1.1 Introduction

Midwives have been acknowledged as critical to achieving the 2030 Agenda (UNFPA 2011, 2014a). This agenda has been described as ‘A plan of action for people, planet and prosperity’ (United Nations 2015), and currently, amongst numerous global efforts, the world is aspiring towards universal health coverage and promoting good health and well-being for everyone. Embodied in the new agenda, there is the vision to enable women, children and adolescents everywhere not only to survive but also to thrive and contribute to the transformative change anticipated with the realising of the Sustainable Development Goals (SDGs). In reflecting on the Millennium Development Goals (MDGs) and anticipating the SDGs, it has been stated that:

Midwifery is a vital solution to the challenges of providing high-quality maternal and newborn care for all women and newborn infants, in all countries. Improvements in availability, accessibility, acceptability, and quality of midwifery services, within a functioning health system that is responsive to women’s needs and requirements, is crucial…to the development of the post-2015 agenda’s goals and targets, in which emphasis on reduction in maternal and newborn morbidity should be even stronger than it has been in the past. (ten Hoope-Bender et al. 2014:7)

Given the enormous agenda that has been presented to the global community, it would seem appropriate initially to examine these issues in...
some detail and the vital contribution of midwifery in this context and then to reflect on the historical, geographical and political issues that have influenced and will continue to influence progress in this critical area of human life, before considering some of the contemporary challenges facing the world of today and tomorrow. In considering the historical as well as the contemporary challenges, it is claimed that well-educated midwives strategically placed, given appropriate support and working within an enabling environment serve as critical catalysts in this anticipated global transformational process.

1.2 The Sustainable Development Goals

The most outstanding global co-operation ever witnessed has been enshrined in the Sustainable Development Goals (SDGs). These were launched by the United Nations (UN) in January 2016 following a global meeting of heads of states held towards the end of 2015. It has been declared that the SDGs are ‘the blueprint to achieve a better and more sustainable future for all’ (United Nations 2019a). These goals have been designed based on the successes of the Millennium Development Goals (MDGs) which are discussed in Chapter 2. There are 17 SDGs and 169 associated targets which interconnect, addressing issues including poverty, inequality, health, clean water and sanitation, gender equality, climate, prosperity and peace and justice (Fig. 1.1). The interconnection between the goals has been stressed since the achievement of one goal may be dependent on tackling issues more commonly associated with another (UNDP 2019a).

Several partnerships have been developed in the early years of the SDG programme. For example, the European Union (EU) and the United Nations (UN) have embarked on a new, global initiative centring on SDG 5 and spotlights eliminating all forms of violence against women and girls (VAWG). This is especially relevant to the health and well-being of women, children and adolescents. The Spotlight Initiative focuses on women’s empowerment and gender equality and is described in more detail later in this chapter.
equality. Special emphasis has been placed on violence both in the family and within the domestic environment and on sexual and gender-based violence. There is also a focus on harmful practices, female infanticide, trafficking of human beings and sexual and economic labour exploitation (United Nations 2019b). At the launch of the initiative, the deputy Secretary General of the United Nations Organization deplored the ‘global pandemic’ of VAWG and stated that this initiative was an essential tool to make such violence ‘a thing of the past’. It was acknowledged that almost half of the murders of women committed worldwide are carried out by partners or ex-partners. VAWG is often deeply embedded in the accepted practice and norms of some societies. An extreme form of such violence surrounds the killing of female infants (Mohammed 2018). Midwives clearly have a role to play in promoting and achieving a number of these goals.

The SDG relating to health is embedded in SDG 3 ‘good health and well-being’ and specifies the aim to ensure healthy lives and promote well-being for all. It includes targets to reduce the maternal mortality ratio (MMR) and preventable deaths of babies and children under 5 years of age. Universal health coverage is also regarded as integral to achieving SDG 3, ending poverty and reducing inequalities. Furthermore, it has been stressed that gender-sensitive, rights-based approaches are critical to address inequalities across all sectors (UNDP 2019b). Of the 17 SDGs, goals 1 and 6 relating to eliminating poverty and providing clean water and sanitation respectively have been identified along with SDG 3 as being the most important for health services development in vulnerable populations. However, Homer (2018) identifies several key SDGs that are intricately connected to SDG 3 (Fig. 1.2).

