The Principles, Policy and Practice of Global Midwifery: 2030 and Beyond

17.1 Introduction

This book set out to be an authoritative, in-depth publication about global midwifery, exploring the available evidence for the contribution of skilled, professional midwives to the provision of high-quality, respectful maternity care and to the achievement of the 2030 Sustainable Development Goals through partnership with women and their families, enabling them to ‘survive, thrive and transform’ (Every Woman Every Child 2015).

This final chapter uses two well-known tools, PESTLE (Political, Economic, Social, Technological, Legal and Economic) and SWOT (Strengths, Weaknesses, Opportunities and Threats) analyses, to draw out from the detailed exploration in the previous chapters of this book,

**Expected Learning Outcomes**

By the end of the chapter, the reader should be able to:

1. Reflect on issues relating to the principles, policy and practice of global midwifery across the globe and consider the key issues in looking forward to 2030 and beyond.
2. Identify the political and economic factors that influence the provision of high-quality, respectful maternity care by midwives and the fiscal benefits to a nation where this is provided.
3. Discuss the socio-cultural issues that influence maternal and neonatal health and the importance of the midwife’s role in understanding and addressing these.
4. Evaluate the influence of new technologies on midwifery education and practice and their impact on childbearing women/people and their families.
5. Identify the legal frameworks required to protect women during pregnancy and birth and to regulate the profession so that only midwives competent to global standards are licensed to practise midwifery.
6. Discuss environmental factors that may influence the lives of women and their families, midwives’ practice and efforts to strengthen midwifery globally.
7. Evaluate the final recommendations offered in this book and consider how these may be prioritised, progressed and implemented to the maximum benefit of every woman, newborn and midwife across the globe.
factors that have influenced the past and the present of global midwifery and those that will continue to have influence for the future. Drawing together the findings of these analyses, a detailed synthesis of the principles, policy and practice of global midwifery is then presented before offering recommendations for consideration by those who would attempt to continue to build a safer, more acceptable world for every woman and newborn on the planet at that crucial and costly time that surrounds birth.

17.2 The PESTLE Model

PESTLE analysis is a marketing and business model useful for identifying and addressing challenges that may affect the planning and implementation of a new strategy or project (Professional Academy 2020). It can also be used in the health sector to view complex issues from a wide perspective (Edwards and Seda 2016; Ralph et al. 2014). PESTLE is an acronym that stands for Political, Economic, Social, Technological, Legal and Environmental factors. These factors are tackled in turn below.

17.2.1 Political Factors

Midwifery is political (Medway and Digance 2017), and this book has charted the struggle that midwives have faced in recent centuries for autonomy and political power. Midwifery is also closely linked to the politics of gender and patriarchy (Walsh 2016); women’s lives can be saved, but only if their lives are considered worth saving (Chapter 2) (Fathalla 2006). Such a statement moves the ball firmly into the political arena.

Chapters 1–4 showed that the value of midwifery to the survival of women and newborns was recognised in 1987 with the launch of the Safe Motherhood Initiative (UN 1986, 2020a, 2015, 2016, 2019). However, the subsequent drive to meet globally agreed targets such as the Millennium Development Goals led to the blurring of midwives’ identity. Different cadres and initiatives (such as skilled birth attendants) were introduced to produce more ‘midwifery personnel’, to substitute for midwives and to provide short-term solutions to human resource shortages. In some situations, these short-term solutions became long-term solutions. As a result, midwifery education suffered, policymakers became confused about what midwifery actually is and does, and further disparities in midwifery practice emerged in low-, middle- and high-income countries (WHO 2008, 2013, 2017, 2018a; Gherrisi et al. 2016; Luyben et al. 2017).

With an indistinct identity and a variety of education programmes of differing quality, midwifery has struggled to make itself visible and to be acknowledged as a separate profession. Since the 1950s, midwifery has often been conflated with nursing; this has compromised women’s sexual and reproductive health right to have care from a midwife, as the appropriate care giver, and means that midwifery, as a smaller profession, has often been overlooked (Cadée and Wikund 2020). Midwives have not always been involved in decision-making at national, regional and global levels. Weak health systems where the need for midwifery was greatest meant that midwifery was not supported to achieve at its best; nor were midwives able to perform the full scope of practice for which they had been educated, nor to meet the needs of women, babies and their families.

Because midwives lack political power, in many countries, the midwifery workforce strategy is developed in the absence of midwives. As a result, midwifery is not prioritised. Political and civil unrest, wars and massive population movements have also hampered, and continue to hamper, the development of midwifery globally. The COVID-19 pandemic overwhelmed demands on healthcare systems globally, further delaying progress. The initial lack of recognition of midwives as key service providers during the pandemic, or appreciation of the risk of COVID-19 transmission to midwives due to the very nature of midwifery services, demonstrates the need for effective advocacy for political commitment to midwifery (ICM 2020).

1 Combining or confusing two separate things as one.
There are examples from different continents where political commitment has improved outcomes from women and their families and increased access to care (Chapters 1 and 2). These include Sweden, having educated and appointed midwives in remote and rural areas from the mid-eighteenth century (Högberg 2004) and, during the early twentieth century, countries including Thailand, Malaysia and Sri Lanka and later Egypt, Cuba, Honduras and Tunisia (Meléndez et al. 1999; Koblinsky 1999, 2003; Pathmanathan et al. 2003; Shiffman 2007; Shiffman and Smith 2007). However, the lack of political leadership and advocacy at national and regional levels have slowed down the growth of midwifery and recognition of midwives in other countries, which have therefore not gained maximum benefits from their investment.

