midwifery skills education and training in low- and middle-income countries (LMICs). Few LMICS are educating providers to international standards, even where health workers are being given the professional title "midwife".

The midwifery model of care has a substantive impact on cost reductions arising from higher rates of spontaneous vaginal birth, less postpartum haemorrhage, fewer admissions to neonatal units, and increased breastfeeding rates. Cost savings primarily result from a reduction in the use of interventions including caesarean section and episiotomy, and an improvement in short and long-term outcomes for women and newborns.

Investing in midwifery education cannot take place in a vacuum. Strengthened regulation, deployment and better working conditions and remuneration are needed. Midwifery education contributes to the transformation and expansion of the health workforce and increases the potential to accelerate inclusive economic growth and progress towards health equity.

Radical reform in midwifery education will require a coordinated and comprehensive effort from health, education, finance, labour and foreign affairs sectors of government, together with civil society, the public and private sectors, trade unions and associations, institutions and academia.
Midwives want better education, including access to higher education and development, to be empowered to take leadership, to know their skills are valued by medical doctors and to provide better quality of care for women and their newborns.

1.4 Midwives are demanding better education: their voices matter

Educating midwives is not only about better skills and competencies. It is about empowering a predominantly female profession with knowledge, improving midwifery leadership and increasing the rights of women and their newborns to quality care.

Transforming midwifery education will require acknowledging and addressing significant sociocultural, economic and professional barriers experienced by midwifery providers. These barriers are rooted in gender inequality, visible in social and institutional hierarchies of power, and mitigate against women’s rights, education and employment.

1.5 Reaching global consensus on action: evidence and stakeholder consultations

A series of multistakeholder global consultations have taken place to inform this report. Consensus has been reached on three strategic priorities for strengthening midwifery education: all women and newborns should be cared for by a midwife educated to international standards; midwifery leadership must be strengthened; and global partners must align to invest more effectively in midwifery education.

Combining global evidence and findings from the consultations, a seven-step action plan provides guidance to governments and implementing partners to help transform midwifery education. This plan recognizes the wide variation in what is currently provided across many countries and acknowledges that whereas some countries can rapidly move to a high-quality cadre of midwives, other countries will have more investment to make. It is important to educate and empower the personnel already in place to meet the urgent needs of women and newborns.

1.6 Why we need to act now

Quality midwifery education is critical to the achievement of global health targets.

The Global Strategy for Women’s, Children’s and Adolescents’ Health 2016–2030 (GSWCAH) sets out an operational framework based on the goals of “survive, thrive and transform”. This strategy aims to end the preventable deaths of women, newborns, children and adolescents, and to reduce the number of stillbirths.

Alongside the GSWCAH, the Global Strategy on Human Resources for Health: Workforce 2030 focuses on the need to invest in capacity-building of educational institutions and adapt curricula and education methodologies to competency-based learning through transformative education.

In October 2018, world leaders recommitted their support to primary health care by endorsing the Astana Declaration that commits to care and services that promote, maintain and improve maternal, newborn, child and adolescent health; and mental health and sexual and reproductive health.
In 2019 WHO, UNFPA, UNICEF and eight other global partners developed the SDG 3 Global Action Plan for Healthy Lives and Well-being for All (2018–30), in which they commit “to align our joined-up efforts with country priorities and needs, to accelerate progress by leveraging new ways of working together and unlocking innovative approaches, and account for our contribution to progress in a more transparent and engaging way.”

Midwifery education is essential to the delivery of the SDG 3 Good Health and Well-Being Action Plan, as it enables interdisciplinary alignment, accelerates progress through improving quality of care, and with careful monitoring and evaluation will help us to account for our actions in improving outcomes for all women, newborns and their families.

Midwifery makes the connections between individuals and health workers over time (from birth to adulthood) and place (from home to community to facility). It is critical to implementing primary health care, ensuring universal health coverage (UHC) and the implementation of the “survive, thrive, and transform” ambitions of the Global Strategy for Women’s, Children’s and Adolescents’ Health. Strengthening quality midwifery education is the first step.

Figure 1.1 The critical importance of midwifery to the implementation of the GSWCAH and Universal Health Care (UHC)
1.7 Who is this report for?

The audience of the report includes all those determined to improve the lives of women and newborns everywhere. Midwifery is a complex intervention involving both women and newborns, taking place at home, as well as in primary, secondary and tertiary facilities. The report is therefore for those in government, or outside government, involved in health, health financing, education, water and sanitation (WASH), transport and communications, as well as gender and rights-based issues and advocacy.

Stakeholders include the current, and future midwifery workforce, leaders who work in or with governments, nongovernmental organizations, civil society, UN agencies, professional associations, academics and researchers. It is for our partners in the private sector, foundations and bilateral donors, the media and human rights advocates. It is for those working in conflict and other humanitarian disasters.

The report aims to inspire those passionate about the education and empowerment of midwives and other health workers to improve quality of care, and is for those who are deeply engaged, every day, in educating midwifery-care providers.

Ultimately, this report is for the women and newborns who need our help, and for the midwives and others who provide their care.
2. The impact of midwifery education

“Midwifery education is the bedrock for equipping midwives with appropriate competencies to provide high standards of safe, evidence-based care”.  
Bharj et al. Midwifery 2016

2.1 Midwifery education – the first and most fundamental step

The education of all health workers is the first and most fundamental step to transform all health outcomes – quality care cannot exist without the quality education of health-care providers. At the World Health Assembly in 2013, Member States passed Resolution 66.23 Transforming health workforce education in support of universal health coverage (UHC).
This set out the need for transformative education, including the strengthening of education and training institutions, accreditation, regulation, financing and sustainability, monitoring and evaluation, and governance and planning.

Scaling-up transformative education is defined by WHO as “the sustainable expansion and reform of health professionals’ education and training to increase the quantity, quality and relevance of health professionals, and in so doing strengthen the country health systems and improve population health outcomes”21.

The WHO Global strategy on human resources for health: workforce 203022 highlights the need for integrated approaches to education. WHO has also developed the Global strategic directions for strengthening nursing and midwifery 2016–20 report, which highlights education along with policy development, leadership, intra- and interprofessional partnerships and greater investment in the workforce23.

The Global Strategy on Women’s, Children’s and Adolescents’ Health 2016–30 focuses on actions to prevent maternal and newborn deaths and improve the lives of all women and newborns everywhere. Investing in midwifery is a critical strategy to achieve this. Strengthening midwifery education for midwives, as well as for the nurses and doctors in the interprofessional team who make a significant contribution to midwifery care, is the first step.

2.1.1 Quality midwifery care improves outcomes for women and newborns

Over the past two decades, scientific findings from a range of disciplines have converged. They prove that good quality midwifery care is vital to the survival, health and well-being of women and newborn infants.

Quality midwifery care reduces harm and enhances the short- and long-term health and well-being of women and children24. Increased initiation and duration of breastfeeding, more positive experiences of birth, less postnatal depression and improved mother–infant interaction, as well as more efficient use of interventions and of health service resources25, have all been shown to result from good-quality midwifery care26.

The geographical and social proximity of midwives to the communities they serve is a key strength, maximizing integrated people-centred care, and ensuring local knowledge and flexibility in responding to changing circumstances including emergencies27.

2.1.2 International standards and interprofessional working improve outcomes

The evidence is clear. Outcomes for women and newborns are improved with care provided by midwives who are educated, trained, licensed, and regulated to international standards, and who work in an effective interdisciplinary team with other professionals28.

International standards and resources for the education of midwives have been developed by the ICM, which has also collaborated with WHO and other implementation partners to develop the WHO Midwifery Educator Core Competencies 29. Although midwives educated to international standards can provide most of what healthy women and newborns need, interprofessional team working is critical to ensuring that women and newborns are provided with additional care where necessary30. This includes when complications arise or where specialist medical
The Lancet Series on Midwifery (2014) reports that universal coverage of midwifery care to the standard defined “could avert a total of 83% of all maternal deaths, stillbirths, and neonatal deaths”.

Homer et al

Reaching beyond the prevention of maternal and newborn deaths, good quality midwifery care improves over 50 other outcomes.

Renfrew et al

care is needed. Teamwork with specialist neonatal nurses is essential to ensure the best care for small, premature and sick babies.

This team includes nurses and nurse-midwives (who may or may not be educated to international standard midwifery), family physicians, obstetricians, paediatricians and community health workers. In some contexts, it will be important to include Community Health Workers (CHWs) and traditional birth attendants (TBAs), whether trained or not trained31. They can all make an important contribution to meeting the needs of women and newborns. Whatever the specific workforce configuration, interprofessional education is essential to promote effective and efficient teamwork and to avoid fragmentation and gaps in care32.

Outcomes for women and newborns are improved even further where a midwife educated to international standards, or a small team of midwives, is enabled to lead on all care needed by women and newborns from pregnancy to the

Box 2.1

Over 50 outcomes for women and newborns improved through midwifery care

With the 50+ outcomes improved by midwifery plus preterm birth rates etc. and/or diagram of the breadth of impact on outcomes. TO FOLLOW

Box 2.2

Midwifery

Midwifery is defined as “skilled, knowledgeable and compassionate care for childbearing women, newborn infants and families across the continuum from pre-pregnancy, pregnancy, birth, postpartum and the early weeks of life.

Core characteristics include optimizing normal ... processes of reproduction and early life, timely prevention and management of complications, consultation with and referral to other services, respecting women's individual circumstance and views, and working in partnership with women to strengthen women’s own capabilities to care for themselves and their families.”

Lancet Series on Midwifery, 2014
end of the six-week postnatal period, supported by a well-functioning health system should complications arise. This is known as midwife-led continuity of care.

With this model of midwife-led continuity of care, the Cochrane Database of Systematic Reviews (2016) found that women are 19% less likely to lose their baby, 24% less likely to experience a preterm birth, and 16% less likely to have an episiotomy. The experience of women is also enhanced. The Cochrane Review found most of the evidence came from high-income countries where midwifery is well established, and education of midwives is to international standards. There is a great need to find out if this model works well in other contexts.