The links between these goals may seem fragile at times, but it could well be considered that

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**Fig. 1.2** The interdependence of SDGs in relation to health. (Derived from Homer 2017)
midwives provide a network imperceptibly intertwining these global targets. Global midwifery with a woman-centred approach to achieving health and well-being offers both direction and dexterity in a dynamic world drama unfolding in the early twenty-first century.

Debate surrounds the issue as to whether the SDGs are realistic given that low income countries do not always have the resources or the support to achieve these goals (World Economic Forum 2015). Whereas the SDGs can be seen as an unrealistic financial challenge by some, efforts have been made to urge heads of governments and donor countries to invest in funding and policymaking that embraces the vision of universal health coverage (Summers 2015). It is also asserted that investing in ‘pro-poor pathways’ through realising the SDGs and ensuring universal health coverage has been identified by a world leading economist and Nobel prize winner as ‘an affordable dream’. Sen (2015) reckons that there is considerable evidence that universal health care not only powerfully enhances the health of a population but that a strong relationship exists between health and economic performance. It is worthy of note that during the efforts to achieve the MDGs, it was agreed that there should be no poor solutions for the poor. The world may need to reconcile these thoughts in the context of the SDGs.

In launching the SDGs, delegates from the United Nations member states recognised the fundamental principle of the dignity of each individual and committed their nations to ensuring that no one got left behind. The aim to reach all people in all sections of society in all nations was set, with the commitment to reach those who were furthest away from the targets first (United Nations 2016).

WHO has identified specific targets within SDG 3 (Box 1.1). Along with these, underlying issues are to be addressed that include research and development, increasing health financing, recruiting and retaining staff and the strengthening of capacity in low income countries (WHO 2019).

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**Box 1.1. Global health targets for SDG 3**

Targets to be achieved by 2030 unless otherwise stated...

1. To reduce MMR to <70/100,000
2. To end preventable deaths of babies and children under 5 years
3. To end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases
4. To reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being
5. To strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
6. To halve the number of global deaths and injuries from road traffic accidents (by 2020)
7. To ensure universal access to sexual and reproductive healthcare services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes
8. To achieve universal health coverage, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all
9. To substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination

WHO (2019)

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Research into the critical issues affecting the health and well-being of women and babies has traditionally attracted the funding and focused on complication management (Tuncalp et al. 2015).
However, Kennedy et al. (2016) purport that in undertaking research, midwives may be asking different questions. They suggest that:

…studying ways of providing such care has the potential to improve the provision of quality care for all, enhance women’s and infants’ own capabilities, and maximise the health promotion potential of midwives.

Kennedy et al. (2016: e778)

Midwifery research and the identified priorities are discussed in some detail in Chapter 12.

### 1.3 Early Historical Landmarks

There are numerous global issues that impact the lives of women, newborns and families. Midwifery, with the emphasis on supporting women through childbirth has always played an important part in contributing to global health, though until comparatively recently, recognition of this fact has been very limited. For several centuries, making childbirth safer has challenged generations of communities, professionals and politicians across the world. During the eighteenth and nineteenth centuries, Sweden led the way in markedly reducing maternal mortality by the early twentieth century. Norway and the Netherlands soon improved their outcomes, and like Sweden, the achievements were largely accounted for by extensive collaboration between physicians along with midwives known to be very competent and who were available in the local communities. Between 1751 and 1900, the Swedish maternal mortality ratio (MMR) fell from 900 to 230 (Högberg 2004). By contrast, the MMR in England and Wales was 440 at the beginning of the twentieth century, and in the United States, it was estimated to be between 520 and 850 at that time (Loudon 1992). Landmark achievements in northern Europe have served as important pointers in the battle against maternal and perinatal mortality. The significant achievements in Sweden were realised in a country challenged by scattered populations beset by poverty, with many living in remote rural areas; this was prior to the introduction of medical, pharmaceutical and technological advances. Blood transfusion, antibiotics and reliable communication networks were non-existent, but progress was real and sustained. In considering the unprecedented progress in Sweden, Högberg (2004) asserts the impact of ‘midwife-assisted deliveries’ on the outcome of maternal and child survival to be of ‘major historical importance’ and maintains that progressive reduction of maternal mortality in these countries would not have been as significant if it were not for the establishment of welfare states. In his comprehensive review of the decline of maternal mortality, Loudon (2000) states that since the causes of death in countries with high MMRs today reflect the situation in the global north more than 50 years ago, it is therefore reasonable to assume that the measures that were effective in the former would currently be valuable in the latter. In reviewing the critical historical issues, confidential enquiry into every maternal death has also been highlighted as an indispensable approach to preventing avoidable mortalities (Loudon 2000; Högberg 2004).

