THE STATE OF THE

WORLD'S MIDWIFERY

2014

A UNIVERSAL PATHWAY. A WOMAN'S RIGHT TO HEALTH

UNFPA
International Confederation of Midwives
Strengthening Midwifery Globally
World Health Organization

Executive Summary

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

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

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

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

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

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

The evidence and analysis in *SoWMy 2014* is structured by the four domains that determine

whether a health system and its health workforce are providing effective coverage, i.e. whether women are obtaining the care they want and need in relation to SRMNH services. These four domains are: availability, accessibility, acceptability and quality.

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

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

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

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

Accessibility: Although nearly all of the 73 countries recognize the importance of financial accessibility and have a policy of offering at least some essential elements of SRMNH care free of charge at the point of access, only 4 provide a national "minimum guaranteed benefits package" for SRMNH that includes all the essential interventions.

Gaps in the essential interventions include those known to reduce the four leading causes of maternal mortality: severe bleeding; infections; high blood pressure during pregnancy (pre-eclampsia and eclampsia); and unsafe abortion.

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

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

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

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

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

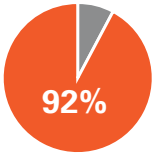
The ultimate goal of professional associations is to foster a dynamic, collaborative, fit-for-purpose, practice-ready team of health-care professionals who are responsive to the needs of women and children. Although almost all countries have at least one professional association for midwives, nurse-midwives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

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

KEY MESSAGES

The report shows that:

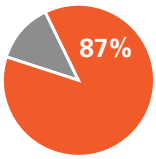
1 The 73 Countdown countries included in the report account for more than **92% OF GLOBAL MATERNAL AND NEWBORN DEATHS AND STILLBIRTHS** but have only **42% OF THE WORLD'S MEDICAL, MIDWIFERY AND NURSING PERSONNEL.** Within these countries, workforce deficits are often most acute in areas where maternal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



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

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

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



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

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

7 Legislation, regulation and licensing of midwifery allow midwives to provide the high-quality care they are educated to deliver and thus protects women's health. High-quality midwifery care for women and newborns saves lives and

CONTRIBUTES TO HEALTHY FAMILIES AND MORE PRODUCTIVE COMMUNITIES.

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

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

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

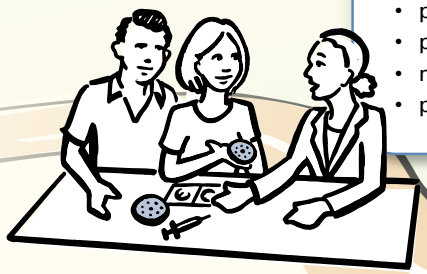
Midwifery2030: Quality midwifery care is central to achieving national and global priorities and securing the rights of women and newborns. *SoWMy 2014* has developed *Midwifery2030* as a pathway for policy and planning. Starting from the premises that pregnant women are healthy unless complications,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

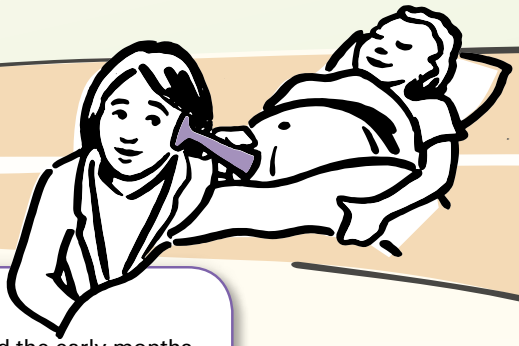
Midwifery2030 focuses on increasing the availability, accessibility, acceptability and quality of health services and health providers to achieve the three components of universal health coverage (UHC): reaching a greater proportion of women of reproductive age (increasing coverage); extending the basic and essential health package (increasing services); while protecting against financial hardship (increasing financial protection). Central to this are an enabling policy environment that supports effective midwifery education, regulation and association development, and an enabling practice

MIDWIFERY2030: A PATHWAY TO HEALTH

PLANNING AND PREPARING *means:*

- delaying marriage
- completing secondary education
- providing comprehensive sexual education for boys and girls
- protecting yourself against HIV
- maintaining a good health and nutritional status
- planning pregnancies using modern contraceptive methods





ENSURING A HEALTHY START *means:*

- maintaining your health and preparing yourself for pregnancy, childbirth and the early months as a new family
- receiving at least four antenatal care visits, which include discussing birth preparedness and making an emergency plan
- demanding and receiving professional supportive and preventive midwifery care to help you and your baby stay healthy, and to deal with complications effectively, should they arise

WHAT MAKES THIS POSSIBLE?