In the second decade of the twenty-first century, the Sustainable Development Goals, with the accompanying concept of Universal Health Coverage and the global agenda of ‘leaving no one behind’ (World Health Assembly 2013), catapulted midwifery back into the limelight and created a more positive political environment for midwives. Evidence from the State of the World’s Midwifery Reports (UNFPA 2011, 2014) and The Lancet Midwifery Series of papers (The Lancet 2014) provided vital evidence for the contribution of midwives, prompted a seminal shift from fragmented to women- and newborn-centred care services and showed policymakers that midwifery and midwives are crucial to the achievement of national and international goals and targets in reproductive, maternal, newborn and child health (ten Hoope-Bender et al. 2014). Global policies were developed including the ‘Midwifery Pathway: the 2030 agenda’ and ‘Survive, Strive Thrive and Transform’ (WHO 2018b) which emphasised improving health outcomes and quality of life for women, newborns and their families rather than just preventing deaths and disabilities. Countries moved closer to talking about midwives instead of the other cadres and titles which had led to confusion. Political strategies adopted by many countries, such as ‘Road Maps’ for sexual, reproductive, maternal, newborn and child health, enabled midwifery to continue to rise (WHO and World Bank 2017). A growing emphasis on human rights-based approaches also compelled governments to strive to meet global standards for developments in midwifery in education and regulation (Chapters 4 and 5); a difference began to appear between political rhetoric and political action (Chapter 16).

Undoubtedly, global leadership by the International Confederation of Midwives (ICM) and UN Agencies, including the United Nations Population Fund (UNFPA) and the World Health Organization (WHO), contributed to this shift in policy. Chapter 6 described the role of the International Confederation of Midwives (ICM), in championing midwifery on the global political stage and in strengthening regional and national midwives associations to be the political voice of midwives and midwifery, promoting autonomous, well-educated, regulated and supported midwives, working in an enabling environment, as the most appropriate caregivers for childbearing women (Jerie 2014).

Moving forward, global midwifery will be further strengthened if there is political will to support different models of midwifery practice (Chapter 7), to keep centre-stage the rights of women/childbearing people and their families to high-quality, respectful maternity care, to develop ambitious midwifery workforce strategies that promote gender-equity and social inclusion (Chapter 8) and to find responsible, innovative approaches (Chapter 9) to working together at policy level, ensuring that no one is left behind, especially those in fragile stages and conflict-affected populations (Chapter 14). Political support is welcomed for global midwifery partnerships (Chapter 15) as a way to accelerate progress. Political commitment and advocacy are also critical for the harmonisation of midwifery in order to develop a common philosophy and identify (Chapter 16).

### 17.2.2 Economic Factors

Health and economic wealth are closely linked. Poverty has a significant negative impact on health, especially for women and girls (WHO...
In return, health also impacts economies, as evidenced by the global economic downturn resulting from the COVID-19 pandemic. The economics and distribution of wealth in a country have also influenced the development of midwifery. A mapping of midwifery across the globe (Chapter 3) revealed that in some situations, availability of wealth led to medicalisation of maternity care, especially in high-income countries, thus reducing the number of women who benefit from high-quality maternity care from midwives (Kennedy et al. 2018; Camacho et al. 2015).

This book has demonstrated that investing in midwives is cost-effective and efficient when they are educated to international standards, regulated, supported and organised by well-led and well-managed professional associations and are working in an enabling environment (World Health Organization 2019). Midwives can bring a 16-fold return on investment and an additional 50 positive health outcomes, besides the reduction of deaths and disability (UNFPA 2014; WHO 2019). However, some governments cannot afford, or are unwilling, to educate midwives according to global standards, especially for the 3-year direct entry programme (Nathe 2017; WHO 2018b, 2019) and continue to engage in the production of different cadres as substitutes for midwives, that do not bring the same returns in investment. In some situations, this is unwittingly propagated by donors who fund these programmes either to fulfil their own agendas or genuinely do not understand the reality of the value of well-educated midwives. E-learning, increasing in popularity, is more affordable but varies in quality.

Around the world, there are different models of maternity care (Chapters 7 and 8) and different remuneration packages for midwives. Many do not receive a salary sufficient to support their families’ basic needs for survival (Chapter 3) (WHO 2016a, b). As a result, some midwives resort to holding two jobs or engage in unscrupulous practices such as asking for ‘under the table’ payments from women and their families for care (Mannava et al. 2015). Midwives can also be exposed to economic exploitation if they choose to migrate to higher-income countries, where they believe they will be able to earn a living wage (Anderson and Isaacs 2007). Unfortunately, in this quest, they are sometimes trafficked and sexually and/or economically exploited. In settings where health professionals compete for wealth, some have made it difficult for midwives to work in private practice, as they are perceived as a challenge to other care providers.

To safeguard women’s and newborn’s health and the global economy for the future, midwives, their leaders, supporters and communities must advocate to governments and health policymakers about the value of investing in midwives educated to global standards. Midwives should be paid a living wage (Chapter 16), enabling them to support their families and to avoid migration to higher-resource settings. Countries should maximise the potential of educating indigenous women to serve their own communities; promising attempts have been initiated in some countries including, in the past, Sweden and more recently Indonesia and the Maldives (WHO: SEARO 2020). Midwives should be supported to practise privately in rural areas where many other healthcare professionals are not willing to work. Innovation by and for midwives has the potential to improve efficiency, effectiveness and affordability of midwifery care (Chapter 9).

**17.2.3 Social Factors**

Society is constantly changing and midwives must continue to examine and understand the social and cultural context in which they provide care to women (ICM 2014b). However, midwives also have the power to change society themselves (Chapter 8) and to act as change agents within the society of midwifery itself (Chapters 6, 9, 11, 12 and 15; van Teijlingen 2015). When maternity care services are provided in a dignified, respectful manner, women emerge at the end of the birthing process empowered, confident and able to look after their own health and that of their families (Alonso 2019).

Numerous societal issues have been explored throughout this book, and also the role of the midwife in caring for women and birthing peo-
ple in many different circumstances. At the heart of these are the capabilities of a woman to make decisions both for herself and for both her unborn baby and her child and to take control of her life as a human being; midwifery strengthens women to do that (WHO 2020a; Alonso 2019). The midwifery model of care (International Confederation of Midwives 2014a), discussed in Chapter 7, has the concept of ‘woman-centred’ care at its core.

