Making the Case for Midwifery:

A TOOLKIT FOR USING EVIDENCE FROM *THE STATE OF THE WORLD'S MIDWIFERY 2014* REPORT TO CREATE POLICY CHANGE AT THE COUNTRY LEVEL

Available for download in English, French and Spanish at bit.ly/MidwifeAdvocacy

FAMILY CARE INTERNATIONAL

International Confederation of Midwives
Strengthening Midwifery Globally

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Table of Contents

Acknowledgements

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This toolkit is available for download in English, French, and Spanish at bit.ly/MidwifeAdvocacy
The complete *The State of the World's Midwifery 2014: A Universal Pathway. A Women's Right to Health* report is available for download in English, French, Spanish, and Arabic at www.sowmy.org

Foreword

Every second, across the 73 developing countries profiled in the *The State of the World's Midwifery 2014: A Universal Pathway. A Woman's Right to Health* report, another five women become pregnant. This totals 300 pregnancies each minute, which is well over 400,000 per day.

Each of these women needs, and must have access to, the essential maternal health services that can keep her safe and healthy throughout her pregnancy, labour, and beyond. All of the 135 million babies born per year need and deserve care to bring them safely through the critical first days and weeks of life. And every woman — young and old, poor and wealthy, in every region and country — has a right to reproductive health and family planning services and information that empower her to make her own decisions about whether and when to have a baby. They need, quite simply, the care that midwives provide.

Today, the world is failing far too many of those women and newborns. For tens of millions of them, essential reproductive health services, and the skilled midwives and other health workers trained to provide them, are just not *available*. Even when available, services are not *accessible* to many women, because they are too far away or are unaffordable. In order to be effective in saving lives, services must actually be used, and often the care provided is not *acceptable* to women — disrespectful of their culture, their rights, or their personal wishes and needs. Services, in far too many cases, are of poor *quality*, due to insufficient resources for midwifery education and supportive supervision, stock-outs of medicines and other commodities, and gaps in the regulatory and policy environment.

The result, tragic and terribly unjust, is a world in which nearly 300,000 women and 3 million newborns die each year, and where 2.6 million stillbirths occur, nearly all of them from preventable causes.

The State of the World's Midwifery 2014 (SoWMy 2014) report contains a rich and valuable presentation and analysis of current data and trends on the state of midwifery in 73 countries, and recommendations for strengthening midwifery programmes and policies at all levels. This toolkit has been developed as a companion piece to support national efforts to use the *SoWMy 2014* report, through national launches and other follow-up actions at the country level. This is not a stand-alone tool, but one meant to support the use of the *SoWMy 2014* report.

The midwives and other providers of midwifery services for whom this toolkit was developed are at the heart of the solution. You and your colleagues are committed to providing women and babies with the care they need. Midwives educated to international standards can save lives every day.

Well-educated, regulated, and supported providers are also a key to progress, because midwives and others — through professional associations — can be a profound and powerful voice for change in countries. Midwifery service providers understand the health care needs of women and newborns, because they work to meet those needs every day. They see the gaps in their health care systems — in resources, staffing, facilities, and policies — because they struggle to fill those gaps, day in and day out. They speak the truth about midwives' need for training, for support, and for enabling policies — because this is the job to which they have dedicated their lives and livelihoods.

Although this toolkit is geared towards midwives and midwives associations, its broader message can be adapted and utilised by other technical and professional organisations, community- and country-level stakeholders, and opinion leaders. Improving midwifery services and meeting the needs of women and newborns is the responsibility of all; the more partners and supporters that take up this toolkit and call to action, the more successful the advocacy movement will be.

When service providers speak in a united voice, filled with knowledge and passion, policymakers listen. Now is the time to speak up. Change will come, lives will be saved, and countries will move forward to a brighter, healthier future.