### 1.4 Geographical Variations

Historical achievements cannot be reviewed in isolation from geographical factors. Where a woman is domiciled and gives birth is as relevant as the timing of her lifespan. It was acknowledged towards the end of the twentieth century that the rates of maternal mortality showed greater disparity between the rich and poor nations than any other public health indicator. It was also recognised that most of the women who die live in remote areas and are poor (Royston and Armstrong 1989). Undoubtedly geographical location can be critical in determining whether a woman will survive childbirth and whether her baby will be born alive. It has long been recognised that 99% of maternal deaths occur in low income countries and that most of them are preventable (WHO 2018). Midwives working within a supportive healthcare system are deemed to be best able to provide the solution to this global burden of death and disability (UNFPA 2014a, b). It has been stated that:
…midwives, when educated and regulated to international standards, have the competencies to deliver 87% of this service need. (UNFPA 2014a:i-v).

However, in most cases, midwives comprise just 36% of the midwifery workforce, and it is a fact that many countries do not have ‘a dedicated professional cadre focused on supporting women and newborns’ (UNFPA 2014a, b:i-v). Midwives, as primary care providers, work closest to where women live, and therefore, this would not have to be an issue if the world promoted and retained well-educated and regulated midwives in all geographical settings. Issues relating to education and regulation are discussed in Chapters 4 and 5.

There are indeed wide geographical inequities in maternal and newborn health outcomes. This has been identified at regional, national and sub-national levels in countries of varying economic status. The location of relevant health services is a crucial determinant of whether women can access care (Thaddeus and Maine 1994; Gabrysch and Campbell 2009; Ravelli et al. 2011; Okwaraji et al. 2012). Therefore, where a woman lives and where health facilities are located can be a matter of life and death in many communities across the world if there is no means of covering the distance between these two focal points.

In China, although substantial economic growth had been reported by the turn of the millennium, a vast geographical difference remained in the numbers of maternal deaths, and this has been related to inequity in socio-economic development between urban and rural areas (Gao et al. 2002; Rudan et al. 2010; Wang et al. 2010). Survival can undoubtedly be shown to vary depending on geographical location, since it had been reported that in sub-Saharan Africa as many as 1 in 16 women may die from pregnancy-related complications, in Asia this decreased to 1 in 94 and in Europe the risk had been reduced to 1 in 4000 (Sibbald 2007). By 2015, it was declared that in sub-Saharan Africa, the lifetime risk of dying in childbirth was 1 in 36, in the European Union it was 1 in 8400 and in ‘fragile and conflict affected areas’ it was 1 in 46 (World Bank 2019). However, there is also evidence of considerable variation in MMR between different racial and ethnic groups in high-income countries. For example, in the United States, there has been a higher MMR reported amongst African-American women than amongst white women (Lang and King 2008). In the Netherlands (Schutte et al. 2010) and in Germany (Razum et al. 1999), there has been a higher incidence of maternal death amongst the immigrant populations by comparison with the indigenous populations. So, it would seem that in attempting to survive childbirth, who you are in relation to the ability to access health care, is as relevant as where you are, in addition to the timing of your lifespan. The issue is likely to be complex. It could relate to inaccessibility disadvantaging some ethnic groups, to racial discrimination, educational and linguistic limitations or economic hardship where equitable access to free health care is not available.