2.1.3 Quality midwifery education for the full range of sexual, reproductive, maternal and newborn care

Education to international standards enables midwives to provide the full range of care that all women, newborn infants and families need. Midwifery is a complex intervention that includes, but goes far beyond, a set of clinical skills for pregnancy, childbirth and the postnatal period. It includes care for newborns and mothers in the six-week postnatal period, as well as services for sexual and reproductive health more broadly.

Box 2.3
The Midwife

International Confederation of Midwives (ICM) definition of a midwife

“A midwife is a person who has successfully completed a midwifery education programme that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education and is recognized in the country where it is located; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title ‘midwife’; and who demonstrates competency in the practice of midwifery.”

Read more here

Figure 2.1 The impact of midwife-led continuity of care
Midwives care for all women and newborns, whether their circumstances are straightforward or if rapid life-saving decisions are needed to respond to complications. This care is founded on human rights principles, providing respectful care for all regardless of individual need or context. Transforming education for midwives, and others who provide elements of midwifery, must include knowledge and skills of all these aspects.

Figure 2.2 The full scope of midwifery education and care
INFOGRAPHIC TO FOLLOW

2.2 Improvements in midwifery education are making a difference

2.2.1 Countries are strengthening midwifery education

Countries that have implemented good quality midwifery education have transformed outcomes for women and newborn infants, and also women’s experiences of care. Over 140 years ago, Sweden dramatically reduced maternal and newborn mortality rates through the introduction of formal midwifery education. This was achieved in conditions similar to those experienced by very low-income countries today.

More recently, low- and middle-income countries (LMICs) that have successfully strengthened midwifery education as part of a strategy to reduce maternal mortality include Burkina Faso, Cambodia, Indonesia and Morocco.

Some high-income countries have also strengthened midwifery. In the 1990s Canada introduced midwifery care – grounded in good-quality education - into a system that had been solely led by obstetricians, supported by nurses. New Zealand, Sweden and the UK are examples of countries that continue to strengthen their well-established midwifery education in line with new evidence.
Box 2.4

Sweden cuts maternal mortality by educating midwives

In 1686, concern at high maternal mortality rates in Sweden led the authorities to introduce a regulation in the Stockholm area designed to make midwifery education compulsory and midwives more accountable. Under the new law, midwives had to be formally educated and to pass an exam. If successful, they were then required to take an oath to the city’s magistrate to be allowed to practice and provide health care to women.

As a result, there was a rapid decline in maternal mortality between 1861–99. This was achieved before the discovery of antibiotics, electric light, modern systems of transport and communication, and represents what can be achieved by investing in midwives even in the most challenging circumstances.


Credits to the Swedish Association of Midwives

Box 2.5

Long-term commitment to midwifery education and care brings results in Burkina Faso, Cambodia, Indonesia and Morocco

Burkina Faso, Cambodia, Indonesia, and Morocco have all developed pre-service education for midwives as part of a core strategy to improve maternal and newborn health. An analysis of these four LMICs by the Lancet Series on Midwifery shows what was needed:

- high-level political commitment and the support of civil society;
- data and evidence to identify priorities and steer budget allocations for quality midwifery education, including professional regulation and investment in educational infrastructure;
- sustaining quality education and supporting midwives including with appropriate remuneration;
- removing barriers to access for women, including removing financial barriers and establishing close-to-women facilities, promoting equity;
- focusing on quality as well as coverage, to ensure respectful, women- and newborn-centred care, and resources for midwives to practice effectively.

Additional action will be needed to reduce over-medicalization and the overuse of interventions such as caesarean section and antibiotics. This includes tackling financial incentives and changing views by professionals and the public that an intervention focus is “modern”.

Lancet Series on Midwifery 2014
Ulf Högberg, an obstetrician stated in his dissertation in 1985 that “the midwife service in rural areas, and antiseptic techniques, were the single important preventive intervention in reducing maternal mortality during the 19th century in Sweden.”

Today, all women of reproductive age in the country have access to a midwife who can provide the full range of maternal, neonatal and child health-care services. Sweden has one of the lowest maternal mortality ratios (MMR) and neonatal mortality rates in the world.

Source: Swedish Association of Midwives
Ref: The decline in maternal mortality in Sweden: the role of the community midwife. Ulf Högberg, 1985. Available at: https://www.avhandlingar.se/avhandling/c3fe23497f/

2.3 Why more needs to be done
2.3.1 Improvements in maternal and newborn mortality are stalling

Progress was made in reducing maternal and newborn deaths during the Millennium Development Goal (MDG) period, with a global reduction in the MMR from 385/100 000 live births in 1990 (534 000 maternal deaths per year) to an MMR of 216/100 000 live births (303 000 maternal deaths) in 2015.

There was a rapid decline in the under-five mortality rate which dropped from 92 deaths per 1000 live births in 1990 to 41 deaths per 1000 live births in 2016. However, while there was an increase in coverage of births attended by skilled birth attendants (SBAs) from 58% in 2000 to 69% in 2012, rates of maternal and neonatal mortality did not decline as much as expected.

Preah Vihear may be a remote province in Cambodia but the 16 Makara hospital has good facilities. The pregnant woman here didn’t have to travel far for prenatal care.
The reasons for this are not fully understood but there is increasing evidence to indicate that a consistent barrier to improving maternal and newborn health has been the poor quality of care provided by midwives, nurses, doctors and other health workers. In a systematic mapping of barriers to the provision of quality care by midwifery personnel, the issue of poor midwifery education – often reduced to a matter of weeks – without qualified faculty and lacking in practical application, was identified as a major constraint. Additionally, many of the education programmes described lacked crucial components of basic training, such as infection prevention and respectful care, leading to possibilities of links between poor education, poor clinical care, sepsis and mistreatment of women in facilities.

A shortage of health workers is also a key factor. The State of the World’s Midwifery Report (SOWMy) 2014 notes that of the 73 countries from which data was gathered, only four countries have the workforce capacity to provide the care needed by women in their reproductive years and newborns.

2.3.2 Poor quality of care at facilities

Access to a facility does not in itself improve outcomes where the workforce lacks the competencies needed. For example, cash incentives have helped more women and newborns to reach facilities to give birth, but this has not always measurably reduced maternal and newborn mortality. The lack of well-educated midwives at facilities is contributing to poor quality care.

2.3.3. Clarity needed on which health provider has which midwifery skills

Published literature on midwifery skills’ education describes a range of health workers, both professional and non-professional, who are providing some midwifery skills. Among the various health workers described, there is a lack of consistency in the use of the term “midwife” and so it is not clear which of the health workers are educated and trained to the international standard of a midwife. Nursing and midwifery education is often combined, rendering midwifery skills education and training invisible in policy, as well as in practice.

Since 2004 there has been a focus on SBAs. The definition of the SBA has recently been updated and since 2018 describes “skilled health personnel (competent health-care professionals) providing care during childbirth.” While making a contribution to the overall decrease in mortality, the training, regulation and deployment of SBAs with a specific focus on childbirth has varied widely across countries, with uneven levels of proficiency and regulatory support.

Not all SBAs provide all areas of maternal and newborn care or are trained to deal with unexpected complications. In a recent scoping review, only 15% of those working as SBAs were reported to identify themselves as “midwives”, and it is not clear whether those who described themselves as midwives were educated to international standards.

“High quality health systems could prevent 1 million newborn deaths and half of all maternal deaths each year.”

Lancet Quality of Care Commission

“Poor quality of care is a bigger barrier to reducing mortality than insufficient access to care.”
“In a scoping review of the health personnel considered SBAs in 36 LMICs, a total of 102 unique cadres names were identified. Of the cadres included, 16% represented doctors, 16% were nurses, and 15% were midwives. There was substantial heterogeneity between and within countries on the reported definition of an SBA and the education, training, skills and competencies that they were able to perform.”

Hobbs et al. PLoS One 2019

2.3.4. Lack of investment, policy, strategic alignment, monitoring and evaluation

New research has found a “startling lack of investment” in midwifery education. This finding acknowledges the efforts to improve quality education that have been made by many partners under the leadership of ICM, as well as by the International Federation of Gynaecology and Obstetrics (FIGO) and the International Paediatric Association (IPA), and through UN agencies, donors, foundations and major international and national nongovernmental organizations. Much of the work to date has focused on curriculum development, in-service training and more recently the potential for mHealth and e-learning opportunities.

Only 20 of 73 LMIC countries surveyed in 2017 were found to have an online policy on midwifery skills education, and this was often limited to a curriculum outline. All online policies were focused on pre-service training with an absence of any focus on in-service skills.

Key stakeholder interviews with development partners revealed significant variations in the models of education being implemented, indicating a global lack of strategic alignment on best practice.

There is also little evidence of programme level monitoring and evaluation of midwifery education. There are only a small number of studies in LMICs of pre- and in-service education, almost all of low quality, indicating a longstanding lack of investment in midwifery education internationally.

2.3.5. Educators lack skills, access to clinical sites and training materials

Early results from a WHO survey of Midwifery Educators in five WHO regions provides a stark picture of the realities of constrained teaching and learning environments. Educators are more confident with theoretical classroom teaching than clinical teaching.
Many are unable to access clinical settings, or simulation tools, to support competency-based education with women and babies. Large gaps in educator skills are evident, including basic postnatal care of women and newborns, and the provision of family planning. Few educators reported having the education materials needed. The survey further highlighted inconsistencies in the content and duration of education courses, as well as variations in the competencies required, as well as the plethora of pathways to becoming a “midwife”, indicating a wide variation in the standard of education and training, and thereby variations in the quality of care provided.

2.3.6. Poor infection prevention and control

The early findings from the WHO Midwifery Educator Survey also highlight the poor state of many educational institutions that lack basic infrastructure, including water and toilets for staff, students and women being cared for in the teaching facility. Infection Prevention and Control (IPC) is a core nursing and midwifery responsibility, essential to the prevention of maternal and newborn sepsis, especially in a time of antimicrobial resistance. Without a constant supply of water and access to sanitation, IPC is unlikely to become the everyday habit it needs to be.

The 2016 High Level Commission on Health Employment and Economic Growth report recommends that radical reforms are needed in the manner in which the health workforce is allowed to acquire the right skills.

