3

The Contribution of Midwifery to Global Health and Development

Expected Learning Outcomes
By the end of this chapter, readers should be able to:

1. Position and profile midwifery onto the global health agenda
2. Demonstrate the relationship between midwifery services, global health and development
3. Explain the critical nature of the contribution of midwives and midwifery to the strategies for the achievement of the global health agenda
4. Describe some successful evidence-based midwifery pathways for the enhancement of global health
5. Outline the challenges to the contribution of midwives to the global health agenda
6. Map out midwives and midwifery across the globe and the variety of health systems in which midwifery functions

3.1 Evidence on the Value of Midwives’ Contribution

Evidence abounds on the critical importance of midwives’ contribution to achievement of better health outcomes for women, newborn and their families (Renfrew et al. 2014; UNFPA 2011, 2014a, b). It is therefore reasonable to postulate that without the contribution of midwives providing quality midwifery care, the achievement of the global health agenda for women and newborn would be difficult.

3.2 Positioning and Profiling Midwifery into the Global Health Agenda

During the MDG era (2000–2015), three goals in particular were most relevant to midwives and midwifery. These were Goal 3: to promote gender equality; Goal 4: to reduce child mortality and Goal 5: to reduce maternal mortality. The achievement of these goals relied on quality midwifery services. Hence, the focus on rapid production of midwives and other cadres who were intended to fill in the gap for serious shortages of midwives where they were needed most and the introduction of skilled attendants at birth (see Chapter 2). Some of the said ‘skilled attendants’ were actually not skilled (UNFPA 2014a, b; WHO 2015a, b, c, d), and this posed a problem. The evidence further demonstrated that to get the best out of midwives’ contributions, the midwives had to be well educated, regulated, supported and work within a well-functioning health system. Numbers alone were not enough. Management systems, infrastructure and other logistic issues had to be
addressed (UNFPA 2011, 2014a, b; Renfrew et al. 2014; WHO 2015a, b, c, d).

The Global Health Agenda (2016–2030) focuses on ensuring that everyone everywhere has access to basic health care at a cost that does not leave the individual impoverished (WHO 2017a, b, c, d). The global strategy for women’s, children’s and adolescents’ health (2016–2030), launched to operationalise the 2016–2030 agenda, envisions a world in which every woman, child and adolescent in every setting realises their rights to physical and mental health and well-being, has social and economic opportunities and is able to participate fully in shaping prosperous and sustainable societies (WHO 2015a, b, c, d). In a world that is becoming more connected through globalisation, with advances in technology and innovation, it would be tempting to think that Universal Health Coverage (UHC) is easy to achieve. Yet evidence shows that women and children are still disproportionately affected by issues like poverty, environmental vulnerability, hunger, conflict, discrimination and violence (The World Bank 2017). To address these inequalities, initiatives like the UHC, Every Woman Every Child (EWEC) and Every Newborn Action Plan (ENAP) were launched to ensure that in the post 2015 global health agenda no one was left behind. The Sustainable Development Goals (SDGs) provide focus to all these initiatives, specifically SDGs 3.8; 3.8.1 and 3.8.2 which cover women and newborns (Box 3.1). Through the operationalisation of these strategies, midwives’ contributions lead to improvement in equity, empowerment of women and, ultimately, strengthening the health system because strengthening midwifery services positively impacts on the health system.

SDG indicator 3.8.1: Coverage of essential health services (defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health; infectious diseases; noncommunicable diseases; and service capacity and access; amongst the general and the most disadvantaged population).

SDG indicator 3.8.2: Proportion of population with large household expenditures on health as a share of total household expenditure or income.

Source: World Bank, World Health Organization (2017). Tracking Universal Health Coverage: 2017 Global Monitoring Report

In the majority of low- and middle-income countries, 73 of them surveyed during the State of the World’s Midwifery study (UNFPA 2011, 2014a, b) where the highest burden of maternal and newborn mortality and morbidity occur, midwives were the care providers closest to where women live. And yet it was in these same countries where midwifery was not perceived as a distinct profession. The practising midwifery workforce was not easily identifiable by country data. There were deficits in both numbers and competencies amongst the workforce. Coverage of births by a competent workforce and quality care was limited. Regulation and regulatory processes were insufficient to promote the professional autonomy of a midwife and to fulfil government obligations to protect the public; educational pathways and capacity required strengthening, and policy coherence and adherence were disjointed (UNFPA 2011:30). Midwifery services were, therefore, not able to take their position as a critical aspect of healthcare services because of prevailing socioeconomic and gender issues. Hence, in the SDG era, focus on improvement of midwifery education and services took centre stage (WHO 2016a, b, 2017a, b, c, d, 2018a, b, 2019a, b). Midwives were still the key to the achievement of global maternal and newborn health.