1.5 Political Issues

The location of a family’s habitat and the maternal and neonatal outcomes will inevitably be greatly influenced by the political environment in which they currently reside. It has been stressed that there is considerable evidence that the most reliable predictors of health outcomes across the lifespan are the societal or structural causes of ill health (Navarro 2004; Raphael 2009). In considering issues surrounding maternal and newborn mortality, McGibbon (2011:343) maintains that these ‘structural causes are best articulated within the realm of the political economy of health’. She also suggests that it is imperative to consider ‘the societal context within which women live’ because it is the societal causes of maternal mortality that become the ‘causes-of-the-causes’ underlying the deaths of these women. McGibbon therefore proposes using a ‘political economy lens’ in order to attempt to understand and confront these issues, maintaining that the growing inequities in health outcomes are related to such matters as class distinction, racism and sexism. These, she maintains, are ‘the structural determinants of health’.
In considering why some global health initiatives achieve political visibility whereas others do not, Shiffman (2008) asserts that several factors are involved. These include the existence of credible evidence proving the severity of the problem. Whether or not there is appropriate leadership which can offer ‘effective global champions for the issue’ has been highlighted and whether a set of institutions exist whose members are able to advance the matter successfully through advocacy. Shiffman admits that more research is needed to uncover ways of achieving further political visibility but offers pointers which are more likely to lead to success in achieving this (Box 1.2).

Box 1.2. National health advocates are more likely to succeed if they…
1. Coalesce into unified policy communities, translating their potential moral and knowledge-based authority into political power and pressing national political officials to act
2. Bring into their communities respected and well-connected national political entrepreneurs with track records in placing public health issues on national agendas
3. Develop credible measures that mark the severity of this problem and make political leaders aware of these measures so that they cannot plausibly deny that a problem exists
4. Organize large-scale focusing events such as national forums to generate widespread attention to the issue.
5. Present leaders with clear policy alternatives proven to be effective, so that policymakers come to believe the problem can be surmounted and know what they are expected to do.

Shiffman (2008)

Nanda et al. (2005) underline the importance of evidence-based advocacy in order to promote an enabling policy environment and enhance political commitment. Shiffman (2007) conducted case studies in five countries to examine the level of political commitment apportioned to reducing maternal mortality. The studies were carried out in Guatemala, Honduras, India, Indonesia and Nigeria. He discovered that there was considerable variation in the political priority accorded to this matter in these countries. Shiffman identified three criteria which he used to assess the situation in each country (Box 1.3).

Box 1.3. Shiffman's criteria for assessing the level of national political priority
1. National political leaders publicly and privately express sustained concern for the issue
2. The government, through an authoritative decision-making process, enacts policies that offer widely embraced strategies to address the problem
3. The government allocates and releases public budgets commensurate with the problem’s gravity

Shiffman (2007:796)

Using these criteria, Honduras rated ‘very high’ in the level of political priority afforded to reducing maternal mortality. The priority in Indonesia was high, whilst in India it was rated as moderate at the time, but low in Guatemala and Nigeria. Honduras managed to reduce maternal mortality by 40% during a 7-year period from 1990. With QMNC becoming a high political priority, Honduras demonstrated one of the most significant reductions in MMR in the shortest time span ever observed amongst low-income countries (Meléndez et al. 1999, Koblinsky 2003, Shiffman et al. 2004). The example of Honduras well illustrates the effect that political commitment can have in reducing mortality.

However, maternal mortality is a complex subject demanding attention to a number of issues. In acknowledging Nigeria’s situation with one of the highest numbers of maternal deaths across the world, it has been asserted that in Nigeria advocates of maternal mortality reduction:
will need to focus more attention on developments in the educational sector and not just on making direct improvements to the healthcare system. (Mojekwu and Ibekwe 2012:135)

This reverberates established epidemiological findings that claim that improving the education of women has been influential in improving maternal outcomes (WHO 2012). Multifactorial it may be, but there are strong indications that without political commitment little will change in the aspiration to achieve safe childbirth for all. At a global conference in Mexico City in 2015, it was stressed that political leadership acting on scientific evidence was a priority and that the public should be empowered to make demands that would improve maternal and newborn survival. Furthermore, it was agreed there that governments and societies were obliged to embrace and implement an evidence-based maternal and newborn health agenda and monitor its progress (Momentum 2015).

1.6 Contemporary Challenges

Building on the lessons learned historically, giving cognizance to geographical location and emphasising the importance of political commitment, there remain an ever-increasing number of contemporary challenges. Commitment by the global community to promote maternal and newborn health is a solid foundation upon which to build a better future. However, the numerous contemporary challenges which constantly arise can frustrate the purposes and delay achievement. Amongst others, these can include epidemiological, demographic, socio-economic and political factors which are liable to change, particularly in fragile states and typically affecting those who are most vulnerable.