1
All women of reproductive age, including adolescents, have universal access to midwifery care when needed.

2
Governments provide and are held accountable for a supportive policy environment.

3
Governments and health systems provide and are held accountable for a fully enabled environment.

4
Data collection and analysis are fully embedded in service delivery and development.

5
Midwifery care is prioritized in national health budgets; all women are given universal financial protection.

environment that provides access to effective consultation with and referral to the next level of SRMNH services. This should be underpinned by effective management of the workforce, including professional development and career pathways.

Implementing the recommendations of *Midwifery2030* can lead to significant returns on investment. A value for money assessment in Bangladesh reviewing the education and future deployment of 500 community-based midwives ranked positively for economy, efficiency and effectiveness. The assessment calculated a beneficial impact comparable to that of child immunization, with a 16-fold return on investment and confirms that midwifery is a "best buy" in primary health care.

Essential building blocks for putting the *Midwifery2030* vision into practice include political will, effective leadership and midwifery "champions" who will drive the agenda, supported by the current regional and international momentum for improvements to SRMNH.

SUPPORTING A SAFE BEGINNING *means:*

- safely accessing midwifery services with the partner of your choice when labour starts
- finding respectful, supportive and preventive care, provided by competent midwives who have access to the equipment and supplies they need and receiving emergency obstetric care if required
- participating in decisions about how you and your baby are cared for
- having the privacy and space to experience birth without unnecessary disturbance and interventions
- being supported by a collaborative midwifery team in the event that you do need emergency obstetric care

CREATING A FOUNDATION FOR THE FUTURE *means:*

- starting to breastfeed immediately and being supported to continue breastfeeding as long as you wish
- being provided with information about and support in caring for your child in the first months and years of life
- receiving information about family planning so you can efficiently space your next pregnancy
- being supported by the midwifery team to access child and family health services and vaccination programmes at the appropriate time

6
Midwifery care is delivered in collaborative practice with health-care professionals, associates and lay health workers.

7
First-level midwifery care is close to the woman and her family with seamless transfer to next-level care.

8
The midwifery workforce is supported through quality education, regulation and effective human and other resource management.

9
All health-care professionals provide and are enabled for delivering respectful quality care.

10
Professional associations provide leadership to their members to facilitate quality care provision.

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Please share the evidence, inform policy dialogue, take action, so that all women and newborns obtain quality midwifery care.

Every woman and her newborn have the right to quality care during pregnancy, childbirth and after birth #SoWMy2014

#Womenshealth and #midwives go hand in hand. Stand up for keeping women safe: #SoWMy2014

#Midwives can help avert two thirds of all maternal deaths. Send a heart for #womenshealth #SoWMy2014

Every woman and every child has the right to good-quality health care. #SoWMy2014

Sweden managed to drastically lower its maternal death ratio by using the services of midwives. #SoWMy2014

#Midwives help with the elimination of mother-to-child transmission of HIV

Coordinated by UNFPA
605 Third Avenue
New York, NY 10158
www.sowmy.org

HOW TO USE THE *SOWMY 2014* COUNTRY BRIEFS

The country brief has been designed to prompt and inform policy discussions on how the composition, skill-mix, deployment and enabling environment of the midwifery workforce impacts on the delivery of SRMNH services for all women and newborns who need them. This visual guide describes the graphics on the two-page country brief and provides examples of the indicative policy questions that may arise.

First page: Where are we now?

The first page of the country brief can be used to discuss the extent to which the workforce is currently able to deliver SRMNH services for all women and newborns who need them. Proxies for availability, accessibility and quality are presented to facilitate these discussions. All data are from 2012.

WHAT DO WOMEN AND NEWBORNS NEED?