Box 3.1. SDG targets 3.8, 3.8.1 and 3.8.2

SDG target 3.8: 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.
3.3 Midwifery Services, Global Health and Development

According to the Merriam Webster Dictionary (2018), *development* is ‘a process that creates growth, progress, positive change or the addition of physical, economic, environmental, social and demographic components’. That is what midwifery does for women. Midwives provide comprehensive sexual and reproductive health services, including family planning counselling and services, post-abortion care, treatment of malaria in pregnancy and the prevention of mother-to-child transmission of HIV (UNFPA 2014a, b). Through their community education services, they contribute to the creation of awareness of non-communicable diseases and the value of families to seek care. Midwifery, by its very nature, when provided by midwives who are well educated, regulated and supported within a functioning healthcare system will lead to a reduction of up to 80% of maternal deaths, still births and neonatal deaths (WHO 2019a, b). Further evidence demonstrated that besides reduction of deaths and disability, there are 50 more advantages of quality midwifery services provided by qualified midwives the most important of which is health and well-being of women, newborn and their families (WHO 2019a, b), so that women and newborn do not only survive but thrive and transform. Healthy families constitute a healthy nation. A healthy nation is the prerequisite to economic growth and development of a nation. However, Saraki (2017) suggests that there is a perception gap between midwifery and development that must be addressed, citing the example of midwives in Africa who often make the difference between life and death in their communities.

For effective provision of safe, accessible midwifery services, there is a need for water, electricity, effective and efficient communication and transport systems and purpose—built health facility infrastructure to ensure efficient and respectful care for women. Respectful care of the care providers includes the provision of respectable and safe housing with adequate water and sanitation, security, methods of connectivity with the rest of the world, relevant amenities such as schools for the children, recreation and shopping facilities for families and any other amenities that add comfort to life. All these contribute to the general development of a community. In this light, midwifery services, when well supported by a government become a conduit for development. When governments invest in midwifery, they get a 16-fold return on investment in terms of lives saved and interventions prevented (UNFPA 2014a, b). It is therefore in every country’s advantage to invest in midwifery. Thus, global health and development are closely intertwined with each facilitating the other.

3.4 Emphasising the Critical Nature of Midwifery and Midwives’ Contribution

Global health initiatives are about ensuring that every woman everywhere has access to care—‘Leaving No One Behind’ (The World Bank 2017). In many countries, up to 80% of the population live in rural areas, some of which are inaccessible for various reasons and considered ‘remote’ or ‘hard to reach’ (The World Bank 2017). To achieve UHC and therefore *leave no one behind*, services must be available, accessible physically and psychologically to this large segment of the population irrespective of the changing demographic, epidemiological and technological trends occurring globally. Despite these changes, midwives continue to constitute the numerical bulk of the care providers providing services in difficult settings in low- and middle-income countries including in crisis situations (UNFPA 2016; FCI 2014; WHO 2016a, b). According to the ‘Midwives Realities’ report, ‘Midwives are deeply committed to providing the best quality of care for women, newborns and their families’ (WHO 2016b:2). As a result, midwives, continue to offer comprehensive services and promote woman-centred care and the well-being of women and newborns across the continuum of sexual, reproductive, maternal, newborn and child health (SRMNCH) (UNFPA 2014a, b). The WHO Regional Office for Europe...
(2015b) in ‘Health 2020’ described midwives as ‘a vital resource for health’ and provided evidence that midwives contribute to improving health and preventing disease, empowering individuals and communities. They contribute to developing evidence-based practice, conducting health research and developing innovative practices; have expertise and potential to improve population health and that with effective policies and workforce planning, regulatory frameworks, educational standards and supportive managerial practices, as part of an interdisciplinary team, midwives provide safe, high-quality and person-centred care, improve the coverage and integration of health services and reduce the costs of healthcare organisations and health systems (WHO European Region 2015b). Even in Europe, midwives comprise the majority of healthcare professionals providing maternity care, have close contact with many people and use every opportunity to influence health outcomes, influence social determinants of health and the policies necessary to achieve change (WHO 2015a, b, c, d; WHO, World Bank 2017; UNFPA 2017).

### 3.5 Some Successful Evidence-Based Midwifery Pathways

Global bodies have developed creative and innovative ways of enhancing the contribution of midwives and midwifery to the global health agenda and to operationalise the concepts of survive, thrive and transform. The selected frameworks and pathways below support and enable governments who wish to invest in the development and promotion of midwifery services in their countries based on evidence-based tools and frameworks.