In an examination of the social epidemiological issues surrounding QMNC, Cwikel (2008) asserts that a review of Semmelweiss’ study of hand washing to prevent puerperal sepsis could act as a benchmark from which contemporary women and QMNC advocates could identify salient issues today. She stresses that marginality and social exclusion still dictate who can access a safe birthing experience and identify which women risk their lives in giving birth. The Covid-19 pandemic has added new dimensions to this problem in 2020.

Cwikel argues that when health researchers critically use the tools of social epidemiology in research and practice, there is a good chance that public health goals can be achieved. This can bring about valuable behavioural change, evidence-based medicine and community-based participatory action research. Such an approach can also be beneficial in reducing maternal mortality and morbidity as well as improving other areas of women’s health. Cwikel stresses that the current epidemiological practice in women’s health can help to promote public health predominantly benefitting women who are marginalised and most particularly those in low-income countries. Several of these basic approaches may well have alleviated some of the devastation caused by the Ebola outbreak in more recent times. It has been claimed that the advances that had been made in achieving QMNC in West Africa were largely wiped out during that epidemic (UNFPA 2014a).

In 2016 the World Health Organization (WHO) declared the Zika virus and its complications a public health emergency of international concern. This was decided because 84 countries, territories or national areas were identified as having evidence that this mosquito-borne infection was being transmitted (WHO 2017a). The infection was related to foetal abnormalities with numerous babies being born in affected areas with microcephaly. This problem cast a shadow over the 2016 Olympic Games in Brazil with many top athletes declining to travel to the region (Attaran 2016) and again the novel coronavirus Covid-19 has caused cancellation of the 2020 Olympic Games in Tokyo.

It is fitting to consider at this point not only what the world has learned from these experiences but to reflect on how midwives were able to contribute to addressing such international crises. These catastrophes have sorely affected the progress of QMNC and fundamental issues of perinatal and sexual and reproductive health. If the world’s midwives were not critically involved in
seeking and assisting in delivering solutions, then the question why must be asked. Midwifery needs to be on the global agenda for such times as these which inevitably reverberate across the continents with alarming frequency at times.

Malaria continues to be a global epidemiological challenge and can result in maternal illness with considerable risk to the newborn child (WHO 2017b). The advent of the human immunodeficiency virus and acquired immune deficiency syndrome (HIV/AIDS) shocked the world in the early 1980s, and it was not until 1997 that an antiretroviral therapy became available which reduced the death rate in the United States by 47% (Nall 2018). In 2018 it was estimated that this global epidemic affected 36 million people worldwide (Cichocki 2018).

The effect that the movement of populations can have has been illustrated above in respect of the Zika and Covid-19 viruses. However, numerous issues have caused mass migration challenging health and threatening the possibility of providing QMNC. In the early twenty-first century war, civil unrest and natural disasters have caused massive evacuations from some parts of the world and many women give birth in refugee camps or even when travelling to escape conflict, danger, abuse or persecution. These issues which cannot be separated from some of the socio-economic challenges and political matters are discussed further in Chapter 14. In celebrating the seventieth anniversary of the founding of the United Nations Organization, a new agenda was agreed. It was acknowledged that it was the first time ever that the world leaders had pledged their commitment to such a broad and universal policy agenda, the 2030 Agenda. It was from this that the SDGs described above were generated (UNDP 2019c).

1.7 The 2030 Agenda

In looking forward, it is pertinent to remember that the world is challenged by a new Agenda. This has been introduced at the beginning of this chapter and is guided by the purposes and principles of the Charter of the United Nations (1945a, b). It encompasses total respect for international law and is grounded in the Universal Declaration of Human Rights, international human rights treaties, the Millennium Declaration and the 2005 World Summit Outcome Document (United Nations 1948, 2000, 2005). Additionally, the 2030 Agenda is informed by other instruments such as the Declaration on the Right to Development (United Nations 1986). The new agenda recognised that the targets for some of the Millennium Development Goals were not reached, particularly those relating to maternal and child health, and these are discussed in see Chapter 2. The SDGs would prompt recommitment to achieving these goals and a new commitment to giving focused and scaled up assistance to those nations most needing support (United Nations 2015). In order to achieve the health-related targets of the 2030 Agenda, 12 international organisations (Box 1.4) have committed to