Gender inequity has been a key thread throughout almost all chapters. Readers will have understood that although Sustainable Development Goal (SDG) 3 promotes gender equity, midwives have thus far been unable to take their rightful place in many societies (Chapters 1 and 3) where midwives face cultural and societal prejudice and are held in low regard because of their gender. Male midwives also share in this experience because midwifery, as a female-dominated profession, is affected by gender-inequity as a whole (WHO 2016a, b). The impact of gender inequity on midwifery education (Chapter 4) and the professionalisation of midwifery (Chapter 10) have been explored. Effective quality midwifery care (Chapter 8) enables governments and health systems to focus on the SDGs’ demands for gender-mainstreaming of programmes, women’s empowerment, addressing gender-based violence and reduction or even abolition of infanticide. However, midwives report that, although they know the solutions to providing high-quality midwifery care, their ability to do so is seriously compromised by their lack of voice or seniority within the broader political arena (WHO 2016a, b).

Violence against women has also been discussed by the authors. This takes several forms whether it be domestic violence, violence as a result of war or migration, obstetric violence (Chapter 7) or female genital mutilation (FGM), an inhumane and unacceptable act of abuse. Since 2012 there has been an annual day promoting zero tolerance of FGM and, in 2020, the United Nations focused on ‘unleashing the power of youth’ in order to help eradicate harmful socio-cultural practices including FGM (UN 2020b). The book has also highlighted violence against midwives themselves, other female health workers and the systems in which they work (Chapter 13; Nathe 2017). Midwives have the right to a safe and respectful working environment, free from discrimination, coercion and violence (Chapter 13).

Discrimination in its many forms within midwifery has also been explored. Women and midwives both face race discrimination in maternity services; for example, in United Kingdom, women from black ethnic backgrounds are five times more likely to die in childbirth and are at greater risk from other adverse pregnancy outcomes; midwives and maternity support workers are more likely to experience bullying at work, to face disciplinary processes and less likely to advance in their careers (MBRRACE-UK 2019; RCM 2020a). LGBTI people have historically been marginalised within healthcare and the maternity services (ICM 2017; Lai-Boyd 2020), and many still experience discrimination and harassment (House of Commons 2019). Midwives themselves are diverse in sexual orientation; midwifery is strengthened and enriched by having a diversity of practitioners that reflects the communities they serve (ICM 2017). Younger midwives can also face discrimination; midwifery has been called an ageing profession (RCM 2017; Callender et al. 2020). In many parts of the world, young or newly qualified midwives are posted to hard-to-reach areas where health facilities have poor access to essential amenities such as running water, electricity and security. Midwives in such situations are often the only care provider, are separated from their families and receive minimal or non-existent support with no access to continuing professional development. To retain and develop young people in the profession, it is important that they are supported and nurtured; yet they must be offered significantly challenging responsibilities to develop as midwife leaders (Nathe 2017) who are prepared to lead services with diverse populations and midwifery practitioners from differing backgrounds and cultures (Chapter 11). Midwives must provide inclusive care to all clients with respect to human rights and without discrimination (ICM 2014b).
This book calls for the formation of creative, collaborative partnerships (Chapter 15) amongst midwives, women and other healthcare professionals in order to maximise efforts and ensure women’s access to high-quality midwifery care and to work towards equity and equal respect for all healthcare workers including midwives. This demands a concerted effort for women’s and midwives’ empowerment.

17.2.4 Technological Factors

The role of technology in advancing midwifery globally has been highlighted by the book’s authors, in particular in Chapters 4 and 9. Technology can facilitate monitoring of progress, identification of potential problems and access to treatment; it can also enable reporting of outbreaks before there is a risk to life. Improvements in communication technologies make it possible for midwives to receive remote support and guidance on care issues. Chapter 9 highlighted technologies that aid decision-making, provide solar power to health facilities in remote areas and give midwives easy access to evidence-based information.

Technology has also made health-related information more accessible to women and their families; this increased knowledge has encouraged women to demand high-quality care and to retain control of their bodies, their own care and that of their newborns, as well as to retain their right to make choices. This behoves midwives to be open minded, to remain current in their knowledge and practice and to include women in decision-making about their care.

Technology has transformed midwifery education (Chapter 4), making it possible for student midwives to study their curriculum’s theoretical components remotely, in their homes or workplaces, through technologies including virtual reality. It has also enhanced clinical practice as practitioners can conduct research and learn from each other without being in the same physical space. Clients can participate in health education through technological applications without needing to attend a health facility (Chapters 4 and 9).

As a result of the COVID-19 pandemic, there was a significant expansion in the use of technology in midwifery to provide virtual consultations to clients, to offer antenatal education and to continue the delivery of midwifery education (Chapter 9). However, the RCM (2020b) cautions that virtual consultations must adhere to the same standards of care that would be provided during in-person consultations and that discussing sensitive issues is better managed in-person.

To utilise new technologies, midwives must be digitally literate. As midwifery is an ageing profession, this can pose challenges to older midwives who may need support with digital access. Additionally, the amount of digital information available can become overwhelming for midwives and their clients; in the COVID-19 pandemic, this was described as an ‘infodemic’, an overabundance of information, both online and offline, that undermined the global response and jeopardised measures to control the pandemic (WHO 2020c). In some countries, new career opportunities are being developed for ‘digital midwives’, harnessing the power of technology to improve maternity care and supporting colleagues in new ways of working.

Unfortunately, technology has also contributed to an increase in inequality, widening the gap between populations of different economic means. However, Chapter 9 explored how some companies are developing appropriate technology, such as the low-fidelity models developed by Laerdal Global Health in collaboration with its partners, making learning technologies accessible for midwives in low-resource countries.