FAMILY CARE INTERNATIONAL AND INTERNATIONAL CONFEDERATION OF MIDWIVES

Abbreviations

AAAQ	Availability, Accessibility, Acceptability, and Quality
APP Online Tool	*The Advocacy Progress Planner: An online tool for advocacy planning and evaluation*
CHW	Community Health Workers
FCI	Family Care International
FTE	Full-Time Equivalent
HIV	Human Immunodeficiency Virus
HRH	Human Resources for Health
ICM	International Confederation of Midwives
ICN	International Council of Nurses
MDG	Millennium Development Goal
MMR	Maternal Mortality Ratio
MNH	Maternal and Newborn Health
MOH	Ministry of Health
MP	Member of Parliament
NCH	National Council on Health
NGO	Non-Governmental Organisation
NMR	Newborn Mortality Rate
PMNCH	Partnership for Maternal, Newborn & Child Health
RMNCH	Reproductive, Maternal, Newborn, and Child Health
SBA	Skilled Birth Attendant
SoWMy 2011	*The State of the World's Midwifery 2011: Delivering Health, Saving Lives*
SoWMy 2014	*The State of the World's Midwifery 2014: A Universal Pathway. A Women's Right to Health*
SRMNH	Sexual, Reproductive, Maternal and Newborn Health
TBA	Traditional Birth Attendant
UN	United Nations
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WRA	White Ribbon Alliance

Introduction

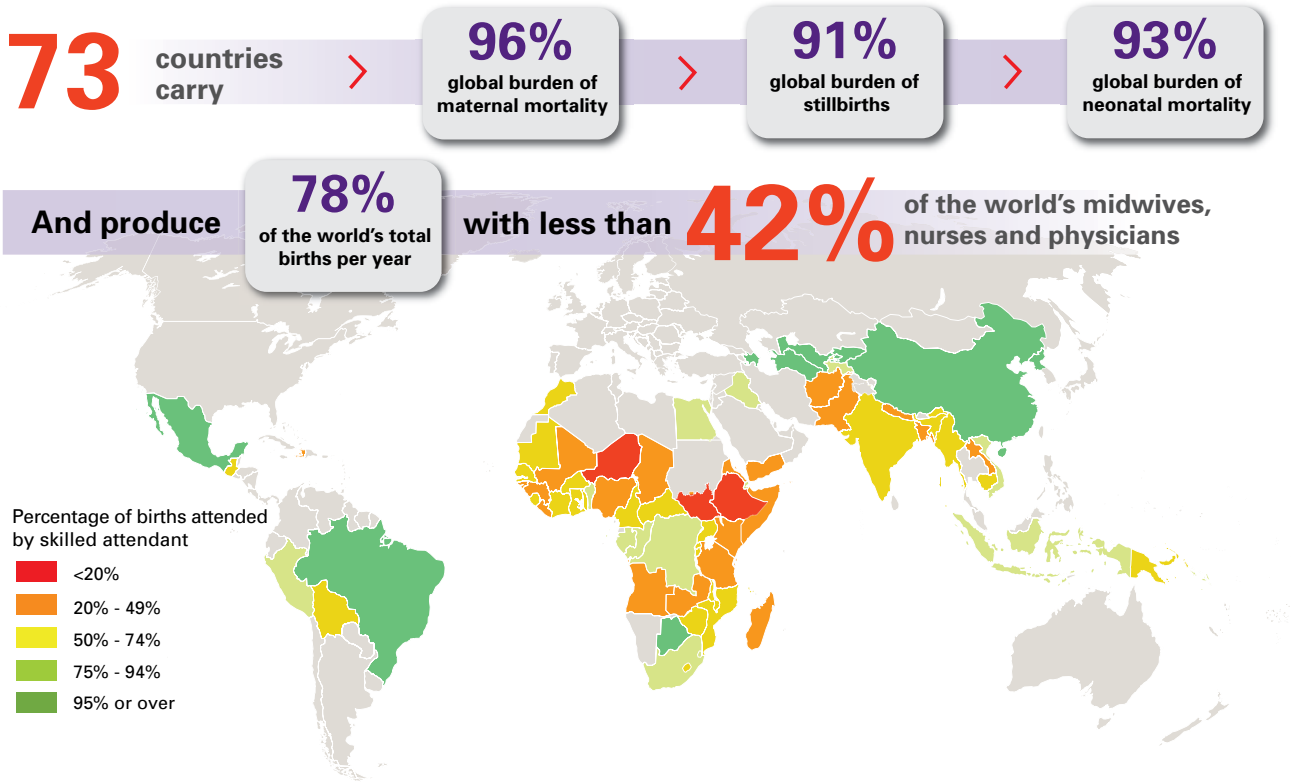
The world needs midwives today more than ever. Midwives save lives, and in doing so, they preserve and protect families. Midwives play a crucial role in the safe delivery of babies, but also do much more in supporting and caring for women and newborns during pre-pregnancy, pregnancy, labour, and the post-partum/postnatal periods. Midwives promote woman-centred care and the well-being of women and newborns across the continuum of sexual, reproductive, maternal, and newborn health (SRMNH).[1] They 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.[2]