The brief starts by showing some of the indicators of need that must be met if universal coverage is to be attained. The number of pregnancies, their geographical distribution, and the volume of services that must be provided are displayed in this section. Other needs include the provision of sexual and reproductive health services, including addressing unmet need for family planning.

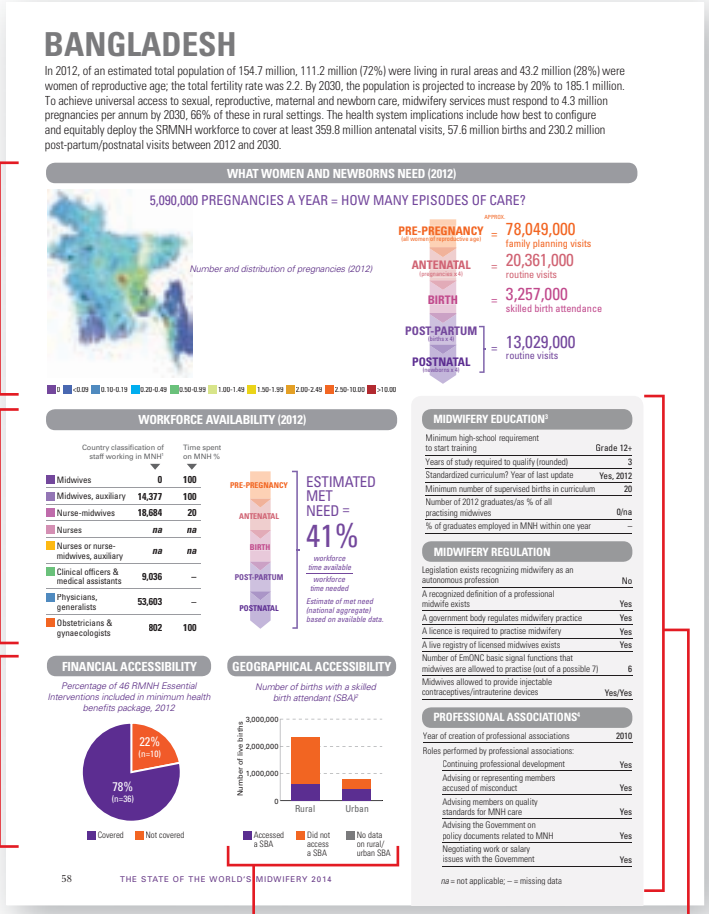
Indicative policy question: *Is the policy and planning environment in the country consistent with universal coverage of SRMNH services, responsive to what women and newborns need?*

WORKFORCE AVAILABILITY AND MET NEED

The brief then considers how many health workers are available to meet this need. The number (by headcount) of all workers reported and the percentage time each one spends on MNH services are shown. This information provides the number of available health workers by their full-time equivalent. Only by considering the number of full-time equivalent health workers can a true picture of availability be constructed. Health workers are grouped by category, while their country cadre name is provided in footnote 1.

The section also provides an estimate of how workforce availability compares with need. An estimated percentage for the national aggregate summarizes the extent to which the available midwifery workforce, taking into account which health workers provide which services, has enough time to deliver the 46 essential SRMNH interventions to all women and newborns who need them. The estimate of met need is highly sensitive to the package of care (e.g. the 46 essential interventions), the number of health workers reported, the percentage of time they spend on SRMNH services, and the roles they perform.

Indicative policy questions: *Have all cadres that contribute to the midwifery workforce been reported, by name and by the percentage of time each cadre spends on SRMNH services? Does the estimate of met need at the national aggregate level mask inequities, e.g. at the sub-national level, or when disaggregated by urban/rural and socio-economic strata?*



FINANCIAL ACCESSIBILITY

Even if there are sufficient health workers, the services they provide may not be affordable. This graph shows the number of the 46 essential SRMNH interventions that are included in each country's minimum health benefits package and available free at the point of delivery, as an indication of the degree of financial protection offered to women and their newborns in accessing SRMNH care.