The International Confederation of Midwives produced tools such as the Midwifery Services framework, to support governments who wish to enhance the quality of their midwifery services to engage in a consultative and collaborative approach to planning and developing the services. Other tools like the Health System Building Blocks have been produced by the World Health Organization. All these tools support governments to stay abreast of developments in technology.
17.2.5 Legal Factors

Chapter 5 demonstrated the legal struggles that have been faced by midwifery globally. These include lack of recognition by governments and other healthcare providers, lack of professional identity as the word ‘midwife’ is not always a protected title, lack of standardised remuneration for midwives and varying scopes of midwifery practice in different parts of the world. The separation of midwifery from nursing is a perpetual legal issue that has made it difficult for midwives to stand up and be counted autonomous professionals. In many countries, midwifery is subsumed in nursing, despite the global acknowledgement of the value of a midwife in saving the lives of women and newborns. Without effective regulation, it is difficult to exercise professional autonomy, to claim professionalism (Chapter 10) and to delineate the midwifery scope of practice. Neither is it possible to negotiate professional boundaries, midwifery specialist roles and a career framework for midwifery.

The International Confederation of Midwives’ midwifery regulation toolkit supports governments in developing regulation for midwifery services in their countries (ICM 2016). This has had some effect where it has been used but the ICM’s (2017) records demonstrates that very few countries have midwifery regulation. As a result, the education and practice of midwives remains unregulated, leading to gaps in the standard of education, scope of practice and professional title. Hence, midwifery remains conflated with other cadres who also provide midwifery care (The Lancet 2014).

Moving forward, the tools developed by the ICM and the WHO (Chapters 6 and 16) make it possible to begin the process of harmonising midwifery globally. The essential competencies for basic midwifery practice (ICM 2019a, b), the Global standards for midwifery education (ICM 2013), Midwifery Educator Competencies (WHO 2014) and the Global Midwifery Education Accreditation Programme (ICM 2019a, b) are now available to guide curriculum development, midwifery teacher education and assessment of the quality of midwifery education globally. The Global Standards for Midwifery Regulation (ICM 2016) and the Midwifery Regulation Toolkit (ICM 2018) can support governments to develop separate national midwifery regulation. The Lancet series of five papers on Midwifery (2014), a great resource for countries wishing to strengthen their regulation of midwifery, identified the different aspects of midwifery and all the factors, including legal issues, impacting on it. Once harmonised, it will be possible for midwifery to claim and assume the professional autonomy, accountability and responsibility it deserves.

Midwifery trade unions and professional associations have a role in leading the process of redefining midwifery and midwifery professionalism. They should advocate for countries to have legislation which mandates the existence of midwifery as a separate profession as well as regulation which controls the education and practice of midwives. The development and recognition of midwifery as a profession have been discussed in Chapter 10 and remain a dynamic and evolutionary process supported within a critical legal framework.

17.2.6 Environmental Factors

In this section, two meanings are applied to the term environment. Firstly, the surroundings or conditions in which midwifery is practised. This environment encompasses the legal, regulatory and policy frameworks, the physical infrastructure and space where midwifery can be practised as an autonomous profession providing dignified respectful, quality care. Secondly, the environment is defined as the natural world, how it impacts on midwifery and how midwives and maternity care reciprocally affect the planetary environment.

The surroundings in which midwifery is practised have largely been explored in the previous sections of this PESTLE analysis. In summary, disabling policy frameworks (Kennedy et al. 2018) deprive a nation of the best of midwifery and inhibit women’s right of access to high-quality, respectful maternity care from Midwives.
With regard to the planetary environment, Chapter 13 described how the impact of natural hazards, such as earthquakes, tsunamis, floods and wild fires, are exacerbated by climate change and population growth. The interaction between natural hazards, conflict and vulnerability is the cause of most humanitarian disasters, laying bare inequality and discrimination. Humanitarian crises take a disproportionate toll on women and girls, and midwives too may become victims of a crisis. In some situations the work environment poses life-threatening risks to midwives and other care-providers due to epidemics such as Ebola, malaria and Zika viruses, and pandemics such as COVID-19. Women and their families have the right to quality midwifery care, even in crises; midwives also have rights to a safe working environment and protection from harm. Emergency preparedness and response planning are essential in disaster-prone areas, and midwives must be allowed to take their place in this at the highest of levels and to provide technical guidance.

Midwifery has been able to lessen reduce its carbon footprint by reducing local, national and international travel for the purposes of education and replacing this with remote learning technologies (Chapters 4 and 9). Global midwifery partnerships can also be supported and maintained through internet communication, reducing the number of international travellers (Chapter 15).

The results of the PESTLE analysis are summarised in Table 17.1.

The PESTLE analysis has demonstrated that there are multiple factors that have impacted on midwifery globally. Some have posed opportunities; some have revealed weaknesses and strengths, and others have led to the awareness of threats to the profession. The next section presents a SWOT analysis of the profession in the global context.

**Table 17.1 Summary of the PESTLE analysis results of global midwifery**

| Political factors | Economic factors |
|-------------------|------------------|
| • The global health agenda—Safe Motherhood Initiative, Millennium Development Goals and Sustainable Development Goals and the related strategies made midwifery and its value visible | • Midwifery is cost-effective and efficient |
| • Support from global bodies (UN agencies, international NGOs and global healthcare professions associations) | • Poor remuneration for midwives leading to migration and unscrupulous practices and poor quality of care |
| • Disparities in midwifery practices and models of care in different countries | • Migration led to the economic exploitation of midwives in their host countries |
| • Desire to meet global indicators led to development of multiple cadres with the title Midwife, multiple pathways to entry and differing levels of education, which blurred midwives’ identity | • Some countries were not able to afford educating midwives at global standard |
| • Multiple cadres all being called midwives with different levels of education and pathways to entering midwifery as governments wished to meet the indicators for global initiatives blurring the identity of midwifery | • Midwifery underfunded globally |
| • Governments’ political impatience and inability to resource the education of midwives to global standard (3 years perceived as too long) | • Distribution of wealth in different countries and sometimes within countries led to the increase of medicalisation of childbirth especially amongst the rich |
| • Midwifery has to work within weak health systems in many countries | • Some governments lacked appreciation of the economic value of midwifery—the 16-fold return on investment in midwifery in lives saved |
| • Midwives’ lack of political power and weak leadership, thus not represented in policy- and decision-making |  |
| • National political strategies such as road maps for SRMNCH make midwifery relevant |  |
| • Weak midwifery leadership led to lack of advocacy on critical issues |  |
Table 17.1 (continued)