Local, national, and global efforts to provide the best possible care during pregnancy and childbirth are having an impact. Although Millennium Development Goal 5 (improve maternal health) and Millennium Development Goal 4 (reduce child mortality) will not be reached in many countries, change is happening and maternal and child mortality have declined.[3]

Despite this progress, women and newborns are still dying because they do not have access to functioning health facilities, to qualified health professionals, or to quality care. Although the effort to provide universal access to sexual and reproductive health is part of a shared global agenda, inequalities persist across and within countries with regard to the realisation of these rights, the ability to obtain quality care, and equality of access.[4]

If their services were available and accessible to all women and babies who need them, midwives could help avert two-thirds of all maternal deaths and half of all newborn deaths, provided they are well-educated, well-equipped, well-supported, and authorised.[5] *The State of the World's Midwifery 2014: A Universal Pathway. A Women's Right to Health (SoWMy 2014)* report provides data on the extent to which the midwifery workforce is able to deliver available, accessible, acceptable, and high-quality midwifery services across 73 countries with high burdens of maternal and newborn mortality. It also reveals critical service gaps and highlights the need to strengthen health systems and the health workforce in order to ensure that all women and families have access to high-quality midwifery care.[6]

FIGURE 1 **Key indicators for maternal and newborn health and the health workforce in 73 of 75 Countdown countries**



WHAT IS ADVOCACY?

ADVOCACY — the process of building support for an issue or cause and influencing others to take action — can achieve policy change. Advocacy can also help to:

- ensure that key decision makers are informed about existing policies and their responsibility for implementing those policies.
- ensure that sufficient financial resources are allocated for programmes and services.
- create support among community members and to generate demand for implementing government policies.
- at the grassroots level, inform the general public and opinion leaders about an issue or problem and mobilise them to apply pressure on decision makers to take action.

The policies that you work to develop or change through advocacy may include written plans, strategies, laws, regulations, codes of practice, or guidelines. You may advocate for the creation of new policies that support midwifery, or to ensure that existing policies that contribute to improving SRMNH outcomes and reducing mortality are implemented. Advocacy may also be needed to change existing policies that are not supportive of midwifery services. National policies, especially in countries with decentralised health systems, can be further endorsed and adopted at provincial, district, and other subnational levels, where specific policies can be developed in response to local needs.[10] Part III of this toolkit provides additional details on developing an advocacy strategy and on identifying partners and resources to support your advocacy efforts.

KEY *SoWMy 2014* MESSAGE: The *SoWMy 2014* report illustrates the disproportionately heavy burden of poor maternal and newborn health that these 73 countries carry. They account for:

- **78% of the world's total births – 107 million babies per year (as of 2009)**
- **96% of all maternal deaths**
- **91% of all stillbirths**
- **93% of all newborn deaths[7]**

These 73 countries, at the same time, have only 42% of the world's midwifery, nursing, and medical personnel.[8] Within these countries, workforce deficits are most acute in areas where maternal mortality and morbidity rates are highest.