Figure 2.3 Percentage of respondents in total and in African countries (English-speaking) who experienced a lack of access to clean water for teaching IPC
Box 2.6

Water and sanitation availability in educational institutions affecting staff, students and childbearing women: early findings from the WHO midwife educator survey

Access to clean water, soap and hand rub

A significant number of respondents experience a lack of access to clean water for teaching. Except for respondents from the WHO Region of the Americas, all other educators had trouble accessing clean water and functioning toilets in their educational institutions.

This includes lack of clean water for teaching infection prevention and control, cleaning the environment and sterilizing equipment, as well as lack of soap or hand rub for basic hand hygiene. In Africa, over 50% of respondents in (English-speaking) countries and 75% in (French-speaking) countries sometimes lacked access to clean water (Fig. 2.3).

Toilet facilities

Respondents from both WHO African and South East Asian Regions reported lack of regular access to a functioning toilet. This was most significant in African (English-speaking) and (French-speaking) regions where 50% of educators surveyed reported they do not always have a functioning toilet in the institution where they teach. This badly affected the care they were able to offer women during labour or postnatally, with two thirds of respondents from French-speaking African countries raising concerns (Fig. 2.4).

Maintain personal hygiene

A significant number of respondents reported they were unable to help women maintain their personal hygiene. Those who reported always being able to provide this care were: 25% of respondents from French-speaking African countries, less than 40% of those from English-speaking African countries, and just over half from the South East Asian Region.

Figure 2.4  Percentage of total respondents and respondents from the African countries (French speaking) who were unable to support women to use the toilet due to inadequate facilities

Source: WHO Early findings from the Midwifery Educator Survey
2.4 Good quality midwifery education focuses on the needs of women and newborn infants

Good quality education is essential to prepare midwives with the knowledge and skills to provide the full scope of international standard care that women and newborns need. The Lancet Series on Midwifery analysed hundreds of studies to identify evidence-informed components that all midwives need to know to be skilled enough to meet the needs of women and newborn infants. This is summarized in the Quality Maternal and Newborn Care framework (QMNC) Figure 2.5.

The competencies of midwives as defined by the ICM have been mapped to these components. The competencies all map to the QMNC framework, showing that midwives meeting the ICM standards practice the full scope of midwifery (shown by the blue line in Figure 2.5). Interprofessional working is essential to provide the care identified in the top right-hand component of medical, obstetric and neonatal services for women and newborns who need specialist medical care.

To achieve good quality care staff must be educated and trained to provide knowledgeable, skilled and respectful care for all. They must know how to practice across all stages from pre-pregnancy, pregnancy, labour and birth, postpartum and the early weeks of life. They must be skilled in providing the preventive and supportive care that keeps women healthy as well as identifying and responding to complications.

This requires much more than a focus on specific tasks and emergency situations. It includes: knowledge, understanding and skills in organizing care and providing continuity across community and facilities; ensuring values such as good communication and tailoring care to individual needs.

Midwifery has a philosophy of optimizing normal physiological processes, ensuring women’s own capabilities are strengthened. Other important aspects include care providers’ knowledge and skills in identifying and responding to complications when they arise, and knowing how to work in partnership with the interprofessional team as needed, including obstetricians, paediatricians, family physicians, nurses and community health workers.

Figure 2.5 Framework for quality maternal and newborn care, showing the scope of midwifery

Scope maps exactly to the ICM competencies of the midwife: full scope midwifery = international standard midwife

Source: Renfrew, McFadden, Bastos et al The Lancet 384,19948, 1129 – 1145, 2014
The great majority of this care can be provided by midwives educated to international standards, working in interprofessional teams. Others working together can contribute some components, but care is likely to be more fragmented.

2.5 Midwifery education will help save lives in health emergencies

Childbearing women and newborns are among the most vulnerable in emergency situations including epidemics (such as Ebola), during a natural disaster (such as floods, cyclones, earthquakes) or when caught up in a military conflict. Midwives, and nurses, living close to affected communities are the first point of contact especially in hard to reach areas. Midwives educated to international standards will be able to provide most of the care that women and newborn infants need in these circumstances.

Important midwifery competencies include being able to accompany women through pregnancy, childbirth and the postnatal period, no matter what the circumstances. In Liberia, midwives supported women who had no choice but to give birth in the open bush, even when under cross-fire.63

Looking after the baby immediately after birth by encouraging skin-to-skin care with the mother (also known as Kangaroo Mother Care, KMC), and keeping the baby warm and dry, is life-saving under any conditions. This is especially important in times of disasters, where there is early evidence of increased preterm births.64 Supporting the mother to breastfeed and upholding the International Code on the Marketing of Breast-Milk Substitutes 65 is critical to avoid deaths from exposure to contaminated water supplies and diarrhoeal diseases.

Midwives also need to have increased awareness of gender-based violence and rape, particularly in conflict situations, and be able to care for women who have experienced such violence. Additionally, midwifery provides much needed access to family planning, treatment for sexually transmitted diseases, post abortion care, as well as education on menstrual hygiene in stressful circumstances.

2.5.1 Midwifery leadership in health emergencies

Midwifery leadership and engagement in emergency preparedness, response and post crisis rehabilitation is critical. Emergency coordination mechanisms are the responsibility of government, but in some cases multiple countries are involved or the disaster is so huge and the response so complex that international coordination and support is required. Identifying entry points for the engagement of the Government Chief Nursing and Midwifery Officer (GCNMO) will give voice to the needs of women and their newborns.

The GCNMO can ensure that:

- the national emergency/humanitarian response plans include education of midwives in preparation for response to, and rehabilitation from, emergencies;
Box 2.7

Midwives and nurses play a vital role in Fiji’s national cyclone response programme

Working closely with the national disaster team at both hospital and primary health-care level, midwives have helped with planning to ensure that essential care is available for pregnant women and the wider community in the event of an emergency. “Babies still need to be delivered and patients still need emergency care,” says the Fiji Government Chief Nursing and Midwifery Officer.

When the country goes into cyclone preparedness mode, midwives and nurses are ready to be called up and their shifts immediately switch from eight to 12 hour stretches in all 22 hospitals. In remote health centres and nursing stations, pregnant women who are due to deliver will be taken to the

- the national midwifery curriculum is adapted from international standards to include emergency response;
- midwives are embedded in emergency medical teams.

There are good examples of leadership, research and action for education in these areas. In Fiji, the leadership of the GCNMO is ensuring all midwives and nurses are trained and prepared to take action in cyclones (see Box 2.7 below). In Sudan, midwives are receiving additional training on the care of newborns in humanitarian settings.

In Europe recent research from the Operational Refugee and Migrant Maternal Approach (ORAMMA) project has informed the development of new online training materials for all midwives, social workers and peer supporters identified as being critical to the needs of pregnant refugee and migrant women. This education recognizes the additional need for skills in cultural awareness, mental health care for women fleeing war zones, support to women who are pregnant as a result of rape or who have experienced gender-based violence, and importantly, greater emphasis on a model of high-quality midwife-led care.

There is great potential for midwives to make an immediate difference in humanitarian crises, where their local knowledge and links with communities can enable access, trust and an appropriate response. There is an urgent need to examine and develop the role of midwives in these settings.

2.6 Barriers to education experienced by midwifery personnel

2.6.1 Sociocultural, economic and professional barriers

A systematic mapping of barriers to quality midwifery care found that to transform midwifery education, the significant sociocultural, economic and professional barriers experienced by midwifery providers, which prevent the provision of quality care, will need to be acknowledged and addressed.

These barriers mitigate against women’s rights, education and employment.

In a predominantly female profession, deeply held sociocultural views around the role of women in the workplace, combined with beliefs that childbirth is low-skilled “women’s work” can lead to a lack of acceptance of midwifery as a profession, and of women being educated and trained as midwives. Wages are often lower than for other professionals with a similar level of responsibility, (the “gender penalty”), and salary payments are all too often delayed and insufficient to meet even basic living costs.

The most significant finding was that the low sociocultural and economic status attributed to midwifery care resulted in lack of investment in education. This is combined with a lack of professional autonomy (although when alone on night duty, or working in remote areas, midwives will have full responsibility for all care).
Additionally, institutional hierarchies of power inhibit midwives from being able to practice to their full ability, or from accessing further education to increase their knowledge and leadership skills. All these factors overlap and reinforce each other, leading to burn-out among staff, and poor quality of care for women and newborns.

These barriers were all found to be based on gender inequality, requiring those who are strengthening midwifery education to pro-actively take gender transformative action. These barriers are not limited to low-resource countries, or even to countries without professional midwifery. These findings were confirmed, and expanded upon, by 2470 midwifery personnel in a global survey published in the report Midwives Voices, Midwives Realities.73

2.7. Investing in midwifery education is cost effective and brings sustainable benefits

2.7.1 Radical reform needed

The evidence presented does not support a business-as-usual approach but notes the opportunities to be realized depend upon “radical reform”. This includes putting gender equality and women’s empowerment at the centre; transforming the education of health professionals; investing in rural training to reach the underserved; reappraising the contribution to be made by nurses, midwives, community-based health workers and other underutilized groups within the health and non-health workforce.

The report also recommends paying greater attention to young people and their education needs to prepare them for decent jobs in the health sector; and considering more deeply the part to be played by technical and vocational education and training. Radical reform will also require a coordinated and comprehensive effort from health, education, finance, labour and foreign affairs sectors of government, together with civil society, the public and private sectors, trade unions and associations, institutions and academia.
The 2016 High Level Commission on Health Employment and Economic Growth found that

- effective investments in the health workforce could generate enormous improvements in health;
- the evidence does not support a business-as-usual approach;
- transforming the education of health professionals is needed.

2.7.2 Midwives educated to international standards save resources

The midwifery model of care has a substantive impact on cost reductions arising from higher rates of spontaneous vaginal birth, less postpartum haemorrhage, fewer admissions to neonatal units, and increased breastfeeding rates. This has been shown using a range of research designs including randomized controlled trial, cross-sectional study, modelling and observational study for women of all risk profiles.

Cost savings primarily result from a reduction in the use of interventions including caesarean section and episiotomy, and an improvement in outcomes for the woman and newborn infant. Midwifery counter-balances the commercial forces that can support the over-medicalization of care, with health service resources spent on facilities and equipment rather than on the personnel who can prevent complications.