#### 3.5.1 The ICM Midwifery Services Framework (MSF)

At the advent of the SDGs, despite consensus having been reached about their value in SRMNC, midwives and midwifery were not part of the regular healthcare system in many countries. ICM exists to strengthen midwifery globally, so it developed a tool that allows systemic and systematic approaches to strengthening midwifery services and the quality of midwives a country could produce. The tool allows a wholistic approach to the scrutiny of healthcare systems and services and places midwives and midwifery services into their rightful place in the healthcare system. It presents a step-by-step approach for developing and strengthening midwifery (Annex 3.1).

#### 3.5.2 The Midwifery Pathway 2030

The Midwifery Pathway 2030 envisions that all women of reproductive age and adolescents have universal access to midwifery care by 2030. The Pathway outlines key planning and policy measures that increase maternal and newborn survival leading to healthy communities (Annex 3.2).

#### 3.5.3 The Framework for Quality Maternal and Newborn Care (QMNC)

Described in detail in the Lancet Series on Midwifery (2014), the QMNC demonstrates that midwifery care covers 100% of the greater part of the health needs of women and newborns, and they continue to contribute to care even when other care providers get involved during complications (Renfrew et al. 2014). Annex 3.3 provides a detailed description of the framework.

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1 For the aims of WHO European Region’s objectives for Health 2020, see Chapter 11, Box 11.6.

2 For a more detailed description, see Annex 3.1.
3.5.4 State of the World’s Midwifery Reports 2011 and 2014

The State of the World’s Midwifery Reports 2011 and 2014 describe in great evidence-based detail the situation of midwifery in high burden countries and what needs to be done to improve the situation (UNFPA 2011, 2014a, b). These reports elucidate the impact of scaling up midwifery in individual countries under different scenarios. The scenarios are excellent frameworks for decision-making for countries. An evaluator process was in progress starting 2019 for the production of the State of the World’s Midwifery Report 2021 which will include data from all countries, not just from those with a high burden of maternal and newborn mortality.

3.6 Challenges to Effective Full Potential Midwifery Contribution to These Initiatives

For effective and optimum benefit from midwives’ contributions, policymakers and governments globally need to listen to midwives because midwives have an in-depth awareness of what is needed to improve the quality of care. Yet, according to the ‘Midwives Realities’ report (2016), midwives’ voices are rarely heard. As a result, key issues are absent from policy dialogue at all levels. Additionally, the understanding of midwives and midwifery has been restricted by a failure to apply consistent definitions, resulting in professional and non-professional staff being seen as midwives (Renfrew et al. 2014). Not all countries use the globally accepted definition of midwifery (Renfrew et al. 2014) (Box 3.2) and of a midwife (ICM 2014) (Box 3.3). In some settings, the understanding of midwifery is confined to pregnancy, birth and post-partum care. The broader, more diverse contributions are not known. As a result, other care providers take responsibility for the SRMNCH of women leading to an increased medicalisation of birth and the confinement of midwives in closed institutions (Ruiz-Berdun et al. 2016). There needs to be better recognition of midwives and midwifery, better understanding of what midwifery is and does and a clearer definition of who is a midwife and what midwifery is through better regulatory frameworks, clearer job descriptions and strengthened midwives’ associations. The matters of professionalisation and professional iden-

Box 3.2. Definition of midwifery
Midwifery is ‘skilled, knowledgeable and compassionate care for child-bearing women, newborn infants and families across the continuum from pre-pregnancy, pregnancy, birth, post-partum and the early weeks of life’. Core characteristics include optimising normal biological, psychological, social and cultural processes of reproduction and early life, timely prevention and management of complications, consultation with and referral to other services, respecting women’s individual circumstances and views and working in partnership with women to strengthen women’s own capabilities to care for themselves.

Source: Renfrew et al. (2014) in the Lancet Series on Midwifery (2014)

Box 3.3. Definition of a midwife
A midwife is a person who has successfully completed a midwifery education programme that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education and is recognized in the country where it is located; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title ‘midwife’ and who demonstrates competency in the practice of midwifery.

Source: International Confederation of Midwives website. Accessed 2 March 2020
tity of midwifery are discussed in some detail in Chapters 10 and 18. The need for better and stronger pre-service education and continuing professional development cannot be over-emphasised. Neither can the need for more representation of midwives in decision-making circles at all levels. Hence, WHO dedicated 2020 as ‘the year of the nurse and the midwife’ for the recognition, improvement and support for the contribution of midwives and nurses to global health.