Midwifery is the common enabling factor to accelerate universal health coverage and achieve the new post-2015 targets in SRMNH.[9] Every woman and her newborn have the right to quality care during pre-pregnancy, pregnancy, labour, and following childbirth.

Now is the time for assertive, effective, evidence-based advocacy: calling upon and mobilising decision makers to create the necessary policies and invest in the health system, midwives, and SRMNH services. No one is better suited to conduct this advocacy than midwives, as individuals and through their professional midwives' associations. Midwives know what is needed to improve their working environments and to enable them to provide the best standard of care. By providing a wealth of newly-collected data on the midwifery workforce and midwifery services, the *SoWMy 2014* report improves the evidence base and creates a point of departure for policy dialogue and health systems strengthening. It can be used as a rallying point to mobilise leadership and action to strengthen SRMNH services, and to facilitate the provision of quality midwifery services for all.

A TOOLKIT TO HELP MIDWIVES CREATE POLICY CHANGE

Availability, accessibility, acceptability, and **quality (AAAQ)** are four components of effective coverage that influence whether women and their newborns can obtain the health services they need that also meet their requirements. The **goal** of this toolkit is to enhance your knowledge, skills, and capacity to conduct advocacy for policy change to improve these four key components of effective coverage of midwifery services utilising evidence and key messages from the *SoWMy 2014* report.

Although this toolkit is geared towards midwives and midwives associations, its broader message can be adapted and utilised by other development partners, including UN agencies, professional organisations, civil society organisations, academia, other community- and country-level stakeholders and opinion leaders. Improving midwifery services and meeting the needs of women and newborns is the responsibility of all. The advocacy movement to strengthen midwifery will be more successful if all partners play a role.

The *SoWMy 2014* report highlights that since 2011, midwives' associations, which are defined as professional associations that midwives can join, have made great strides in improving midwifery, including through policy change:

- 92% of associations are performing continuous professional development

- 88% of associations advise their members on quality standards for SRMNH care
- 77% of associations have advised the government on the most recent national SRMNH or health policy document
- 53% of associations have negotiated work or salary issues with their government[11]

Building on this momentum and the positive results, midwives associations are encouraged to continue advocating for the improvement of midwifery services through policy change.

Thanks in part to the efforts of midwives associations, the *SoWMy 2014* report notes that, since 2011, some governments have taken constructive action through adopting new policies and investing in midwifery:

- 6 countries (8%) have promoted midwifery at higher education levels to increase career prospects
- 18 countries (25%) increased training and deployment of health workers (including midwives) to reduce shortages, including 12 (16%) that opened new midwifery schools and programmes
- 33 countries (45%) reported vigorous attempts to improve retention in remote areas, including the introduction of a bonding system and/or incentives
- 52 countries (71%) reported building data information systems[12]

Despite this progress, the majority of high-burden countries have yet to institute supportive policies for midwifery and therefore provide significant opportunities for advocacy, policy change, and improvement. Policymakers need midwives associations and other colleague agencies to inform them of gaps in and needs of the workforce and health system. Together with other country-level stakeholders, midwives' associations can hold policymakers accountable for allocating the necessary resources and implementing policies to improve the availability, accessibility, acceptability, and quality of midwifery services.

By sharing technical resources, stories from midwives, and examples of advocacy efforts, this toolkit aims to help midwives and other partners better understand the evidence in the *SoWMy 2014* report in order to develop an advocacy strategy that leads to positive policy change.

HOW THIS TOOLKIT IS ORGANISED

The toolkit will help you to identify barriers to (AAAQ) of midwifery services in your country and make suggestions about how you may advocate for change. You will be able to do that

Karl Grobl

once you have become familiar with and knowledgeable about the evidence presented in your country's *SoWMy 2014* two-page country brief. The toolkit also includes **KEY *SoWMy 2014* MESSAGES** that you can use in your advocacy efforts.