| Technological factors                                                                 | Social                                                                 |
|--------------------------------------------------------------------------------------|------------------------------------------------------------------------|
| • Technology has made information accessible to midwives, women and their families,  | • Midwifery empowers women leading to societal transformation          |
|  enhancing care planning, coordination, monitoring and reporting as well as clinical | • Population movements cause demographic societal change, impacting   |
|  decision-making and treatment                                                        |  midwifery practice and demanding clear leadership                     |
| • Women’s access to information enhances choice and behoves midwives to remain       | • Civil unrest leads to the collapse of health systems. Women and      |
|  current and open-minded                                                             |  newborn are most vulnerable. Midwives have to step in                |
| • ‘Infodemic’ leading to confusion due to too much information                      | • Civil unrest and population displacements lead to poor mental      |
| • Use of artificial intelligence in midwifery education and practice, making it    |  health, substance abuse and midwives are not immune to these         |
|  possible to educate many more midwives away from campus                            | • Midwives need to be prepared to address the complications of        |
| • Use of technological applications to provide information to women and conduct     |  unacceptable socio-cultural practices such as FGM and lead initiatives |
|  remote screening such as foetal heart monitoring whilst they are in their homes    |  to counter these                                                      |
| • Technological divide between the rich and the poor but addressed by the          | • The status of midwives in some countries is the same as that of the  |
|  production of equally effective low fidelity models for low income settings by    |  women. Therefore, midwives suffer the same marginalisation that      |
|  companies like Laerdal Global Health and their collaborating partners              |  women experience in that society leading to lack of recognition      |
| • Use of technology in some instances leading to the deskilling of midwives         |                                                                         |
| • The fear that technology might be preferred in place of the human touch of the    |                                                                         |
|  midwife                                                                             |                                                                         |

| Environmental factors                                                                 | Legal                                                                 |
|--------------------------------------------------------------------------------------|-----------------------------------------------------------------------|
| • Inhibitive legislative, regulatory and policy frameworks in some countries denying | • Weak or absent regulation of midwifery in many countries             |
|  women access to quality midwifery care.                                              | • Many countries have no legislation mandating the existence of       |
| • Lack of clear scope of practice leads to poor quality of care, disrespectful care |  midwifery as a separate profession, leading to midwives’ lack of    |
|  and lack of accountability and responsibility amongst midwives                      |  professional identity, recognition and autonomy.                      |
| • In some instances, the work environment poses a risk to the midwives’ lives, e.g.  | • Absent legislation that mandates the existence of midwifery in      |
|  in epidemics like Ebola, malaria, Zika and pandemics like COVID-19                   |  many countries leading to lack of identity, lack of recognition and |
| • Midwives must be educated and enabled to respond to increasing humanitarian crises |  lack of professional autonomy. Difficulty in being recognised as a   |
|  and population movements which disproportionately affect women and children          |  separate profession                                                 |
| • Natural disasters and massive population movements have increased the demand for  | • Lack of legislation and regulation makes it difficult to demand    |
|  midwifery to be up to date in disaster preparedness since it is usually women and   |  appropriate remuneration for midwives and to delineate the scope of  |
|  newborn who are most badly affected                                                 |  practice and for midwives to practise their full scope according to  |
| • Midwifery can lessen its carbon footprint through less travel, more remote        |  their education                                                      |
|  learning, less use of paper, improved use of technology and virtual partnerships    | • Midwifery often conflated with nursing further compromising the      |
| • Technology has made it possible for midwifery to reduce its carbon footprint by   |  identity of the profession                                           |
|  using less paper, flying less to colleges as they can learn from home and write on  | • Global tools exist for the development of midwifery regulation in    |
|  screen without use of paper and also to maintain international partnerships despite   |  different countries, i.e. the Global Standards for Midwifery        |
|  inability to travel for whatever reason                                              |  Regulation (ICM 2016) and the Midwifery Regulation Toolkit (ICM 2018) |
|                                                                                      | • Tool available for the assessment of the quality of midwifery       |
|                                                                                      |  education—the Midwifery Education Accreditation Programme (ICM       |
|                                                                                      |  2019a, b)                                                            |
|                                                                                      | • Midwifery trade unions and midwives’ associations can take on       |
|                                                                                      |  leadership advocating for the harmonisation of midwifery globally    |
|                                                                                      |  using all available tools available                                  |
17.3 SWOT Analysis: Strengths, Weaknesses Opportunities and Threats to Midwifery Globally

The PESTLE analysis above has broadly defined issues explored in this book in a thematic fashion for readers. This is followed by a short SWOT analysis, drawing these themes together to summarise the internal and external resources available for strengthening midwifery globally and the potential internal and external barriers to this. Strengths and weaknesses tend to be in the present; opportunities and threats tend to be in the future (Businessballs 2020). These are explored briefly below and then presented in Table 17.2.

17.3.1 Strengths

Strengths identify the unique contribution of midwives to global health and development. This includes the growing body of evidence that midwives save lives and improve over 50 other outcomes for women and their families. Investing in midwives represents good value for money and leads to gender empowerment. Midwives are geographically close to women, are required in every setting in every country and have a broad skill set to care for women throughout their life course.