Inconsistencies are perpetuated by the variety of pathways to becoming a midwife. SoWMy 2011 describes three main pathways followed in 57 countries: direct entry, combined with nursing and post nursing. Education is provided by either private or public institutions. The duration and content of programmes vary widely with programmes ranging from 6 months to 5 years. There are also variations across and within pathways and between public and private institutions (UNFPA 2011:21). Details and examples of various midwifery education programmes are discussed in Chapter 4.

Professionally, because of lack of opportunities for leadership, especially at national level, midwives are absent from policy dialogue and thus unable to contribute to policy decisions. In some countries, midwives’ professional competence is either unknown or not recognised, leading to inappropriate restrictions on practice. In situations of severe midwife shortages, midwives are compelled to work for the government for a fixed period of time. Most frustratingly, in many low- and middle-income countries, midwives are expected to provide services with minimal or no equipment. The net effect is that some midwives suffer moral distress and burn out. In general, midwives often suffer from overall poor human resource policies and management within health systems (WHO 2016a, b).

Economic challenges are experienced mainly in low- and middle-income countries where the midwife’s salary is so low that midwives are unable to meet the family expenses and are forced to look for other sources of income. In some situations, salaries are not paid regularly or they are not paid at all. This puts midwives into a very difficult situation and creates room for unscrupulous practices where midwives are forced to ask for under-the-table payments from women and families. In some settings, midwives are so few that those available are not able to take a break or can only do so after a long period. In other settings, housing is poor and not safe, and midwives experience security risks including sexual assaults (WHO 2016a, b). Gender inequality predisposes midwives to physical and sexual violence.

In many countries, midwives feel disrespected despite being empowered through their education and training. There are unequal power relations within the health system and within communities. When hierarchical power is wielded by other health professionals, the authority and decision-making ability of midwives are undermined, negatively impacting on the ability of midwives to offer quality care. There is also lack of or limited social capital, solidarity and organisational power because many midwives’ associations do not have the resources to provide support to the profession and to individual midwives. In other countries, there are social norms, legal and regulatory environments that encourage gender inequality and low public opinion of midwives and midwifery (WHO 2016a, b).

Some barriers are systemic and beyond the reach of midwives. These include social inequalities where maternal and child health services are not evenly distributed across population groups; poverty, in some cases extreme poverty which makes populations unable to afford care; and shifting demographics due to massive population movements, natural disasters, civil unrest and conflicts. In other settings, the practice environments militate against the provision of quality care. The status of midwifery and that of women is low (WHO and World Bank 2017). The whole issue of quality in midwifery care is discussed in Chapter 8.

All these barriers make provision of effective quality midwifery care difficult and in some cases impossible. Midwives alone are not able to change such situations. They need support through professional associations, collaboration with other healthcare providers and development partners to optimise their value and take their position in care provision. With strong associations, midwives can negotiate, persuade and dialogue with the policy-
makers and other stakeholders including the community they serve and can add their voice at the decision-making table.

### 3.7 Mapping Midwifery Across the Globe

According to the World Bank database (2019), the global average distribution of nurses and midwives is 3.4 per 1000 people. (Not many countries distinguish or are willing to separate midwives from nurses. As a result, it is difficult to obtain data on midwives only. All the same, the distribution of midwives is influenced by the same factors that influence the distribution of other health care providers especially nurses.) According to SoWMy (UNFPA 2014a, b), the 73 countries profiled account for 96% of all maternal deaths, 91% of all still births and 93% of all newborn deaths but have 42% of the world’s midwives, nurses and doctors, suggesting that, for a variety of reasons, the global distribution of midwives is not directly related to where the need is greatest (UNFPA 2014a, b). Figure 3.1 presents averages across the globe. It is important to note that distribution of healthcare providers differs between and within countries, and these differences are not usually visible on national averages.

### 3.8 Regional Distribution of Midwives

Figure 3.2 presents the distribution of midwives like other care providers in different regions with the same observation that even within a region, there are factors that impact on where midwives are found.

### 3.9 Across Different Economic Groupings

The World Bank database (2019) further shows that economic groupings and collaboration amongst countries and other social factors such as population movements, human development and a country’s income level also impact on the distribution of healthcare providers. Figures 3.3 and 3.4 present these data.