Indicative policy questions: *Is the minimum health benefits package guaranteed to all women regardless of ability to pay? Are there national plans to provide a package of SRMNH services that include and go beyond the 46 essential interventions?*

GEOGRAPHICAL ACCESSIBILITY

Health workers, and the facility from which they work, may not be equally distributed with regards to need. This graph shows the number of births in urban versus rural areas to indicate the geographical need for SRMNH services. Where data are available the graph also shows the number of births where a skilled birth attendant was reportedly available. This provides an indicative measure of workforce accessibility.

Indicative policy question: *Is there a marked difference in access to the midwifery workforce in urban and rural areas and what policy measures can be taken to address this?*

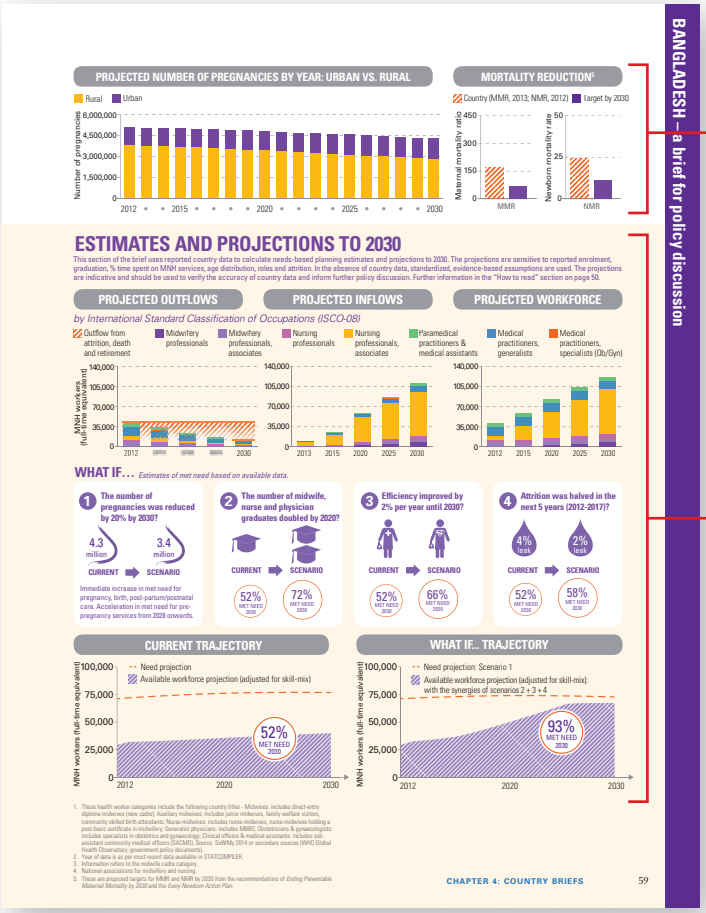
EDUCATION, REGULATION, ASSOCIATION

Education, regulation and professional associations are all crucial to support health workers in delivering quality midwifery care. This section provides information on the strength of the enabling environment within a country.

Indicative policy question: *Is the enabling environment for quality health workers and quality health services meeting national and international standards, and if not where can progress be made?*

Second page: What might 2030 look like?

The second page of the country brief aims to prompt policy discussion on the future evolution of the midwifery workforce compared with the future scale of population need. The last section, "Estimates and projections to 2030", compares future availability of the health workforce and future needs for SRMNH services under a variety of scenarios. Given the absence of data in some countries, this analysis should be seen as a starting point for policy discussions (including around the availability and quality of national data) rather than as a statement of fact.



PROJECTED PREGNANCIES AND MORTALITY REDUCTION

Achieving universal coverage means anticipating and responding to future needs. This section shows the evolution of need (expressed as the annual number of pregnancies in urban and rural areas) in the period 2012-2030. Other needs for sexual and reproductive health services will be determined by changes in the number of women of reproductive age, including the number of adolescents.

The section also provides an indication of the targets for reductions in maternal and neonatal mortality, as proposed in the Ending Preventable Maternal Mortality by 2030 initiative and the Every Newborn Action Plan. These proposed targets are subject to national policy priorities and decisions.

Indicative policy questions: *Is there an opportunity in your country to address unmet need for family planning and therefore reduce the annual number of pregnancies? What is the impact of urban/rural population change on the selection, education and deployment of the midwifery workforce? What are the midwifery workforce implications to achieve the accelerated reductions in maternal and neonatal mortality by 2030?*

ESTIMATES AND PROJECTIONS TO 2030

This section illustrates the potential evolution of the midwifery workforce under "business as usual" assumptions and according to different policy scenarios.