Table 17.2 Strengths, weaknesses, opportunities and threats to global midwifery

| Strengths                                                                 | Weaknesses                                                                                                                                   |
|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------|
| Evidence for the life-saving impact of midwives and the value of high-quality midwifery care (Nove et al 2020, Lancet 2014) | In many countries there is/are still:                                                                                                    |
| Strong current global policy context that recognises midwives unique contribution to achieving global goals | - Insufficient numbers and distribution of midwives                                                                                      |
| Support for midwifery from global bodies such as WHO, UNFPA, international NGOs, global professional organisations | - Disabling regulatory and policy frameworks                                                                                              |
| Evidence for the cost-effectiveness and efficiency of midwives            | - Prevalence of poor quality, disrespectful midwifery care resulting from poor quality midwifery education                               |
| Midwives are everywhere and work closest to where women and their families live | - Too many substitute cadres causing confusion about role and identity of midwives                                                        |
| Midwives provide the full continuum of care through a woman’s life        | - Lack of professional and public esteem for midwives                                                                                   |
| Midwifery enables gender empowerment, for clients and for midwives        | - Conflation of midwifery with nursing                                                                                                  |
| The effectiveness of midwifery services with minimal use of technology   | - Different pathways and educational entry requirements for midwifery education                                                          |
|                                                                          | - Absent career pathway and poor remuneration for midwives                                                                            |
|                                                                          | - Lack of midwifery-specific regulation and legislation                                                                                |
|                                                                          | - Weak midwifery leadership and and lack of representation at policy- and decision- making level                                    |
|                                                                          | - Midwives not able to perform their full scope of practice                                                                           |
|                                                                          | - Poor transport links                                                                                                                 |
|                                                                          | - Insufficient equipment and supplies                                                                                                  |
|                                                                          | - Enabling environment for midwives not clearly defined                                                                               |
|                                                                          | - Globally midwives are not prepared for their role in humanitarian and other crisis situations                                     |
|                                                                          | - Midwives do not always speak with one voice                                                                                           |

17.3.2 Weaknesses

Identifying weakness allows midwives to understand factors internal to the midwifery profession that may hinder progress. This includes the lack of clarity about what midwives are and what they do, the conflation of midwifery with nursing and the development of substitute cadres that lead to confusion amongst service users and policymakers, weak leadership and representation of midwifery at the highest levels, lack of sufficient legal and regulatory frameworks for midwifery in many countries and insufficient opportunities for career progression.
17.3.3 Opportunities

Opportunities usually arise from situations outside an organisation (Mindtools 2020), for example trends that can offer an advantage. Strengths can also be turned into opportunities. Midwives have an opportunity in the current positive policy framework which is supporting the development of global midwifery, for example the WHO’s commitment to strengthening midwifery and global policies such as ‘Survive, Thrive, Transform’ (WHO 2018b) that place midwives at the centre-stage in sexual, reproductive, maternal, newborn and adolescent health. Other opportunities lie in the availability of data, such as that in the State of the World’s Midwifery reports, that strengthens the evidence for the effectiveness of midwives, and technology that supports new ways of communicating, learning and improving practice.

17.3.4 Threats

Threats are those factors that can negatively impact growth; it is important to identify them and take appropriate action to prevent becoming victim to them (Mindtools 2020). Threats to global midwifery include global population movements (including migration of midwives), increasing medicalisation of birth and short-term human resource solutions such as task-shifting and task-sharing. Lack of enabling environments for midwives also threaten progress.

17.4 The Leading Principles, Policy and Practice Issues Emerging from the Text

The PESTLE and SWOT analyses in this final chapter have provided an overview of the themes running through the six different sections of the book: midwifery on the global scene, the three pillars of midwifery, the profession of midwifery, midwifery across the globe and looking ahead. Bringing this comprehensive text to a conclusion, the overarching principles, policies and practice issues for global midwifery are now considered.

17.4.1 Principles

Principles are fundamental truths (Cambridge English Dictionary 2020). In this case, the

| Opportunities | Threats |
|---------------|---------|
| • Opportunity to avert 41% of maternal deaths, 39% of newborn deaths and 26% of stillbirths equating to 2.2 million deaths averted by 2035 through scaling up of midwifery (Nove et al 2020) | • Global health crises such as pandemics and epidemics |
| • New State of the World’s Midwifery Report expected in 2021 | • Conflict, climate change, disasters and human migration |
| • Availability of tools to harmonise midwifery globally | • Impact of colonial past on regulation, education and practice of midwifery |
| • Global initiatives emphasising the importance of midwives and midwifery services | • Global economic downturn following COVID-19 pandemic may turn focus away from investing in midwives |
| • Technological advances present new opportunities for learning, collaboration and practice development | • The rise in medicalisation of birth in both low- and high-income countries |
| | • Not protecting the title midwife leading to continued short-term staff solutions for shortage of midwives |
fundamental truths that serve as the foundation to the beliefs and behaviours of global midwifery are summarised below.

The first principle identified is that to achieve the global agenda for sustainable development and universal health coverage, there must be a move away from the focus on mortality towards good health and well-being for all as a human right. Midwives are instrumental in promoting the reduction of preventable deaths and in demanding political commitment as a crucial component in facilitating this process. Investing adequate financial and material support in midwifery education and practice enhances the capacity of a country to enable the population not only to survive but to thrive and transform their variable situations.

Another principle is that midwifery is an autonomous profession which provides skilled, compassionate midwives’ associations practitioners. To facilitate this, the professional pillars of midwifery comprise regulation to control practice, education to global standards and midwives’ associations which strengthen the profession and promote an adequate and appropriate workforce. In this context, persons interested in practising midwifery should be those educated as skilled practitioners, thus maximising resources.

Principles identified from historical evidence can be used as a basis to promote continuing progress across the globe. So too, principles of harmonisation used elsewhere can be adapted to harmonise midwifery globally. In contrast to standardisation, the principle of harmonisation respects country-specific needs whilst promoting quality care in line with global standards.

Quality Maternal and Newborn Care (QMNC) is evident where midwifery exists within an environment of mutual respect and cooperation. If countries intend to provide quality care for all, then models of midwifery practice should be developed within a philosophy of woman-centred, safe and satisfying care for the provision of Sexual, Reproductive, Maternal and Neonatal Health (SRMNH) at every level.

The principle of listening to midwives, who are closest to women not only in their geographical location but also in understanding their needs and desires, should be observed by policymakers and managers, so that policy and practice are relevant, realistic and respectful, saving lives and promoting health. The principle of a supportive policy environment is also needed encourage the implementation of innovation in midwifery education and practice. The humanitarian community must also hear the voice of midwives and afford them every support in times of crisis.