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**Fig. 3.1** Midwives per 1000 people by all groupings. (Source: World Bank Database 2019. Accesses 1 March 2020)
3.10 Midwifery in High-Income Countries

In most high-income countries, midwifery is an autonomous protected profession and midwives practise their full scope and more at all levels of care across the whole continuum from primary care to tertiary care (Ruiz-Berdun et al. 2016). Midwives are in administration and management, academia and research. In administration, mid-
wives hold posts ranging from managing a hospital and/or a family health centre to carrying out auditing tasks for public and private providers and insurers. Additionally, midwives work in research and teaching at undergraduate and postgraduate levels in public and private universities and professional institutions.

In Norway, midwives are authorised to lead in the care of pregnant women who want to see a midwife. Midwives can be individual consultants, work in obstetric units or in midwife led units. Women have a choice. In Ireland, studies showed that midwifery-led care was as safe as consultant-led care, resulted in less intervention, was viewed by women with greater satisfaction in some aspects of care and was more cost-effective (Ruiz-Berdun et al. 2016).

With migration of health workers from low- and middle-income countries, immigrant midwives complement the staffing levels in high-income countries. Service coverage is high with a coverage index of 77 for North America, Europe and East Asia (UHC Report 2017), and in 2005–2015, 74% of mothers and infants in the richest households received at least six of the seven basic maternal and child health services (see Box 3.4).

Box 3.4. The seven basic maternal health and child services

- Four or more antenatal care visits
- At least one tetanus vaccination during pregnancy
- Skilled birth attendance (birth attended by skilled health personnel)
- Bacillus Calmette-Guerin vaccination
- The third dose of diphtheria–tetanus–pertussis containing vaccine
- Measles vaccination
- Access to improved drinking water

Source: WHO and World Bank (2017). Tracking Universal Health Coverage: 2017 Global Monitoring Report

The greatest challenges in high-income countries are rising intervention rates, the over-use of technology and the increasing use of the right to choose by women with no professional explanation and support. For example, in Norway in 2013, 99.2% of births took place in big institutions (Ruiz-Berdun et al. 2016). Because births take place in big institutions, technology takes over and compromises the human touch of the midwife. More interventions mean that less women benefit from the care of a midwife. Additionally, because of the easy access to varieties of care, and the ability and the right to choose, women choose interventions like epidural as they see it as their legal right to have it. Because of these rights, many women will request or receive interventions without professional assessment or questioning if it is the best for them (Ruiz-Berdun et al. 2016). Medicalisation is therefore a threat to both women and midwives, and this issue is discussed further in Chapter 10.

3.11 Midwifery in Low- and Middle-Income Countries

The situation is very different in low- and middle-income countries where numbers of midwives are low, sometimes dangerously low; the profession is not recognised, the education programmes and processes are weak and the recruitment, deployment and retention mechanisms are missing or weak. Midwives work in rural areas and hard to work environments with minimal or no incentives, no support and poor remuneration (UNFPA 2011, 2014a, b; Renfrew et al. 2014; WHO 2017a, b, c, d, 2019a, b). Midwives are not always permitted to practise to their full scope. Regulation is weak, and job descriptions and definitions are missing or not clear, leading to non-professional staff being seen as midwives (Renfrew et al. 2014).

The massive population movements and migration from low- and middle-income countries to countries where work conditions and remuneration are perceived as better have exacerbated the deficit of midwives where they are most needed. Hence, the International Confederation
of Midwives focuses on strengthening midwifery by creating and strengthening national midwives’ associations. The Midwifery Map shows where ICM has members. The map can be accessed on the ICM website.

The distribution of midwives differs greatly between and within countries with the richer receiving considerably more than the poorer segments of populations. Large inequalities in basic maternal and child health services persist (Box 3.4). The UHC service coverage index is lowest in sub-Saharan Africa (42) followed by South Asia (53); and, between 2005 and 2015, only 17% of mothers and infants in households in the poorest wealth quantile received at least six of the seven interventions compared to 74% in the richest quantile. It is feared that, unless interventions are designed to promote equity, efforts to attain UHC may lead to improvements in the national average of service coverage while inequalities worsen at the same time. This reinforces the importance of restructuring health services so that no one is left behind (WHO and World Bank 2017:2, 4).

The age-old issues of poverty, poor leadership and management of health systems, lack of political will and low socio-economic status and human development persist. Encouragingly, the UHC Report (2017) observed that, never before has there been as much political momentum for universal health coverage as there is right now. And never before has there been greater need for commitment to health as a human right to be enjoyed by all, rather than a privilege for the wealthy few. (p.xii)

3.12 Impact of Global Movements, Epidemics and Pandemics on Distribution of Midwives

3.12.1 Migration

Emigration of healthcare workers to higher-income countries within North America and Europe (Aluttis et al. 2014) led to up to 70 and 75% of the physicians originally from Angola and Mozambique, respectively, practising abroad (Clemens and Pettersson 2008). Approximately, 65,000 doctors and 70,000 nurses from sub-Saharan Africa, which is equal to approximately 28% of the region’s medical workforce, work internationally (Clemens and Pettersson 2008). The outward flow related to low salaries, poor working environments, underfunded healthcare facilities and the lack of opportunities for career advancement (Eastwood et al. 2005) and political instability appear to worsen the outflow.