The first row of three graphs considers the number of health workers who will enter and exit the midwifery workforce in the period 2012 - 2030. The graph to the left illustrates how the full-time equivalent number of health workers will reduce over time, and the shaded area represents the 'outflows' in this period. The graph in the centre identifies the entries from national education institutions, and the third graph to the right the cumulative effect of entries and exits.

'What if' scenarios are presented as examples. These illustrate the potential impact of policy decisions and demonstrate the changes in met need that could be realised through four different scenarios: reducing the number of pregnancies per annum, increasing the supply of midwives, nurses and physicians, improving efficiency and reducing voluntary attrition. The bottom two graphics highlight the difference between "business as usual" and the combination of the policy scenarios. The changes in met need are based on the country data reported and a standard set of decision rules in Annex 5.

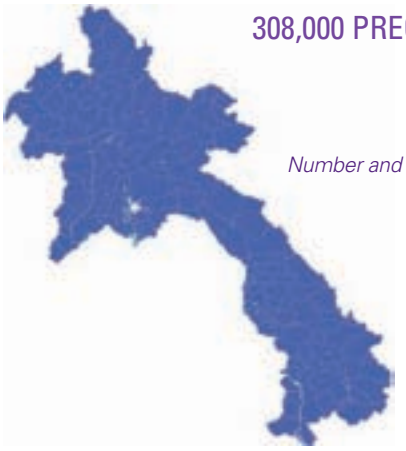
Indicative policy questions: *What are the opportunities to improve the efficiency and management of the current midwifery workforce? What is the turnover of the midwifery workforce today, and are there mechanisms in place to capture all exits and understand why health workers are leaving? What are the national policy priorities for the skill-mix and deployment of the midwifery workforce and how will this impact on met need?*

LAO PEOPLE'S DEMOCRATIC REPUBLIC

In 2012, of an estimated total population of 6.6 million, 5.9 million (89%) were living in rural areas and 1.8 million (26%) were women of reproductive age; the total fertility rate was 3. By 2030, the population is projected to increase by 33% to 8.8 million. To achieve universal access to sexual, reproductive, maternal and newborn care, midwifery services must respond to 0.3 million pregnancies per annum by 2030. The health system implications include how best to configure and equitably deploy the SRMNH workforce to cover at least 22.6 million antenatal visits, 3.4 million births and 13.7 million post-partum/postnatal visits between 2012 and 2030.

WHAT WOMEN AND NEWBORNS NEED (2012)

308,000 PREGNANCIES A YEAR = HOW MANY EPISODES OF CARE?



Number and distribution of pregnancies (2012)

0 | <0.09 | 0.10-0.19 | 0.20-0.49 | 0.50-0.99 | 1.00-1.49 | 1.50-1.99 | 2.00-2.49 | 2.50-10.00 | >10.00

APPROX.

PRE-PREGNANCY (all women of reproductive age) = 3,010,000 family planning visits

ANTENATAL (pregnancies x 4) = 1,232,000 routine visits

BIRTH = 186,000 skilled birth attendance

POST-PARTUM (births x 4) + **POSTNATAL** (newborns x 4) = 745,000 routine visits

WORKFORCE AVAILABILITY (2012)

Country classification of staff working in MNH[1]	Time spent on MNH %
Midwives	673	90
Midwives, auxiliary	*na*	*na*
Nurse-midwives	*na*	*na*
Nurses	*na*	*na*
Nurses or nurse-midwives, auxiliary	*na*	*na*
Clinical officers & medical assistants	*na*	*na*
Physicians, generalists	495	30
Obstetricians & gynaecologists	105	100

PRE-PREGNANCY
ANTENATAL
BIRTH
POST-PARTUM
POSTNATAL

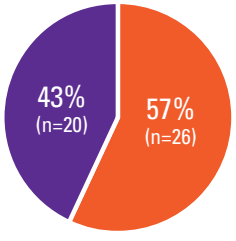
ESTIMATED MET NEED = 19%

workforce time available / *workforce time needed*

Estimate of met need (national aggregate) based on available data.