The principle of professionalisation is a constantly evolving process. Whilst leadership and leadership styles take culture and other characteristics of followers into consideration, a further principle is that reliable research should provide the foundation for evidence-based midwifery practice across the globe.

Just as successful midwifery partnerships depend upon power-sharing and equity, sharing values and commitment, so too other forms of cross-cultural exchange must be nurtured within an enabling philosophy, aiming to provide mutual benefits to both parties and framed within an atmosphere of reciprocal respect for people and planet.

It is upon these principles that the foundation of a skilled global midwifery workforce rests. This dynamic process needs to continue to develop offering safety, security and satisfaction for all women and their families at that precious time surrounding birth, ensuring that ‘no-one is left behind’.

17.4.2 Policy

Policy is defined as a set of ideas, or a plan, agreed officially by a group of people, a business organisation, a government or a political party (Cambridge English Dictionary 2020). In this book, the ‘group of people’ are the policymakers in maternal, newborn and child health. This includes UN Agencies, governments, Ministries of Health and all other leaders in the healthcare provision and decision-making arena. In general, policies are binding to the people governed by them. As a result, policies can either enable or inhibit principles becoming practice and are therefore a crucial component in any process. Political commitment is a critical component in preventing avoidable deaths and disability and in promoting a healthy population through the provision of effective midwifery care. Midwives are in an unparalleled posi-
tion to advocate for enabling policies at each level and across every strata of society and must be enabled and empowered to function if global reproductive health targets are to be achieved. The policy of listening to midwives who are closest to women not only in their geographical location but also in understanding their needs and desires should be observed by decision-makers and managers, so that practice is relevant, realistic and respectful, saving lives and promoting health. A supportive policy environment is also needed to encourage the implementation of innovation in midwifery education and practice. Without doubt, maternal and neonatal healthcare policies must be enshrined in and propagate the human rights agenda. Therefore, policies that promote and facilitate a woman’s right to choose as well as a midwife’s right to practise in enabling clinical and political environments are vital. Similarly, policy at local, national and global levels should promote evidence-based practice and should be reviewed constantly in line with current advances in research undertaken for and by midwives.

Midwives must be represented at decision-making tables for a country to continue to develop and improve its midwifery services. Thus, inviting and encouraging midwives to participate at these levels must become the norm, in order to achieve success.

The quality, or lack of it, of those who educate midwives has been identified across the globe. Midwives should be educated primarily by midwives. National policy needs to ensure that those identified as teachers of midwifery are specifically and formally educated, supported, and afforded opportunities for continuing professional development and maintaining their competency in clinical midwifery practice.

Complementary to the regulation of other healthcare professions with which midwives will work in the multidisciplinary team, midwifery regulation must ensure that midwifery is maintained as a separate profession and must form an integral part of all national healthcare policies.

In order to enhance quality midwifery services for women, newborns and their families, governments, development partners and key stakeholders must support the strengthening of midwives’ associations.

National policy should dictate that the health system infrastructure facilitates effective and timely referrals whenever and wherever they are needed. Safety and respectful care must never be compromised, and so policies outlining strategies to afford continuity of care and of carer suited to the local culture and environment need to be in place and utilised. National, local and institutional policies should uphold the principles contained in the AAAQ Framework in order to promote quality care.

Social innovation and novel approaches to partnership across different sectors are to be encouraged, but these will require sufficient funding and support from global markets. Unarguably, innovation is needed to reach the health-related SDGs and to strengthen midwifery for the future. It is therefore essential that global health policy supports innovative approaches to developing midwifery education, regulation and practice, especially for fragile and vulnerable populations. In order to facilitate this, midwives must have a seat at policymaking tables both nationally and internationally when new approaches are designed. It becomes increasingly evident that as the midwifery profession constantly develops and diversifies, midwives must be engaged at various levels of policymaking and implementation on all issues that affect child-bearing women, newborns, sexual and reproductive health care and midwifery education and practice. In order to maximise these efforts, there must be a demand that governments and key stakeholders support the development of midwifery leadership. This will assist in organising and enhancing the quality of midwifery services as well as contributing to the development and management of the health workforce.

Global and national policy should motivate national governments, donors, implementing organisations and global decision makers to mobilise around three key activities, namely greater emphasis on maternal and newborn health in vulnerable communities, maternal and newborn life-saving interventions in crisis settings and strengthening the role of communities in delivering maternal and newborn health interventions. In addition, a policy should be in place to guide selection and ensure appropriate preparation and debriefing for all who cross borders to strengthen
global midwifery, whether these are professionals or students. This is essential in order to enable maximum effectiveness, minimal disruption due to cross-cultural interactions and prevention of economic exploitation and trafficking. In this context, midwifery partnerships show potential in enhancing the capacity of professional midwives’ associations which in turn can improve the quality of maternity care. For this reason, such partnerships need the support of policymakers.

It has been proposed that political commitment and advocacy are critical components for harmonisation. Harmonisation can function as an enabler in the whole process of providing acceptable, accessible and affordable quality of maternal and newborn care for a total population. The evidence concerning the importance of midwives’ contribution to achieving the SDGs in this context is convincing. Policymakers would appear to hold the key to making numerous ideals a reality through ensuring that their countries use the available global tools for harmonising midwifery such as the global competencies for midwifery practice, the global standards for midwifery education and regulation and the global midwifery accreditation programme rather than perpetuating age old barriers that threaten the 2030 Agenda.

### 17.4.3 Practice

Appropriate midwifery practice depends on the availability of sufficient numbers of well-educated midwives who are high skilled, respected, enabled by policy and guided by considered principles to provide evidence-based care. Without them, there is little chance of achieving the targets of SDG3 in the context of Sexual, Reproductive, Maternal and Newborn Health (SRMNH). Midwives are best placed to provide woman-centred care. Evidence-based practice provided by skilled midwives must be safe, but it should also offer support and a satisfying experience that promotes optimum maternal and newborn health and well-being. It is essential therefore that as principles provide the fundamental truths to be adhered to and policy guides as to how it should be done, midwives operationalise these in their practice. The knowledge that what they are doing is mandated by policy and is based on principle enhances the confidence with which midwives practise as they will be aware of the accepted basis on which their practice rests. Thus, integrating midwives into the health systems in every country and resourcing midwifery services adequately enables midwives to practice confidently, providing quality care.