3.12.2 Epidemics and Pandemics

It is estimated that diseases and infections such as HIV, AIDS and Ebola outbreaks caused a 20% decrease of frontline health workforce especially in sub-Saharan Africa (Chen et al. 2004) in countries with the highest maternal and newborn mortality (Gerein et al. 2006). The WHO indicated a growing deficit of approximately 4.3 million health workers, including midwives, in almost every region of the world. Forty six out of the 47 sub-Saharan countries had significantly less than the required minimum threshold of 2.28 physicians or nurses per 1000 people, to deliver basic health services (WHO 2006) despite the region carrying nearly 24% of the world’s disease burden with only 3% of its healthcare workforce and only 1% of its financial resources for health care (Anyangwe and Mtonga 2007).

In 2019 the Corona Virus Disease 2019 (COVID-19) pandemic killed hundreds of healthcare workers, creating crises in almost every facet of public health systems as well as changing the contexts within which midwifery care is provided. Midwifery, by its very nature, makes the social distancing required to prevent the disease spreading impossible.

3 Social distancing = it was required that individuals keep a distance of one and half metres from each other to prevent the spread of the disease (WHO 2020).
3.13 Where There Is No Midwifery

In their report, ‘Making a case for midwifery’ (2014), Family Care International and the International Confederation of Midwives (ICM) stated that midwives promote woman-centred care and the well-being of women and newborns across the continuum of sexual, reproductive, maternal, and newborn health (SRMNH) including HIV prevention (UNFPA 2014a, b). Midwives act as a hub of information and education for women, giving guidance on everything from nutrition to contraception, educating women on the value of breastfeeding, tackling the information gap amongst women in the immediate lead-up to and aftermath of birth. In thousands of communities, the midwives’ role transcends birth. Midwives are a focal point for community inquiries and information and an entry point for many women to the wider primary healthcare system, including informing women about their sexual and reproductive health rights. Women and families are deprived of all these services or receiving them at less than optimum level when there are no midwives (Saraki 2017).

3.14 Health Systems and the Identity of Midwives

Midwives function in different health systems. The health systems impact on the level at which midwives are perceived to function within the power dynamics enabled by the healthcare system. In medically led systems, it is difficult for midwives to be allowed to function as autonomous professionals who will collaborate on equal footing with other healthcare providers. Society has tended to view the doctor as the most senior healthcare provider with the rest, including midwives, being subservient to them (Puras 2019). There are power gradients and turf wars as a result of these power gradients. Unfortunately, in low- and middle-income countries, because of the quality of education for midwives, this perception of a senior–junior relationship between obstetricians and midwives is perpetuated leading to loss of confidence and identity amongst midwives.

In health systems which are based on midwife-led care, the midwife is perceived and recognised as a specialist in normal childbirth and the obstetrician as a specialist when child birth is complicated. There is mutual trust amongst professional groups. Roles and job descriptions are clear. Midwives are perceived as autonomous practitioners. There is mutual support and eye-level collaboration amongst midwives and other healthcare providers. This amicable relationship in general tends to lead to provision of quality care to women and their families.

3.15 Conclusion

All in all, midwives are crucial, if not vital for the achievement of global health. All the health-related SDGs heavily assume and rely on the effective contribution of well-educated, regulated, supported midwives in a functioning health system. But it has to be acknowledged that no one healthcare profession can do it alone. There is a need for respectful collaboration, mutual support amongst care providers and the effective addressing of health system issues in order to get the best out of midwives and midwifery services as they contribute to global health and development.

3.15.1 Principles

Providing adequate financial and material support to midwifery enhances the capacity of a country to get the best out of midwives and midwifery services. Because midwives are closest to where women live whether in urban or rural areas. Policymakers and managers should listen to midwives in order for them to include all the relevant issues important to women and their families for the reduction of maternal and newborn mortality.

4 In midwife-led care, the midwife is the ‘lead healthcare professional responsible for the planning, organisation and delivery of care given to a woman from initial booking of antenatal visits through to the postnatal period’ (WHO).
3.15.2 Policy

Midwives must be represented at decision-making tables by midwife leaders in order for countries to focus investment on issues that lead to a country’s development and the improvement of midwifery services.