The FIGO Position paper: How to stop the caesarean section (CS) epidemic (2018) highlights that to overcome perverse incentives to increase unnecessary interventions, the delivery fees for physicians for undertaking CS and attending vaginal delivery should be the same, using a mean fee. This should also happen in private practice settings.

The position paper also notes that “money that will become available from lowering CS costs should be invested in resources, better preparation for labour and delivery and better care, adequate pain relief, practical skills training for doctors and midwives, and reintroduction of vaginal instrumental deliveries to reduce the need for CS in the second stage of labour”.

2.7.3 Measuring the costs

Measuring the costs of providing maternal and newborn care is challenging because it involves analysing complex pathways of care with interrelated and variable factors including diverse settings for care, a range of care providers, different models of care and differences between public and private health-care provision. Evidence to date is predominantly from studies in high-income countries, and there is an urgent need to examine the economics of maternal and newborn care in LMICs.

Because of the lifelong impact of healthy pregnancy and birth, family planning, breastfeeding, good mental health, up-take of vaccinations and other interventions, the long-term economic gains resulting from midwifery are even greater than the specific savings from improved short-term clinical outcomes and reduced costs of interventions.

Most substantively, the improved survival, health and well-being of women and children will have a direct impact on the economic well-being of families, communities and societies. Given the escalating rates of caesarean sections and other unnecessary interventions globally, ensuring midwives are educated and regulated to international standards and supported to provide quality midwife-led care is a key consideration in making best use of limited resources.
Midwife-led care in Australia improves outcomes and significantly reduces costs: similar reductions could apply in LMICs.  

Research in Australia found that the costs of care for healthy, low-risk pregnant women when led by obstetricians in a public health system are 45% higher than when a woman receives care from a small group of known midwives throughout her pregnancy, childbirth and postnatal care experience. These costs were increased by a further 9% to 54% when the care was led by obstetricians working in a private sector hospital.

The higher costs are associated with complex pathways of care: in this research largely associated with an increased number of interventions, including caesarean section and episiotomy.

Low costs were achieved through midwife-led care as a result of higher rates of spontaneous vaginal birth, less postpartum haemorrhage, fewer admissions to neonatal units, and increased breastfeeding rates.

Reduced costs from reduced interventions are applicable globally to all settings.

2.8 Why now?

2019 is an unprecedented year in which global strategies for maternal and newborn health, the health workforce, and the education of health workers as well as the SDGs, the Astana Declaration on Primary Health Care and the Universal Health Care Action Plan, provide an extraordinary opportunity for a focus on midwifery and specifically midwifery education. The need for quality of care, not just access to a facility, highlighted in the Lancet Commission on Quality of Care, provides even greater impetus to take action.

The demand from women for quality midwifery care is increasing. In 2020 the launch of the third State of the World’s Midwifery Report, as well as the State of the World’s Nursing Report 2020, will bring further visibility in a year that will also celebrate the 200th anniversary of Florence Nightingale’s birth.

The demand from midwives is also growing. They want better education to be able to provide better quality of care; to have their voices heard through opportunities for leadership, and to make progress through a valued career path.

Multiple stakeholders have gathered over the past two years to share and discuss the evidence and their experience. The next section of this report highlights the findings from these consultations and leads us to an Action Plan developed to help make the urgent changes that are needed.
3 Global voices for change: consultations on the future of quality midwifery education

As well as the evidence provided in Section 3.1, this report builds on a series of joint global consultations held between 2016 and 2018 and convened by WHO, ICM and UNFPA. The aim was to have a better understanding of what action needs to be taken to strengthen midwifery education and improve quality of care. This section sets out the consensus reached, including innovative examples from the participants of progressive change already taking place.

Participants in the seven consultations included: representatives from: government, UN agencies (UNFPA, UNICEF and ILO), nongovernmental organizations, private sector foundations and organizations, academics and researchers, WHO Collaborating Centres in Nursing and Midwifery, ICM and other professional associations including FIGO, IPA and the Council of International Neonatal Nurses (COINN), bilateral donors, regional and country colleagues from WHO, ICM and UNFPA and, last but not least, women’s organizations, midwifery educators and practitioners.

Box 9: Timeline: series of joint WHO-ICM-UNFPA consultations

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tr>
<td>2016 July</td>
<td>hosted by the University of Dundee, Scotland, in advance of the global WHO Collaborating Centres for Nursing and Midwifery Conference. (This was the first meeting to recommend a way forward, with consensus on the need to develop a Global Forum for Strengthening Quality Midwifery Education. For more information see: <a href="https://www.who.int/maternal_child_adolescent/documents/strengthening-quality-midwifery-education/en/">https://www.who.int/maternal_child_adolescent/documents/strengthening-quality-midwifery-education/en/</a>)</td>
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<tr>
<td>2018 January</td>
<td>convened by WHO in Geneva, Switzerland.*</td>
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<tr>
<td>2018 April</td>
<td>hosted by Green Templeton College, University of Oxford, and supported by the Sheila Kitzinger Programme at Green Templeton College.*</td>
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<tr>
<td>2018 July</td>
<td>convened by WHO for the WHO Collaborating Centres Nursing and Midwifery Conference at the University of Cairns, Australia.*</td>
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<tr>
<td>2018 September</td>
<td>convened by ICM in Dubai, United Arab Emirates, at the ICM regional EMRO/SEARO/ EURO Conference.</td>
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<tr>
<td>2018 October</td>
<td>convened by ICM in Asuncion, Paraguay, at the ICM regional AMRO Conference.</td>
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<tr>
<td>2018: December</td>
<td>convened by WHO and the Society for Midwives India, as a pre-meeting to the Global Partners Forum for the Partnership for Maternal, Newborn and Child Health (PMNCH).</td>
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*Draft meeting reports available at: XXX
The consultations were all structured around the following five guiding questions about midwifery education.

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<td>1. What are the three hard-hitting strategic priorities?</td>
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<td>2. What is different, what is radical thinking?</td>
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<td>3. What will the impact be at country level, how will this be measured?</td>
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<td>4. How will this be achieved?</td>
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<tr>
<td>5. How is this relevant to humanitarian emergencies, in conflict and natural disasters?</td>
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The consultations used a range of interactive methodologies including presentations on the latest evidence, group work, panel discussions and focus group discussions; they included a dynamic form of *Petcha Kucha* in which participants had a limited time to present their key issues.
Box 10: Findings from global consultations on strengthening quality midwifery education

1. Three strategic priorities for strengthening quality midwifery education
   - **Every woman and newborn to be cared for by a midwife**, educated and trained to international standards and enabled to legally practice the full scope of midwifery. The title “midwife” should only be used for providers who are educated to international standards.
   - **Midwifery leadership** positioned in high-level national policy, planning and budgeting processes to improve decision-making about investments for midwifery education to help achieve universal health coverage (UHC).
   - **Coordination and alignment between midwifery stakeholders** at global, regional and country levels to align education and training processes, knowledge, research, evidence-based materials, indicators and investment.

2. Innovations and radical thinking for strengthening quality midwifery education
   - “**Rethink**” evidence-informed midwifery education and training to focus on both clinical and theoretical competency, including a philosophy of respect and dignity for women and newborns, the prevention of unnecessary interventions and the strengthening of women’s own abilities.
   - **Engage women and communities in the development of midwifery education**, to prepare midwives to provide with cultural competence what women want and need to survive, thrive and transform.
   - **Focus on faculty** to ensure that teaching achieves international standards, while ensuring educators also remain practitioners and can fully support midwives to provide their full scope of practice.

3. What will the impact be in countries and how will we measure it?
   Midwives educated and trained to international standards will:
   - Lead on averting over 80% of all maternal deaths, stillbirths and neonatal deaths.
   - Ensure universal access to all women and newborns with better quality provision by midwives and enhanced experience of care by women, including in conflict and humanitarian settings.
   - Use a new logic model with indicators used to measure, monitor and demonstrate progress in health outcomes, rational use of resources and the economic value of midwifery.

4. How will we strengthen quality midwifery education?
   - **Establishing National Midwifery Task Forces** to bring a multistakeholder focus to midwifery education.
   - **Review the current system of education and training and base future education on research and evidence**: what really works best for women and newborns, in which contexts?
   - **Address sociocultural, economic and professional barriers** to quality midwifery education acknowledging the need to address social and institutional gender-based hierarchies of power.

5. How is this relevant to conflict and humanitarian settings?
   - **Embed “emergency preparedness and response”** within the curriculum.
   - **Position midwifery leadership** in the national emergency coordination platform.
   - **Promote midwifery-led research on models of care in emergencies**.
3.1 Three strategic priorities for strengthening quality midwifery education

Strategic priority (a): Every woman and newborn to be cared for by a midwife, educated and trained to international standards and enabled legally to practice the full scope of midwifery. The professional title “midwife” should only be used for providers who are educated and regulated to international standards.

The consultations demonstrated a striking global consensus on this strategic priority. While acknowledging this as aspirational in some contexts, because of limited or no midwifery capacity at present, the case studies in Box XX and XX below demonstrate it is possible, even in difficult conditions.

Participants based this priority on the evidence, and on examples presented by participants showing how the introduction of educated, professional midwives has made a radical improvement in outcomes for women and their newborns.

Concern was raised that some providers are being referred to as midwives, although they are neither educated nor regulated to international standards. This lack of clarity on the provider's title was seen to cause confusion among women and families seeking quality care, as well as among health professionals working in an interdisciplinary team.

**Box 11: Bangladesh, India and Nepal introduce new cadres of midwives educated to international standards**

Details to follow

**Box 12: Liberia and Sierra Leone continue to focus on educating midwives to international standards**

Despite experiencing the devastation of civil war and the Ebola outbreak, Liberia and Sierra Leone continue to focus on educating midwives to international standards.

In Liberia:
- ministry of health commitment includes support to six midwifery education institutes;
- options exist for certified (2 year), registered (3 year) or BSc level (3 year) education;
- the Liberian Board of Nursing and Midwifery assesses, accredits and monitors educational institutions that are teaching to international standards;
- the Liberian Midwifery Association is responsible for renewal of licences to practice.
In Sierra Leone:
- the number of midwifery educational institutions has increased from two to three, and the number of midwives has doubled to over 600 in 2018.