FINANCIAL ACCESSIBILITY

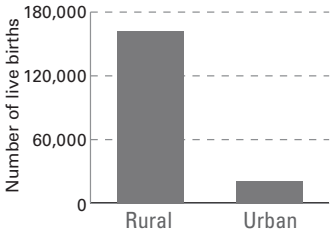
Percentage of 46 RMNH Essential Interventions included in minimum health benefits package, 2012



Covered | Not covered

GEOGRAPHICAL ACCESSIBILITY

Number of births with a skilled birth attendant (SBA)[2]



Accessed a SBA | Did not access a SBA | No data on rural/urban SBA

MIDWIFERY EDUCATION[3]

Minimum high-school requirement to start training	Grade 10-
Years of study required to qualify (rounded)	1.5
Standardized curriculum? Year of last update	Yes, 2013
Minimum number of supervised births in curriculum	20
Number of 2012 graduates/as % of all practising midwives	189/28
% of graduates employed in MNH within one year	100%

MIDWIFERY REGULATION

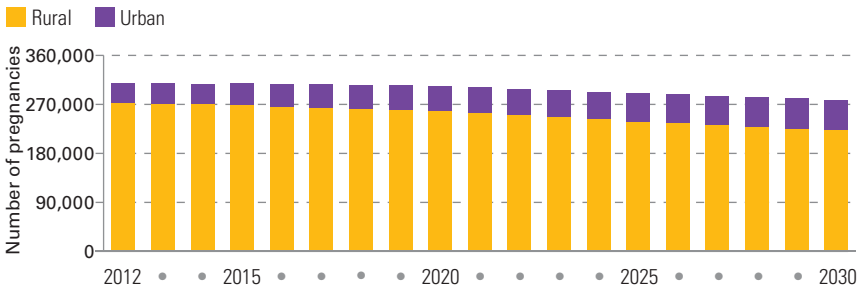
Legislation exists recognizing midwifery as an autonomous profession	No
A recognized definition of a professional midwife exists	Yes
A government body regulates midwifery practice	Yes
A licence is required to practise midwifery	–
A live registry of licensed midwives exists	Yes
Number of EmONC basic signal functions that midwives are allowed to practise (out of a possible 7)	7
Midwives allowed to provide injectable contraceptives/intrauterine devices	Yes/Yes

PROFESSIONAL ASSOCIATIONS[4]

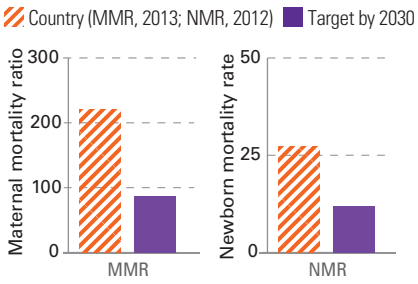
Year of creation of professional associations	2007
Roles performed by professional associations:	
Continuing professional development	No
Advising or representing members accused of misconduct	No
Advising members on quality standards for MNH care	No
Advising the Government on policy documents related to MNH	No
Negotiating work or salary issues with the Government	No

na = not applicable; – = missing data

PROJECTED NUMBER OF PREGNANCIES BY YEAR: URBAN VS. RURAL



MORTALITY REDUCTION[5]