3.15.3 Practice

Governments and development partners must work together to ensure that midwives are integrated into the health systems of nations and that midwifery services are well resourced for the provision of quality care.

Questions for Reflection

1. The text suggested that midwifery is critical for the achievement of the objectives of the global health agenda. Based on your knowledge of midwifery in your own country or region, how far do you think this is true?

2. Critically analyse the concept of universal health coverage. Discuss the possibilities of its achievement or lack thereof in low- and middle-income countries given the current status of midwifery globally.

3. Scrutinise midwifery services in high-income countries. How far do you think the global health agenda and the contribution of midwives and midwifery are applicable in these countries?

Annex 3.1: The International Confederation of Midwives Midwifery Services Framework (MSF)

Published in 2015, the Midwifery Services Framework (MSF) is a framework that provides a step-by-step approach for developing or strengthening midwifery services in all countries irrespective of income level and brings together existing global evidence-based tools, approaches and guidelines in its steps. The tool has specific components (Box 3.2) which enable a country to examine the services that women and their families receive in comparison to the globally accepted minimum benefits package of care and identify gaps in its healthcare system. The country can then develop evidence-based approaches to fill in the gaps. It was the only tool at the time of writing which starts off with what women need and thus avoids turf wars amongst MNCH healthcare providers.

The MSF acknowledges the complexity of issues involved in maternal and newborn deaths and disability. It allows for a detailed, collaborative, examination of the breadth and depth of all these issues and creates a platform where all stakeholders involved in preventing these come together and discuss solutions. The tool pinpoints the areas that need improvement, not only in the care provision, but also in the healthcare system, the education process of midwives and other healthcare providers, the management and leadership process and policies which determine the deployment, recruitment and retention of care providers. Thus, countries which use the tool, besides coming to a clearer and deeper understanding of their healthcare system, own both the problems and their solutions and develop momentum and willingness to implement the solutions.

The ICM implemented this tool in six countries, and an evaluation conducted in 2019 demonstrated some improvement in SRMNCH services. The lessons learnt from the evaluation were used to review the tool and implementation process. Countries wishing to use this tool can contact the International Confederation of Midwives on info@internationalmidwives.org.
Annex 3.2: Steps of the Midwifery Service Framework, Under Review, at the Time of Writing

1. Package of care
   Agree what midwives provide

2. Organization of services
   Agree how services should be organized

3a. Workforce
   Required number
   Distribution
   Recruitment, deployment, Retention, education
   Regulation

3b. Enabling environment
   Facilities, commodities, equipment, transport, respectful working environment

4. Monitor
   Adapt

   Evaluate

   Adapt services to local need

Ongoing: Develop or strengthen the midwives association

Source: https://www.internationalmidwives.org/icm-publications/midwifery-services-framework.html

Annex 3.3: Midwifery 2030

The Midwifery 2030 vision sets out that all women of reproductive age, including adolescents, have universal access to midwifery until 2030. The global number of pregnancies per year between now and 2030 is expected to remain constant at 166 million. To compensate for the shortage of midwives, countries need to strengthen their policies and planning to extend the reach of midwifery. Midwifery 2030, A Pathway to Health, outlines key planning and policy measures that will increase maternal and newborn survival and healthy communities. These are summarised in Fig. 3.5 and the foundations that are considered essential if the pathway is to be realised are set out in Fig. 3.6.

Further information can be found on this topic in at: https://reader.elsevier.com/reader/sd/pii/S0266613815002855?token=7FBA745762526886DAFC0440CF83EBD71D1529F641BD78D292A6F5FFFAEE4D9E7D86DC3986C88E103FC9B976B026424 [last accessed 30.09.2020]
**PLANNING and PREPARING**

...includes: delaying marriage, completing education, sex education, HIV prevention, health & nutrition, planning pregnancies

**SUPPORTING A SAFE BEGINNING**

...includes: accessing safe, respectful midwifery care with a chosen partner during labour, participating in decisions, having midwives well equipped to provide normal care and provide or access emergency obstetric care, avoiding unnecessary interventions and disturbance

**CREATING A FOUNDATION for THE FUTURE**

...includes: immediately starting and then continuing breastfeeding as long as desired, supported by midwifery team to receive information about child health, vaccinations and family planning

**ENSURING A HEALTHY START**

...includes: maintaining health, antenatal care, birth preparedness, emergency planning, demanding & receiving professional midwifery care