Strategic priority (b): *Midwifery leadership is positioned in high-level national policy, planning and budgeting processes to improve decision-making about investments for midwifery education to help achieve UHC.*

This strategic priority reflects the views of participants, and the evidence, that a major barrier to improving quality of care is the absence of midwifery leaders’ voices in global, national, regional and local level decision-making, on investing in sexual, reproductive, maternal and newborn health, as well as in research.

Government Chief Nursing and Midwifery Officers (GCNMOs) and other leaders raised their concerns about the lack of opportunities to be involved at the policy dialogue table. Discussions highlighted concerns that many GCNMOs must cover both nursing and midwifery, and the evidence that where nursing and midwifery leadership is combined, midwifery may become subsumed within nursing.

**Box 13: Reforms in West Bengal**

In the Indian state of West Bengal, policy and structural reforms in the state ministry of health enabled the creation of a Directorate for Nursing and Midwifery. This led to senior leadership positions for nurse-midwives including the first Director of Nursing and Midwifery.

Source: Options consultancy

Strategic priority (c): *Coordination and alignment between midwifery stakeholders at global, regional and country levels to align education and training processes, knowledge, research, evidence-based materials, indicators and investment.*

Participants highlighted the urgent need for partners to align education and training processes, knowledge, research, evidence-based education and training materials, indicators and investment. These partners include:

- government departments, including ministries of health, education and finance;
- international and national health care professional associations (HCPAs), especially between ICM, FIGO, IPA, COINN and national regulatory bodies;
- UN implementing partners, including WHO, UNFPA, UNICEF, ILO, UN Women and the World Bank to provide a “one-UN” approach to supporting governments and other stakeholders;
- international NGOs and NGO partners;
- public and private sectors;
• educational institutions for midwifery, nursing, medicine and allied health professions.

**Box 14: Governance mechanisms assist in aligning multiple stakeholders**

- In 2018 India established the country’s first government-led National Midwifery Task Force. This brought together key stakeholders and enabled midwives in collaboration with others to play a key role in developing national policy on the introduction of a cadre of midwives. The task force provided critical inputs to the development of the Government of India’s first *Guidelines on Midwifery Services in India 2018*. This was launched in December 2018 with the acknowledgement of those engaged. Sub-groups have been established to address specific topics such as the revision of the curriculum to international standards.

  Source: WHO India.

- In Nigeria, local government committees have been established bringing communities and government together to provide a mechanism for increased accountability.


- In Bangladesh a collaborative network to harmonize activities has been established to bring synergies between higher education and research with policy, regulation and practice. Source: Darlarna University, Sweden.

**Box 15: Council of International Neonatal Nurses (COINN) established**

The COINN has been established to work alongside midwives and nurses to provide support to improving the quality of care for small and sick newborns. The focus is on breastfeeding and kangaroo mother care, where the baby is kept skin-to-skin with the mother to provide warmth and protection.

Source: COINN
3.2 Innovations and radical thinking

Participants questioned how midwifery education is currently provided and proposed that the evidence presented on the “startling lack of investment” reported in presentations, requires us to take an innovative, radically new look at how to educate and train midwives. Suggestions included:

(a) “Re-think” evidence-informed midwifery education and training

- **Re-organize midwifery education based on women and newborn needs**, in the places where they most need it including community and facility-based care. This includes adapting education to meet specific health needs: for instance, high levels of: female genital mutilation (FGM); communicable diseases such as HIV/AIDS, TB and malaria; or non-communicable diseases including diabetes and obesity in pregnancy.
- **Train in teams and work in teams**: education and learning in interprofessional teams helps to enable respectful care as well as respect and good working practice between providers. It also prevents unnecessary interventions.
- **Harmonize minimum standards of care** for midwives, but also for all those providing midwifery care.
- **Create flexible pathways for midwifery education and training** to international standards, including work-based learning and apprenticeships to empower young women, and men, to become health workers. Enable remote and community-based education offering bridging courses, close to service delivery points so that midwives can learn while remaining safe, respected and with their families in their own communities.
- **Make e-learning more available** to increase access to information.
- **Listen to students**: introduce 360 evaluation through feedback on educators’ performance by students to support continuous improvement.

**Box 16: Examples of innovation and radical thinking in midwifery education**

<table>
<thead>
<tr>
<th>The Women for Health (W4H) programme in Nigeria, focuses on empowering young women</th>
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<tr>
<td>In five states and 20 educational institutions in norther Nigeria, young women in rural areas are being empowered to become nurses and midwives through a foundation year course.</td>
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<td>Communities nominate girls who have completed secondary education.</td>
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<td>Gender-related barriers are addressed with secure, family-friendly accommodation, crèches for babies and a voice for the students.</td>
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<td>On successful completion of the foundation year, students can apply to the educational institutions for further study.</td>
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<td>The Nursing and Midwifery Council of Nigeria (NMCN) accredits educational institutions and has strengthened the curriculum.</td>
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<tr>
<td>State governments are now investing in education and employing midwives</td>
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back into their own communities.
Source: Adetoro Adekoke, Women for Health

AMREF, east Africa using technology to bridge the gap in access to midwifery education

- AMREF e-learning midwifery courses are used throughout east Africa allowing staff to stay and learn in their facility.
- A work–study programme has the same benefits for students who can stay in their communities; it motivates new leaners and enables lifelong learning for others.
- In Sudan, AMREF developed family-centres to encourage women to learn while also caring for their children.
- These flexible courses are also available for private sector facilities.

Source: Felarmine Muruiri, AMREF

(b) Engage women and communities in the development of midwifery education.

- engage with women and communities to help develop midwifery education so that it is based on their rights and their needs, and to make sure their voices can be heard so that education programmes are designed to be relevant and appropriate.

Box 17: Traditional birth attendants in Hidalgo State, Mexico

In Hidalgo State, Mexico, traditional birth attendants (TBAs) train alongside newly graduated midwives

- The TBA in rural Mexico plays a critical role as the connection between home and health facility.
- Training TBAs alongside newly-graduated midwives enables them to get to know each other, develop trust and help the TBA become more comfortable with referral of women and newborns to the midwives at the facilities.
- Traditionally, the mother-in-law and husband decide whether or not, and how, the woman will reach a facility, so the TBAs have refined their roles to work with families and help them make positive choices.

- advocate with and for women and communities to promote culturally appropriate, respectful care, and empower women to avoid the over-medicalization of birth.
**Box 18: Engaging women in advocacy for midwifery education**

- In New Zealand, women are powerful political advocates for midwives. Their voices and their votes made a difference. More to follow (Source: TBC)

- In India
  - Over X thousand women have responded to the White Ribbon Alliance “What Women Want” campaign. (Source WRA)
  - Advocacy by women and midwives in a private hospital in Telangana State, India, resulted in elective caesarean sections being stopped (caesarean section rates were around 60–70% in private hospitals). Source: Fernandez Hospital
  - Women and midwives together mapped out what kind of care they wanted at the global Partners Forum in new Delhi in 2018. Women wanted respectful care close to their homes, to prevent having to travel long distances to large institutions where they described their chances of costly unnecessary interventions as high. Midwives wanted better education and support to provide respectful care close to where women live, and to prevent unnecessary travel and intervention costs. Source: WHO

- Establish midwifery education-specific improvement committees, involving educators, students, women and communities.
- Incentivize respectful care; disincentivize unnecessary interventions from day one of midwifery education.

(c) **Strengthen education faculty to international standards.**

Participants highlighted an urgent need to focus on the capacity of the teaching faculty. They reported experiences that showed because of a lack of investment, many educators struggle to maintain their own skills to teach evidence-informed midwifery or to teach others. The following was proposed:

- **Assess the skills of educators by adapting the WHO Midwifery Educator Core Competencies tool, available at:**
  [http://www.who.int/hrh/nursing_midwifery/educator_competencies/en/](http://www.who.int/hrh/nursing_midwifery/educator_competencies/en/)
- **Ensure educators maintain clinical practice and clinical teaching alongside teaching theory,** through a practice-teach-practice cycle that will also help educators to remain as active practitioners.
- **Combine theory + simulation + clinical practice,** moving away from a separation of theoretical and clinical teaching.
- **Include mentoring in pre-service and in-service education** to deliver education that provides the midwife with confidence to provide the full scope of midwifery care.

**Box 19: Bangladesh is strengthening its midwifery faculty**

3.3 What will the impact be in countries and how will we measure it?

The consultations emphasized the positive impact of midwifery education on improving quality of care, as evidenced in section 3.1 and the country case studies in this report. However, there was a notable lack of evidence around monitoring and evaluation of midwifery education at programme, subnational or national levels.

Participants described existing tools to measure competencies, such as the objective structured clinical examinations (OSCEs), as well as common programme indicators such as the number of midwives trained. However, these output measures are not always explicitly linked to changes in processes of care or health impact.

This gap in monitoring and evaluation was recognized by participants. There was interest in convening experts with relevant expertise in midwifery, monitoring and evaluation, quality of care, cost-effectiveness and others, to guide development of a standardized monitoring and evaluation framework. This standard framework would allow common measures to track progress, improve programmes and provide data for advocacy.

3.4 How will we strengthen midwifery education and training?

Participants in all consultations shared wide-ranging examples of how midwifery education could be strengthened, based on evidence and experiences. All agreed that the starting point depends on what progress has already been made.

The following is a brief summary of suggestions:

- Strengthen leadership, especially of the Government Chief Nursing and Midwifery officer (GCNMO).
- Establish governance mechanisms that align stakeholders to develop consensus on a national plan, embedded within the national workforce/human resources strategy.
- Carry out research to develop the evidence and a situation analysis on midwifery education.
• Review what policies exist, find out if they are geared to international standards of education and practice. If not, develop flexible education programmes that are appropriate to country context.
• Gather the data. What skills do educators and providers already have; and assess the state of existing educational institutions.
• Acknowledge and address sociocultural, economic, professional and gender-related barriers to midwifery education.
• Engage women and communities in the development of midwifery education so that care is provided to meet their needs, including in times of health emergencies.
• Strengthen faculty, upgrade educational institutions, update the curriculum and use innovative teaching methods.
• Improve monitoring and evaluation.
• Include preparation and response to humanitarian emergencies at every stage.