Box 1.4. The international organizations committed to the Global Action Plan

| GAVI (Vaccine Alliance Lead Global Vaccine Marketing) |
| GFF (Global Financing Facility) |
| Global Fund (to fight AIDS, tuberculosis and malaria) |
| UNAIDS (a joint programme of 11 UN organisations fighting HIV/AIDS) |
| UNDP (United Nations Development Programme) |
| UNFPA (United Nations Population Fund) |
| UNICEF (United Nations Children’s Emergency Fund) |
| Unitaid (an international drug purchasing facility) |
| UN Women (the global champion for gender equality) |
| World Bank Group (five international organizations that make leveraged loans to low income countries) |
| WFP (World Food Programme) |
| WHO (World Health Organization) |
| WHO (2019) |
developing a Global Action Plan. This Plan reflects an historic commitment by global health and development agencies to increase joint action and hasten progress (World Health Organization 2019).

1.8  Conclusion

In looking back and looking forward, there are clearly challenges and opportunities. History offers lessons that should have been learned; a diversity of geographical situations and political issues both confront and offer prospect for progress. Nevertheless, many challenges remain. By 2019 it had already been acknowledged that ‘the world is off-track to achieve the health-related SDGs’. Although there had been progress, it has been uneven, within and between countries. Whilst some countries have made remarkable gains, when examining just the national averages, it is not immediately apparent that many countries are being left behind (UNDP 2019b). A deeper analysis is required in order to perceive the true picture. This matter is discussed further in Chapters 2 and 3.

By the end of 2017, there were 21.7 million people with the human immunodeficiency virus (HIV) who were receiving antiretroviral therapy. However, in 2019 more than 15 million people with HIV were stated to be still waiting for this treatment (UNDP 2019b). Mass migration, national crises and natural disasters have shown no sign of abating. New challenges create new opportunities. Within this complex global situation, the midwife is beginning to be recognised as a valuable resource. It has been estimated that 83% of all maternal deaths, stillbirths and newborn deaths could be averted with the full package of midwifery care that includes family planning (Homer et al. 2014). There is no shortage of opportunity, the challenge remains as to whether the global community will rise to it, recognising the importance of midwifery in global health can never be overstated.

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Key Messages

Principles

The principles identified from historical evidence which have been instrumental in reducing maternal mortality and progress achieved in contrasting geographical areas can be used as a basis to promote continuing progress across the globe. QMNC is evident where midwifery exists within an environment of mutual respect and cooperation between midwives, medical professionals and communities.

Policy

Political commitment to QMNC is a critical component of effective midwifery care. Midwives are the professionals best suited to advocate for enabling policies at each level and across every strata of society. This is in order to enable them to practice effectively and for women to be able to access skilled care which is appropriate and acceptable.

Practice

Well-educated midwives who are highly skilled, respectful and enabled to provide evidence-based care are key to achieving the targets of SDG3 in the context of sexual, reproductive, maternal and newborn health care (SRMNH).

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Questions for Reflection or Review

1. Loudon (2000) asserts that since the causes of death in countries with high MMRs today reflect the situation in the global north decades ago, it is reasonable to assume that the measures that were effective in the former would be effective in the latter. What measures have been influential historically in reducing MMR and how practical would it be to introduce these in countries still struggling with high levels of MMR today? How might the skill of the pro-
Additional Resources for Reflection and Further Study

Look at the website about the Sustainable Development Goals and download the app offered at: https://www.sdgsinaction.com/. Identify goals that are important to you; get updates from around the world and become actively involved in promoting actions

The International Confederation of Midwives (ICM) ‘... envisions a world where every childbearing woman has access to a midwife’s care for herself and her newborn’. Visit the ICM website and reflect on the Bill of Rights for Women and Midwives. https://www.internationalmidwives.org/assets/files/general-files/2019/01/cd2011_002-v2017-eng-bill_of_rights-2.pdf

The following resources may offer some further perspectives for reflection and action: Maclean GD (2017) Achieving safe motherhood globally: an historical overview. Lambert Academic Publishing, Germany

United Nations Population Fund (2014) State of the world’s midwifery: a universal pathway to women’s health. A United Nations publication

United Nations (2015) Transforming our world: the 2030 Agenda for Sustainable Development. United Nations, New York: A/RES/70/1. https://sustainabledevelopment.un.org/content/documents/21252030%20Agenda%20for%20Sustainable%20Development%20web.pdf

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