**2. PREGNANCY**

**3. LABOUR & BIRTH**

**4. POSTNATAL**

**Fig. 3.5** Midwifery 2030: the key components contributing to a ‘pathway to health’ during the four stages of a woman’s reproductive life. (Derived from State of the World’s Midwifery 2014:46–7)

**Fig. 3.6** Ten foundations are considered essential if the 2030 vision is to become a reality. (Derived from State of the World’s Midwifery 2014:46–7)
Annex 3.4: Quality Maternal and Newborn Care Framework

The framework demonstrates the aspects where midwifery care addresses 100% of the needs of women and newborn (shaded in green). The parts shaded pink, midwifery care complements the care provided by other care providers as indicated. Hence, midwifery care is required throughout the continuum of care from home (primary) to the tertiary level of care.

**Characteristics of care**

| Framework components | For all childbearing women and infants | For childbearing women and infants with complications |
|----------------------|--------------------------------------|----------------------------------------------------|
| Practice categories  | Education                             | First line management of complications              |
|                      | Information                           |                                                    |
|                      | Health promotion                      |                                                    |
|                      | Assessment                            |                                                    |
|                      | Screening                             |                                                    |
|                      | Care planning                         |                                                    |
|                      | Promotion of normal processes,       |                                                    |
|                      | prevention of complications           |                                                    |
| Organisation of care | Available, accessible, acceptable,   |                                                    |
|                      | good-quality services – adequate      |                                                    |
|                      | resources, competent workforce        |                                                    |
|                      | Continuity, services integrated       |                                                    |
|                      | across community and facilities       |                                                    |
| Values               | Respect, communication, community    |                                                    |
|                      | knowledge and understanding           |                                                    |
|                      | Care tailored towards women’s         |                                                    |
|                      | circumstances and needs               |                                                    |
| Philosophy           | Optimising biological, psychological,|                                                    |
|                      | social and cultural processes;       |                                                    |
|                      | strengthening women’s capabilities    |                                                    |
|                      | Expectant management, using           |                                                    |
|                      | interventions only when indicated     |                                                    |
| Care providers        | Practitioners who combine clinical    |                                                    |
|                      | knowledge and skills with             |                                                    |
|                      | interpersonal and cultural            |                                                    |
|                      | competence                           |                                                    |
|                      | Division of roles and responsibilities|                                                    |
|                      | based on need, competence and         |                                                    |
|                      | resources                             |                                                    |

The Lancet Series on Midwifery: Framework for Quality Maternal and Newborn Care (QMNC) (Renfrew et al. 2014). Source: The Lancet Series on Midwifery: https://www.researchgate.net/publication/305418621_Midwifery-led_antenatal_care_models_Mapping_a_systematic_review_to_an_evidence-based_quality_framework_to_identify_key_components_and_characteristics_of_care

With earlier Ebola and HIV (Haseeb 2018), several countries made efforts to address the shortage mainly through international policy implementations and regional programmes such as task shifting, skilled attendants at birth, bonding of new graduates and an attempt to comply with policies that minimise migration based on the Global Code of Practice on the International Recruitment of Health Personnel for the ethical recruitment of healthcare workers. The complexity and scope of the issue made it extremely difficult to resolve. The Code was as a policy framework for the ethical recruitment of health professionals (Aluttis et al. 2014; WHO 2017a, b, c, d) intended to address the health worker shortage on the international level. Compliance is voluntary. In regions where public health systems were weak, the rates of disease and mortality were extremely high as in sub-Saharan Africa. A large fraction of the population lacked access to basic healthcare services (WHO 2017a, b, c, d).
Key Messages
Midwives contribute to the development economic and social development of a country.
Midwives are crucial to the achievement of global health initiatives.
Where there are no midwives, women and their families are deprived of critical services and information.

Additional Resources for Reflection and Further Study

Videos
The value of midwives. https://www.youtube.com/watch?time_continue=20&v=2TF4FsQnBOs&feature=emb_logo
Health workers count. https://www.youtube.com/watch?v=QXpp4kmUCLU
What would the world be like without midwives. https://www.youtube.com/watch?time_continue=3&v=d5Mo-5qNmIs&feature=emb_logo
Respectful maternity care. https://www.youtube.com/watch?v=K105F9o3HtU
Causes of disrespect. https://www.youtube.com/watch?v=83FYFPbNFCo
Women’s reproductive rights. https://www.youtube.com/watch?v=R5gDnnPTK7Q
Person centred care. https://www.youtube.com/watch?v=pj-AvTOdk2Q

Map
The Midwifery Map. https://www.internationalmidwives.org/icm-publications/map.html.

Further Reading

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