ESTIMATES AND PROJECTIONS TO 2030

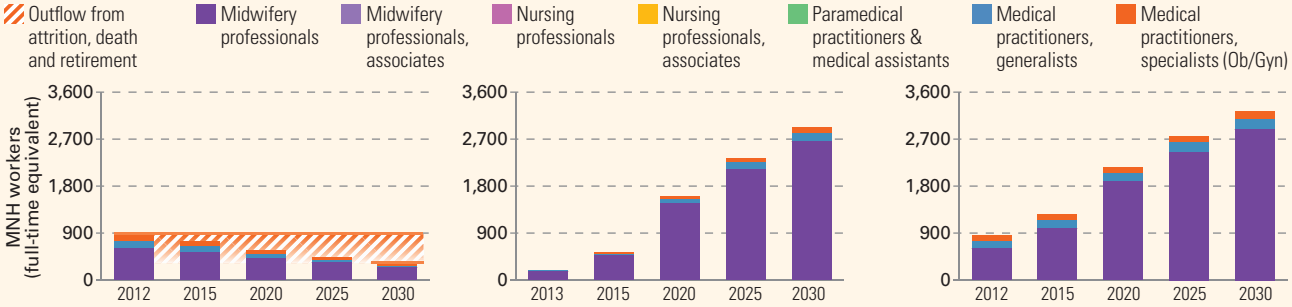
This section of the brief uses reported country data to calculate needs-based planning estimates and projections to 2030. The projections are sensitive to reported enrolment, graduation, % time spent on MNH services, age distribution, roles and attrition. In the absence of country data, standardized, evidence-based assumptions are used. The projections are indicative and should be used to verify the accuracy of country data and inform further policy discussion. Further information in the "How to read" section on page 50.

PROJECTED OUTFLOWS

PROJECTED INFLOWS

PROJECTED WORKFORCE

by International Standard Classification of Occupations (ISCO-08)

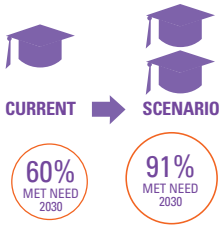


WHAT IF... *Estimates of met need based on available data.*

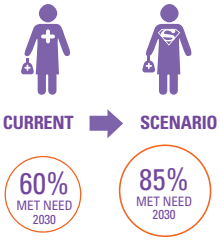
1 The number of pregnancies was reduced by 20% by 2030?

Immediate increase in met need for pregnancy, birth, post-partum/postnatal care. Acceleration in met need for pre-pregnancy services from 2028 onwards.

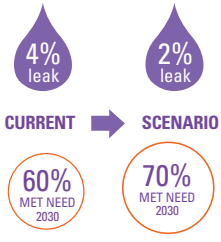
2 The number of midwife, nurse and physician graduates doubled by 2020?



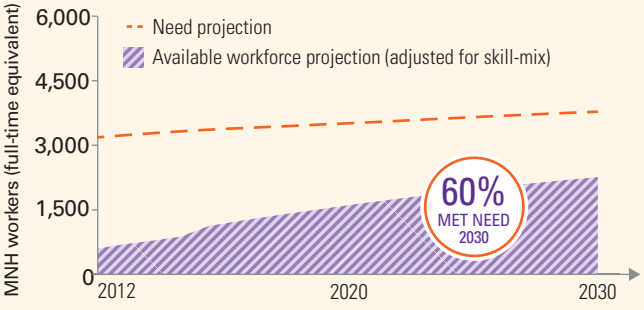
3 Efficiency improved by 2% per year until 2030?



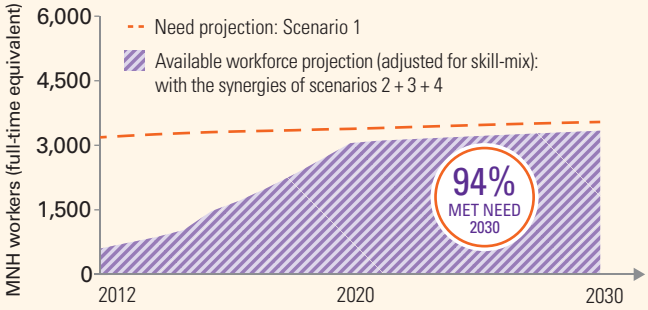
4 Attrition was halved in the next 5 years (2012-2017)?



CURRENT TRAJECTORY



WHAT IF... TRAJECTORY



1. These health worker categories include the following country titles - Midwives: includes community midwives; Generalist physicians: includes generalist physicians, family medicine; Obstetricians & gynaecologists includes: obstetricians & gynaecologists. Source: SoWMy 2014 or secondary sources (WHO Global Health Observatory; government policy documents).
2. Rural/urban SBA coverage is not available. Figure refers to rural/urban births only.
3. Information refers to the midwife cadre category.
4. National associations for midwifery and nursing.
5. These are proposed targets for MMR and NMR by 2030 from the recommendations of *Ending Preventable Maternal Mortality by 2030* and the *Every Newborn Action Plan.*