**Box 20: How Canada transformed its midwifery education and practice**

- The practice of midwifery in Canada was unregulated until the 1990s when enabling legislation led to direct entry university-based midwifery education.
- The driver for change was public demand for greater choice and access to midwives and home birth; all changes seen as increasing the quality of care. Women were strategic advocates; champions within government in both health and education moved the debate forward.
- Autonomous community-based midwifery practice followed.
- The Provincial Government of Ontario was the first to act; over a period of 25 years all but one province has followed.
- Midwifery in Canada now has a common philosophy of practice and common approach to teaching and learning with an emphasis on evidence-informed decision-making, cultural competence and social justice.
- Seven university programmes have highly qualified midwifery faculty including respected researchers who are contributing to the evidence about the effectiveness of midwifery care, including reduced rates of interventions and safe outcomes of home birth.

Professor Karyn Kaufman, Report at the Oxford University consultation, United Kingdom, July 2019
3.5 How is this relevant to conflict and humanitarian settings?

The consultations, which included participants from countries experiencing conflict and health emergencies, highlighted a lack of education for midwives about disaster preparedness, response and rehabilitation. There was a consensus that these issues should be included in all curricula (pre- and in-service), including how to identify and prioritize care for the most vulnerable women and newborns. Participants suggested that students should be taught care for women and newborns in humanitarian settings through simulation of such situations.

There is a dearth of evidence on the outcomes of midwifery education and care in these uniquely difficult circumstances, and consensus was reached on the urgent need for research in this area.

Participants lacked experience, (and there is little evidence), of the engagement of midwifery leadership in national emergency/humanitarian response plans, or of midwives being embedded in emergency medical teams (EMTs). Participants recommended a review of existing policy and strategies to see if midwifery is part of emergency response, and that midwifery leadership should be positioned in the national emergency response team, or wherever is most appropriate.

The participants suggested that refugees and migrants who have midwifery skills should be identified and, where possible, given the additional training needed to be licenced to practice in the country where they are settling.

**Box 21: The Operational Refugee and Migrant Maternal Approach (ORAMMA), Europe**

- The ORAMMA project was designed to build the evidence and identify tools and health system mechanisms to improve outcomes for pregnant refugee and migrant women.
- The project took place during the largest refugee and migrant crisis in Europe since the end of the Second World War.
- ORAMMA is a collaboration between Greece, the Netherlands and the United Kingdom, providing opportunities to explore new approaches to care in different cultural and health-system settings.

ORAMMA’s methodology is based on three phases: developing the evidence; developing the tools and training materials responding to women’s specific needs; and a feasibility study.

Implementation of ORAMMA’s work is based on an identified need for a team approach to care.

The team includes:
- health workers (mainly midwives and doctors)
- social care providers
- locally recruited maternity peer supporters.
Health workers in all three countries needed further education in aspects of primary health care, midwife-led continuity of care, the disease burden of the women's countries of origin (i.e. thalassaemia, HIV and TB), and specifically training in interpersonal, culturally sensitive communications.

The training tools are now available on the ORAMMA website at https://oramma.eu/e-course/

Source: Victoria Vivilaki, ORAMMA coordinator; and Hora Soltani, ORAMMA partner, United Kingdom.

The important work carried out in the seven global consultations has provided a wealth of evidence and knowledge from a wide range of stakeholders with first-hand experience of the many aspects of midwifery education. The consensus reached has been invaluable in formulating the seven-step Action Plan to guide the transformation of midwifery education.
4 Action Plan to strengthen quality midwifery education

4.1 Introduction

This section sets out a seven-step action plan to strengthen quality midwifery education. Each step has been informed by the evidence and the global consultations presented in this report.

The steps act as a guide to help build high-quality, sustainable, pre-service and in-service midwifery education and training. This action plan can be used to develop and/or strengthen a National Midwifery Education Plan, embedded within the National Human Resources for Health Plan. The action plan works as a quality improvement cycle that is continuously updated to review progress, identify barriers, make changes and improve quality of care (Fig XX). At each step, the monitoring and evaluation of change takes place with the aid of a new logic framework that has been developed to assist this process.

**Figure 7: Seven steps to strengthen quality midwifery education**

The strategic objectives identified in the global consultations highlighted that educating and training midwives to international standards is the priority to improve outcomes for women and newborns. However, this action plan recognizes the wide variation in midwifery education provided across many countries and acknowledges that whereas some countries can rapidly move to a high-quality cadre of midwives, other countries will have more investment to make before this strategic priority can
be reached. It is important to educate and empower the personnel already in place to meet the urgent needs of women and newborns.

Education cannot take place in a vacuum. Other developments are needed to create the conditions necessary for good-quality midwifery education, including professional regulation, improvements in practice settings where students learn and interprofessional team working. These and related developments are considered as part of this action plan.

The seven steps directly support implementation of the SDG Action Plan, which prioritizes organizing around the objectives of ALIGN, ACCELERATE and ACCOUNT. Table 1 sets out the actions needed to strengthen midwifery education in line with this process.
Aligning for action

Steps 1–3 aim to align national action and create a positive environment that will

**Table 1. Seven-step action plan to strengthen quality midwifery education**

1. **ALIGN: strengthen leadership and policy**
   - *align* and strengthen national midwifery leadership to improve education
   - establish/strengthen a national midwifery task force
   - review and update national policy on midwifery education

2. **ALIGN: gather data and evidence**
   - identify and synthesize baseline data and evidence
   - *align* with existing indicators and data systems
   - use data and evidence to inform actions 3–7 below

3. **ALIGN: build public engagement and advocacy**
   - develop evidence-based advocacy
   - *align* national consensus

4. **ACCELERATE: prepare educational institutions and practice settings**
   - *accelerate* assessment of educational and training institutions
   - *accelerate* assessment of practice settings

5. **ACCELERATE: strengthen faculty, standards and curricula**
   - *accelerate* assessment of educator capacity
   - strengthen educator capacity to develop/update evidence-based curricula

6. **ACCELERATE: educate students and clinical mentors**
   - *accelerate* assessment of education and training for students and clinical mentors
   - strengthen education provision to include skills, knowledge and behaviour

7. **ACCOUNT: monitor, evaluate, review and adjust**
   - assess and review all progress, measuring only what matters
   - *account* for progress and constraints
   - adjust plans and indicators
help make better midwifery education and training successful. They lay important foundations in terms of leadership and policy, data and evidence, supported by consensus building and advocacy for good-quality care.

4.2 ACTION 1 ALIGN: Strengthen leadership and policy

**Strengthen leadership and policy**

4.2.1 National midwifery leadership

- **Government leadership on midwifery education**, with a clear mandate and accountability structure, is critical to sustainable change. In many countries the official responsible will be a Government Chief Nursing and Midwifery Officer (GCNMO), or a separate Government Chief Midwifery Officer (GCMO).

- **Midwifery leaders must have a “voice at the table”** to enable them to provide knowledgeable and effective leadership to aid decision-making in policy, planning, budgeting and evidence-informed advocacy for investment. Midwives also need to be fully integrated into leadership and policy-making in conflict and emergency situations.

**Box 22: England announces its first Government Chief Midwifery Officer in 2019**

Having had one single post for a joint Government Chief Nursing and Midwifery Officer, England introduced a separate Government Chief Midwifery Officer in 2019.

This is 117 years after the Parliamentary Midwives Act in 1902, when the Royal College of Midwives was established and legal regulation introduced. This meant that a woman could not call herself a midwife, or practise as a midwife, unless she was certified under the Midwives Act.

4.2.2 National midwifery task force

- **National Midwifery Task Force**: Establish or strengthen a National Midwifery Task Force to bring key stakeholders together to ensure ownership and enable all partners to have their voices heard, and their experiences maximized.
Box 23: The National (and/or Subnational) Midwifery Task Force

Key members should include representatives from:

- The government: the GCNMO/GCMO
- The National Midwifery Association and the National Nursing Association
- Related professional organizations such as those for nurses, obstetricians and paediatricians, and others
- The professional regulator
- WHO, UNFPA, UNICEF and other United Nations agencies, as appropriate
- National and international nongovernmental organizations (NGOs)

For more advice, see the WHO Strengthening Midwifery Toolkit

4.2.3 National midwifery policy

- **Policies and laws** should be reviewed and, if necessary, updated to ensure that:
  - midwives are enabled to practise effectively and safely to international standards;
  - evidence-informed standards for pre-service education and practise are agreed nationally;
  - effective professional regulation is in place to set and monitor standards and quality.

- **Planning**
  - Based on strong leadership, collaboration between stakeholders and policy review, the priorities for midwifery education can be identified
  - Midwives need to be fully involved in health emergency planning to ensure the needs of mothers and newborns are anticipated.

4.3 ACTION 2 ALIGN: gather data and evidence

The National Midwifery Education Plan must be embedded within the National Human Resources for Health Plan and based on an assessment of the current evidence and data. It is important to know what is already in place, what is working, what is needed by women, newborns and families, and what existing legislation allows.
The data and evidence collected as part of this Action Step should be updated and used on a continuous basis to inform actions in the following steps 3–7.

4.3.1 Key indicators and global evidence

- **Evidence on the national impact of midwifery and midwifery education**
  - National and local knowledge should continue to be developed at country level, with new and emerging evidence incorporated into planning and policy.
  - Global evidence can be used to provide insights and lessons learned.

- **Country indicators of maternal and newborn health and well-being** should be examined and priorities for action identified through analysis of progress and challenges. Examples of key indicators include:
  - Mortality, morbidity, rates of intervention use, breastfeeding, equity in access and in use of interventions, women’s views of the care they and their newborn infants receive, reports of neglect and abuse;
  - **Workforce data** on women’s access to midwives, deployment, regulation, remuneration

4.3.2 Key analyses of national situation

- **A situation analysis on midwifery education** should be conducted to identify national priorities. Important questions to consider include:
  - Are midwives, or other providers, educated to international standards? Do they reach these standards?
  - What education provision already exists?
  - Who provides midwifery education? Do they reach the WHO Midwifery Educator Core Competencies?
  - What provision exists for educating and upskilling midwifery educators/faculty?
  - What are suitable clinical training facilities and clinical midwifery mentors available for students?
  - Are universities or colleges supportive and involved in midwifery education?