In order to facilitate a high standard of midwifery practice, midwifery educational institutions also need to be adequately resourced and staffed by those skilled in midwifery practice as well as appropriate educational approaches.

Midwifery practice must be controlled and directed by a recognised regulatory framework if the unacceptably high global maternal and perinatal mortality and morbidity rates are to be addressed. Within such a framework, midwives should be enabled to provide skilled, respectful care. The value of midwives’ associations in the context of contributing to the quality of care needs to be further evaluated, but these professional organisations appear to have considerable influence on the practice of midwives in diverse situations. All midwifery care needs to be provided by skilled midwives who have been trained to international standards. Midwives practice in collaboration with obstetricians, paediatricians and other professionals as it becomes necessary. Women, their families and their communities should be able to find the practice of every midwife acceptable and therefore be eager to seek such skilled attendance during childbirth.

Innovation has the potential to transform midwifery practice and to benefit midwives, those who work with midwives and others from different disciplines. Therefore, innovation in midwifery practice should be responsible and should target the populations, and be developed in partnership with, those who most need to benefit from it. For those with digital access, digital innovations can make high-quality midwifery care more accessible. There is potential for midwives to transform their ideas into action where this will enhance practice and promote safety and satisfaction.

Midwives have become highly skilled professionals in many parts of the world. However, they need to practice to their full capacity in political and practice environments. Hence, policy and politics should enable, rather than disable or limit, midwives so that they are accessible to every woman.
Midwifery leaders are well placed to take responsibility for quality assurance as well as ensuring that evidence-based practice is adopted and adapted.

Practising midwives must ensure they are competent to perform all the basic emergency obstetric and newborn care (BEmONC) functions as well as providing respectful maternity care. This includes crisis situations when regular health systems may be fractured. Midwives must engage with women and local communities in planning care. In addition, a systematic feedback mechanism of women’s experience of care and recommendations for improvement could continue to enhance midwifery practice. Midwifery practice, whether clinical, academic or in a consultancy role, needs to place the safety, health and well-being of women and babies within a human rights framework. Similarly participating in a global midwifery partnership involves practicing with similar priorities and can foster personal and professional benefit to individuals and the organisations in which midwives work.

Finally, the concept of harmonisation enhances the provision of quality midwifery services everywhere. Individual professionals will share a common philosophy and a common professional identity which will compel them to practice according to agreed professional standards. Building on these principles, facilitated by enabling policy and implemented in practice, midwives offer substantial hope for the world’s women, their newborns and their families.

Communities served by skilled midwives can have confidence that they will not only survive but also thrive and transform. The principles, policy and practice of global midwifery stands testimony to a brighter future, even for the most vulnerable in the twenty-first-century world in crisis.

17.5 Recommendations

1. Since it has been recognised that political commitment is a critical component in preventing avoidable deaths and disability and in promoting a healthy population through the provision of effective midwifery care, governments need to recognise or renew their commitment in this respect.

2. Since there is a good return on investment as a result of lives saved and interventions averted, global bodies and governments should increase investment in midwifery education, regulation and practice, thus enabling populations not only to survive, but to thrive and to transform their situations.

3. In order to nurture a skilled workforce, governments, development partners and key stakeholders should cooperate to facilitate the retention of midwives through continuing professional development opportunities, providing supportive supervision and ensuring that midwives receive appropriate remuneration and secure working and living conditions whether they are posted to rural or urban locations.

4. There is a need to develop strong midwifery leaders to lead and guide the profession, to advocate for midwives, women/pregnant people and newborns and to represent the profession in policy- and decision-making bodies at all levels.

5. Globally, and in each country, midwifery needs to be recognised as an autonomous profession with the title ‘midwife’ protected and used only by those who meet global standards of competence.

6. Midwives should be educated to global standards by those who meet the global standards for midwifery educators and are able to promote safe, respectful evidence-based care.

7. Models of midwifery practice should be developed within a philosophy of woman-centred, safe and satisfying care for the provision of Sexual, Reproductive, Maternal and Neonatal Health (SRMNH) at every level.

8. If the identified global reproductive health targets are to be achieved, midwives should be participating in the development of, and be encouraged to advocate for, enabling policies and be empowered to function within enabling political and clinical environments.

9. All agencies working in maternal and child health, governments, decision-makers and managers should listen to midwives, so that practice is relevant, realistic, dignified and respectful, saving lives and promoting health.

10. National, local and institutional policies should uphold the principles contained in the
AAAQ Framework in order to promote safe and respectful quality care.

11. Global and national policy should motivate national governments, donors, implementing organisations and global decision-makers to mobilise around three key activities, namely greater emphasis on maternal and newborn health in vulnerable communities, maternal and newborn life-saving interventions in crisis settings and strengthening the role of communities in delivering maternal and newborn health interventions.

12. In order to enable maximum effectiveness and minimal disruption due to cross-cultural interactions and prevention of economic exploitation and trafficking, policies that are acceptable at the global level need to be in place to guide selection and ensure appropriate preparation and debriefing for all who cross borders, whether these are professionals, students or participating in international partnerships.

13. It should be recognised at every level that only midwives practise midwifery and do so in collaboration with obstetricians, paediatricians and other professionals as it becomes necessary.

14. Every woman, every family and every community should be able to access the care of a skilled midwife who is enabled to provide appropriate care supported by both a policy and an infrastructure which facilitates timely referral whenever deemed necessary.

15. The weaknesses and threats to global midwifery identified in this text should be systematically addressed; the strengths should be recognised and maximised and the opportunities seized in order to move with confidence towards the 2030 agenda and beyond.

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