- **An economic analysis of the current model of midwifery education** should be conducted, to include consideration of short-, medium- and long-term costs and the impact on outcomes for women and children. This should include:
  - The costs and the outcomes of current services;
  - How these would change by strengthening midwifery education.

- **An analysis of the conditions needed to support and enable midwives to learn and to work effectively.**

  What are the socio-cultural, economic and professional barriers and facilitators experienced by educators and providers of care? Is there an enabling
environment for midwifery care and midwifery education? The analysis should consider whether the following exist:

- professional regulation of midwifery education and midwifery practice;
- professional associations to provide information, support and networking;
- safe and clean environments for work and study;
- safe transport for students and midwives when working in the community;
- adequate resources for good-quality education and care: such as properly equipped facilities;
- adequate remuneration for faculty, midwives, mentors and students;
- professional and public recognition of midwives’ role and status;
- interprofessional team working and education, with systems for consultation and referral, and interprofessional learning.

### 4.3.3 Humanitarian situations – gathering data and evidence for planning

Gathering evidence and data on midwifery education to improve the humanitarian response in emergencies is important to update the curriculum to include this issue, and address barriers to midwives and students working and learning effectively in health emergencies.

The following **Midwifery Education Evaluation Framework** has been adapted to help guide the gathering of data and evidence. (Source: go2tech).

**Figure 8: Midwifery Education Evaluation Framework**
4.4 ACTION 3 ALIGN: build public engagement and advocacy

Developing public understanding of the importance of midwifery education is essential to harness support. Engaging communities, women’s groups and other concerned stakeholders, through existing and new channels of communication, will help to build awareness, support and a consensus for midwifery education. It will also mean that women are more likely to have confidence and trust in the midwifery services provided.

4.4.1 Participation of women, families and their communities

- **The views and experiences of women, families and communities are important.** They should be involved right from the start of any advocacy initiative to ensure that plans for midwifery education will meet their needs. Ways to do this include:
  
  o engagement with advocacy groups and NGOs that represent the interests of women, newborn infants, families and communities;
  o direct engagement at local level with women, families and community leaders as a core part of developing and implementing the plan for midwifery education, to ensure that it is informed by local knowledge.

**Box 24: The “what women want” campaign**

Example to follow: India and the “What women want campaign”

4.4.2 Engaging parliamentarians and the media

- **Ensuring that decision-makers and influencers are informed and aware of the importance of midwifery education.** This will help to build public support, including for new laws and statutes if required.
  
  o Parliamentarians, local councillors and politicians with interests in women and children and health care, are an important influence on change at national and community levels.
Journalists and influencers in all forms of media – print, radio, television and social media – can have a major impact on public opinion and should be involved at an early stage in plans to raise the profile of midwifery education.

4.4.3 Evidence-based advocacy

- Accurate, up-to-date data and evidence should be compiled and made widely available to the public, key advocates and the media, including:
  - evidence on the contribution that midwifery education can make to a better experience of care for women;
  - data on current indicators showing the health status and well-being of women and newborn infants.

Accelerating action

The next steps, 4–6, are intended to accelerate action. They are all about the learning and teaching environment and are closely linked. The steps have been separated out to ensure planning and action includes consideration of the three essential components – the institutions, the staff/faculty, and the students themselves. These steps should interrelate effectively so that staff and students are well supported both in education and in practice settings.

4.5 ACTION 4: ACCELERATE: prepare educational institutions and practice settings

Educational institutions should be fit for purpose to enable effective learning and also have close links with practice settings. Combining theory and practice is essential so that students have a strong theoretical basis together with the skills and experience that prepares them well for the context in which they will be working.

4.5.1 Educational institutions prepare and provide education and training that addresses all components of the QMNC Framework including:

- care for all women and newborns, including those with and without complications;
- continuity of care across community and facilities;
- respectful care, tailored to the needs of women, newborns and families;
- care that optimizes normal processes, using interventions only when needed;
- interpersonal and cultural competence;
- interprofessional working with obstetricians, paediatricians, family physicians, nurses, community workers and others.

### 4.5.2 Physical infrastructure

The level of facilities provided will be context-specific but as **a basic minimum**, educational institutions should have the physical infrastructure in place for **safe learning**. The *WHO Standards for improving quality of maternal and newborn care in health facilities*, 2016, set out the essential physical resources needed.

This protects the human rights, health and well-being of students and staff including:

- clean water and sanitation facilities; refer to the WHO-UNICEF indicators below
- security, including lockable doors and windows, separate changing space for women and men, and security staff;
- access to transport to enable students and staff to travel safely;
- clean classrooms with heating, lighting and desks;
- clean and accessible areas for eating, drinking, informal learning and socializing.

*Figure 9: WASH in Health Care Facilities*

![WASH in Health Care Facilities Global Indicators](image)

### 4.5.3 Learning and teaching facilities

**Essential facilities for good-quality learning and teaching** include:
- IT, including computers, access to the Internet and web-based resources;
- a library, including current journals and books;
- access to essential learning resources including notebooks, pens, pencils, a photocopier.

4.5.4 Close links between educational institutions and practice settings

Educational institutions should be closely linked with practice settings to enable frequent and effective interchange between education and practice staff. In addition to geographical proximity, this should include:
- shared protocols and procedures to ensure consistent practice;
- facility and institutional arrangements to enable staff to work in both settings;
- accreditation processes should consider the educational institution and the practice settings together;
- access to interprofessional learning opportunities in both educational institutions and practice settings.

4.5.5 Engaging high-level support to ensure good-quality midwifery education

Senior managers of educational institutions and practice settings should be fully informed and engaged in developing quality midwifery education. Their support is critical to ensure:
- provision of appropriate facilities, infrastructure and resources;
- that staff/faculty are properly appointed, remunerated and supported;
- all processes are in place and functioning effectively, including recruitment, theoretical and practice assessments, compliance with regulatory requirements and accreditation procedures;
- interprofessional learning opportunities.

4.6 ACTION 5: ACCELERATE: Strengthen faculty, standards and curricula

Experienced, educated and well-supported staff, in both institutional and practice settings, should ensure their teaching is context-specific and based on agreed national standards.
4.6.1 Strengthen educators in both institutional and practice settings

- **Upskill existing educators and recruit new ones ensuring that all have the WHO Midwifery Educator Core Competencies with** up-to-date theoretical and clinical knowledge and skills, together with knowledge and experience of effective teaching methods.
  - Educators should be supported and enabled to work across both education institution and practice settings.
  - Being taught by others in the interprofessional team is important for building effective collaboration, but experienced midwife educators should have the core responsibility for teaching both at pre-service level and for continuing professional development of midwives.

4.6.2 Evidence-informed curricula that meet national and international standards

**National standards for pre-service midwifery education** should be informed by the latest evidence (see Align 2); this will then act as the basis for developing (or updating) context-specific curricula.

- Standards and curricula should be based on national and international models and be appropriate to the context-specific needs of women, newborn infants and families. They should include all components of the QMNC framework (as in Action 4, see also Annex XX).
- Effective professional regulation should be in place to assess and monitor the quality of the curriculum, teaching and learning – both theoretical and practical.

4.7 ACTION 6: ACCELERATE: educate students and clinical mentors

The work of educating students including pre-service and continuing professional development, should be informed by all the previous steps. This work in turn should be monitored and evaluated.
4.7.1 Recruit, educate and train students to international standards adapted to national context.

- Pre-service students should be recruited through a transparent and equitable process, with evidence of appropriate education, personal qualities and the capacity to learn.
- In-service education should focus on the specific knowledge, skills and behaviour needed to address the priority needs of women, newborn infants and families, specific to each context.
- Develop flexible education programmes to reach students in remote areas, and with families and to upskill existing cadres to national standards.

4.8 ACTION 7: ACCOUNT: monitor, evaluate, review and adjust

4.8.1 Assess and review all plans and progress

Monitoring and evaluation is critical to assess progress and to adapt interventions and programmes as needed. The Logic Model below can be used and adapted to context. Illustrative indicators include:

i. Individual level:
- Individual provider knowledge, skills and competencies based on ICM competencies (through OSCE and other methods)

ii. Health facility level:
- Availability of trained providers
- Availability of equipment and supplies
- Availability of WASH
- Women’s experience of care
- Quality of care linking with the common measures of the WHO Standards for improving quality of maternal and newborn care in health facilities.

ii. Education system:
- Availability of quality training institutes
- Educators trained
• Health providers trained
• Management systems in place
• Educators knowledge, skills and competencies

Population level impact:

• Maternal and newborn mortality and morbidity

• **Report regularly** on progress on these measures at national and local levels.
• **Establish review processes** at every level to adjust plans and provision.
• **Use the regulatory mechanisms**, for professional, education and service regulation, to ensure plans and provision are regularly reviewed and appropriate actions taken.

The Logic model is based on existing global monitoring frameworks, including ANC, Quality of Care common measures, RMNCAH HMIS module and others. Examples of activities and indicators are provided.
Table 2: The Strengthening Midwifery Education Logic Model

<table>
<thead>
<tr>
<th>Objective</th>
<th>Activity (example)</th>
<th>Indicators of achievement</th>
<th>Factors that may influence success</th>
<th>Budget/cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Strengthen leadership and policy</td>
<td>GCNMO recruited</td>
<td>National Task Force established</td>
<td>Concerns from HPAs</td>
</tr>
<tr>
<td>2</td>
<td>Gather data and evidence</td>
<td>Situation analysis</td>
<td>Baseline data on educator skills available</td>
<td>Access to remote education institutes</td>
</tr>
<tr>
<td>3</td>
<td>Build public engagement and advocacy</td>
<td>Women's network for midwifery established</td>
<td>Parliamentarians pass law/Act on midwifery education</td>
<td>Wide gender gap, very low status of women</td>
</tr>
<tr>
<td>4</td>
<td>Prepare educational institutions and practice settings</td>
<td>Education institute infrastructure/WASH assessed</td>
<td>WHO-UNICEF WASH in health care facilities achieved.</td>
<td>Links between MoH and WASH provider</td>
</tr>
<tr>
<td>5</td>
<td>Strengthen faculty, standards and curricula</td>
<td>Update curriculum</td>
<td>QMNC Framework components included in curriculum</td>
<td>Resistance to change from some professions</td>
</tr>
<tr>
<td>6</td>
<td>Educate students and clinical mentors</td>
<td>Education of students, clinical mentors in inter-professional groups</td>
<td>Improved quality of care (provision and experience)</td>
<td>Educators not fully updated</td>
</tr>
<tr>
<td>7</td>
<td>Monitor, evaluate, review and adjust</td>
<td>Data collected and assessed against baseline</td>
<td>Improvement in X, Y, Z from baseline</td>
<td>Lack of capacity</td>
</tr>
</tbody>
</table>
5 Making it happen (this section is still being worked on)

ACCOUNT (SDG 3 Action Plan)

i. Committing to Collective Action – why now.
ii. Milestones for Action: national, global.
iii. Midwifery leadership for Collective Action.
iv. Governments, parliamentarians will….
v. Civil society will….
vi. Academic and research institutions will….
vii. The private sector will….
viii. The media will….
ix. UN and multilateral organizations will….

Early draft points below: update to follow

SDG 3 Action Plan “enhancing our joint accountability for delivering collective results for people”.

Strategic objective 3 from global consultations

*Improved coordination and alignment between midwifery stakeholders at global, regional and country levels to align education and training processes, knowledge, research, evidence-based materials, indicators and investment.*

X. What will the following communities do to enhance our joint accountability for delivering collective results on quality, inter-professional care for women, newborns and their families”.

In support of the achievement of the goals of the GSWCAH:

X.1 **The global midwifery community will:** *examples tbc with Management Group*

xxxxx - work in alignment at global, national and local levels to support governments and other key stakeholders to x,z,y
ii. work with women to have their voices heard in the care they want and need to survive, thrive and transform the communities they live in.

iii. etc…

X.2 Which communities? How to divide? Use PMNCH 11 constituencies? Or Nurturing Care Framework (p 43) uses 7 constituencies (government, parliamentarians, policy-makers, civil society, academic and research, business, media, UN and other multi-laterals, bilateral organizations and philanthropic).

- Data, monitoring and evaluation
- Economists.

X.3 Align with the WASH community to (taken from EB resolution Jan 2019, to get final approval at the WHA 2019).
Annex 1: glossary

to come
Annex 2. The Lancet Midwifery Quality Maternal and Newborn Care (QMNC) Framework

**What does good quality midwifery education look like?**

Good quality education is essential to prepare international-standard midwives\(^6\) with the knowledge and skills to provide the full scope of care that women and newborns need. A review of hundreds of studies has identified the key components of care that all midwives need to know and to be skilled in. These are summarized in Figure X\(^8\).

Framework for quality maternal and newborn care

**Component 1: The practices that all childbearing women and newborn infants need**

To stay well and healthy all women need the information and care that a midwife offers. Education should ensure that midwives have the knowledge and skills to provide the range of evidence-informed practices needed across the continuum of care, from pre-pregnancy, pregnancy, labour and birth, postpartum and the early weeks of life. This should include:

- **Education, information, and health promotion for all women:** this will include, for example, ensuring that women have information and support about avoiding infection, stopping smoking, optimizing maternal nutrition,
promoting breastfeeding, resources for family planning, preparation for birth, parenting and relationship building

- **Assessment, screening, and care planning for all women and newborn infants**: this will include the ability to assess the woman and the newborn infant for physical, psychological and social complications, to conduct screening tests and to work with the woman to plan the care that she and her infant need. If complications are identified that need the involvement of the interprofessional team, it will also include the ability to consult and refer as needed, and to plan care jointly.

- **Promotion of normal processes, prevention of complications for all women and newborn infants**: this will include practices that promote health and well-being and the abilities of women's own bodies, and which avoid complications developing; for example, encouraging mobility in labour and an upright position at birth, ensuring hydration, avoiding routine procedures such as episiotomy, practising delayed cord clamping, keeping the newborn infant warm and encouraging skin-to-skin care, supporting the initiation of breastfeeding, and avoiding infection. Even women who do develop complications need this care, to prevent additional complications developing; for example, a woman who has a caesarean section can still have skin-to-skin care and can breastfeed.

**Component 2: Additional practices needed by childbearing women and newborn infants with complications**

Women and newborn infants who develop complications need extra care, and they need it promptly. The midwife is often in the best position to identify and respond to complications, and to consult with and refer to the interprofessional team if necessary. It is essential that education prepares the midwife to:

- **Identify complications and provide first-line management**: this will include circumstances where the midwife is able to resolve the complication, such as perineal suturing and help with breastfeeding problems, as well as complications where timely consultation and referral to the interprofessional team is needed. Whatever the complication, the ability of the midwife to identify it and to respond appropriately is critically important.

- **Work with the interprofessional team, including medical, obstetric, neonatal, and other services**: the midwife should be educated to work with the interprofessional team so that all women and newborn infants receive the care that they need. They must know and understand other services and the abilities and roles of interprofessional colleagues, and know how to work as a team. They must know how to continue with the midwifery care that women need when other professionals are involved, such as providing continuous support in labour for women in preterm labour.
Component 3: The organization of care and services

Midwives need education to ensure that their care, and the services they work within, are organized appropriately. This will include:

- **Available, accessible, acceptable, good quality services with adequate resources and a competent workforce:** midwives need the education to ensure that their work is founded on a human rights perspective, reaching out to all women and newborn infants regardless of their circumstances, and taking pro-active steps to ensure that their services are available, accessible and acceptable to all, with a consistent level of quality. If resources are lacking, or they or their colleagues are not adequately educated for the circumstances in which they are working, they need to know how to take action and to advocate for improvement.

- **Continuity, services integrated across community and facilities:** a key characteristic of midwifery is that it is practised in all the settings where women and newborn infants are – the home, community, health centre and hospital. Midwives need to have the education and experience to practice safely in each of these settings, to avoid women receiving fragmented care, and ensure that the care that women receive is seamless. The most important element of this is midwifery continuity of care, where the same midwife cares for a woman throughout her childbearing journey. This has been shown to reduce mortality and preterm birth, and improve a wide range of outcomes.

Component 4: Values

Just as important as providing the right practices and interventions is providing it in the right way. Education must prepare midwives who demonstrate core values that include:

- **Respect:** Respectful care is the foundation of quality care, and it should be a core part of the education that all midwives receive. If care providers do not treat women and families with respect, or do not take women’s views into consideration, women may not ask for help or access the care that they need. Respectful care includes giving information that women need to make decisions, asking for consent for treatment and interventions, and providing a safe environment for the woman and her newborn infant.

- **Community knowledge and understanding:** Knowing the local community enables the midwife to access resources quickly and effectively, and to encourage women to access support and services they need. Knowing how to work with local communities and services is an important component of midwifery education.

- **Tailoring care to women’s circumstances, views, and needs:** The clinical, social, economic, family and psychological circumstances of each woman...
matter. They will influence her health and well-being and her ability to care for herself and her infant. Midwives must learn to treat every woman as an individual, and to assess and respond to her specific needs and preferences.

**Component 5: Philosophy**

The philosophy of care affects the way in which care providers interact with women and families, and with each other. The great majority of childbearing women are not ill, and to treat them as patients who need treatment risks the use of unnecessary and expensive resources, as well as causing harm. Education must prepare midwives who understand that their role is to support and promote women’s own abilities, intervening when – and only when – needed.

- **Optimizing normal processes, strengthening women’s own capabilities:** Women’s bodies have a powerful ability to be pregnant, give birth, breastfeed and care for their newborn infant. These abilities can be interrupted or blocked, by fear, for example. A fundamental component of quality midwifery that all midwives must learn is the ability to work with women to promote women’s own capabilities, helping them to feel healthy and confident, and enabling them to seek help when they need it.

- **Using interventions only when indicated:** Interventions in pregnancy and childbirth can be necessary, appropriate and life-saving for the women and newborn infants who need them. But they can also be mis-used and applied routinely, as is seen with induction of labour, caesarean section and with the use of breast-milk substitutes, for example. This can cause harm, exposing women and infants to unnecessary procedures, increasing over-medicalization and wasting resources. An important skill in midwifery is learning when to intervene and when to avoid using interventions.

**Component 6: interpersonal and cultural competence, working with others**

Care providers must learn not only to work directly with individual women and infants, but to work within a community and a health system. They must practice appropriately for their context, and they must work with colleagues to ensure all women and infants receive the care they need in a timely way. Quality education should enable midwives to learn:

- **Combining clinical knowledge and skills with interpersonal and cultural competence:** knowing the right practices and skills is essential, but it must be combined with the ability to communicate, build relationships and understand and respect cultural differences and context.

- **Division of roles and responsibilities based on need, competencies and resources:** knowing and understanding their own competencies and skills, and the abilities and roles of colleagues, enables midwives to work as part of an interprofessional team to meet the needs of women and infants in a timely way. This is especially important if there are complications, when midwives will need to consult and refer. Timely discussion with interprofessional
colleagues will help in organizing team working, which is critically important in avoiding delays in referral when women and infants need treatment
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THIS IS ALL GAVINE and the WHO Policy Research piece – advice please

Gavine

Gavine

WHO Policy Research

SBA doc etc.

Definition of skilled health personnel providing care during childbirth: the 2018 joint statement by WHO, UNFPA, UNICEF, ICM, ICN, FIGO and IPA


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WRA WHAT women want campaign

Midwives Voices Midwives Realities

Provide link to what methodology Petcha Kutcha is

ADD Reference to the WHO human resources for health plan

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Participants from over 20 counties contributed to the artwork, each charged to add a representation of where they come from, their home, their place. Over two days the art work came alive, as nurses and midwives connected and shared their stories. From this the artist began to weave the story of the participants capturing the unique connections of a global nursing and midwifery workforce. The central embryo with its rivers of green represent the rivers of life.

Artist: Elverina Johnson / 12th Biennial Conference of the Global Network of WHO Collaborating Centres for Nursing and Midwifery (GNWHOCCNM), Cairns, Queensland, Australia. 18th & 19th July 2018.

‘Sustainable Development Goals are everyone’s business’.