The toolkit is divided into three parts, which will guide you through an assessment of the current state of midwifery in your country, its future, and your opportunities to strengthen midwifery and health outcomes through advocacy for policy change:

PART I: The State of the Midwifery Workforce

Part I begins with an overview of the *SoWMY 2014* report, including how the data in the report was collected and key concepts used in the report. Part I then provides an overview of the country brief, followed by a close look at the first page of your brief, focusing on each of the four components of effective coverage (AAAQ). A series of questions will assist you in analysing, interpreting, and discussing your country's data, identifying barriers to improving AAAQ, and identifying policy changes that can help remove those barriers.

PART II: The Future of the Midwifery Workforce

Part II guides you through the second page of your country brief, which focuses on evidence-based future projections of your country's workforce compared to population need from 2012 through 2030.

PART III: Making the Case for Midwifery: How to Develop an Advocacy Strategy for Using the Evidence from the *SoWMy 2014* Report to Create Policy Change at the Country Level

PART III of the toolkit provides practical suggestions on how to develop an advocacy strategy and conduct advocacy to address the barriers and priorities you identified in PART I and PART II. PART III includes suggestions on how your midwives' association can identify advocacy

partners and resources to support your outreach to policymakers and other decision makers and suggests how you can leverage global initiatives and involve other stakeholders in advocating for midwifery.

Advocating for policy change is a complex endeavour. You will need to balance targeting the government as both a critic and a partner. Your midwives' association may have specific protocols or guidelines for organising new initiatives or advocacy efforts, especially when it comes to relationships with government officials. Before you get started, be sure that you are in compliance with both your association's rules and regulations and any legal limitations on the political and advocacy activities of midwives associations, and aware of current national advocacy to promote midwifery programmes and policies that you can build on. ICM and other partners are available to help your midwives association identify resources to support your advocacy work and to help build your advocacy skills.

Family Care International

PART I: THE STATE OF THE MIDWIFERY WORKFORCE

THE STATE OF THE WORLD'S MIDWIFERY 2014: A UNIVERSAL PATHWAY. A WOMAN'S RIGHT TO HEALTH (SOWMY 2014) REPORT

The State of the World's Midwifery 2014: A Universal Pathway. A Woman's Right to Health (SoWMy 2014) report provides data on the extent to which the midwifery workforce is able to deliver available, accessible, acceptable, and high-quality midwifery services across 73 countries with high burdens of maternal and newborn mortality.

How was the information for the report collected?
The *SoWMy 2014* report is based on 1) evidence collected between October 2013 and February 2014 using a questionnaire to collect quantitative data on key indicators relating to the maternal and newborn health (MNH) workforce and MNH services; and on 2) full-day workshops of national stakeholders and experts to initiate policy dialogue that took place in 37 countries. Of the 75 countries invited to participate, 73 completed the questionnaire and 37 held a country workshop. Once the country data had been reviewed and converted into tables, this information was again returned to the country teams for verification, revision, and input. Participants in the process included, depending on the country: government representatives of MNH and Human Resources for Health (HRH) departments, designated representatives from national midwifery and other professional associations, civil society organisations, MNH champions and advocates, academics, donors, UNFPA and WHO focal points, among others, often with the support of a national consultant. You can find a full list of participants, apart from those who requested anonymity, on p. 198 of the report. Make sure you refer back to this list in order to know who to contact if you have questions about the information reported for your country, or to find potential partners for your advocacy efforts.

The State of the World's Midwifery 2011: Delivering Health, Saving Lives (SoWMy 2011) was the first comprehensive analysis of midwives and midwifery services, covering 58 countries. The report confirmed that an additional 350,000 skilled midwives were needed to fully meet the needs of women around the world. It put forward a strategy of education, regulation, and association aiming to ensure proficiency, create a climate of empowerment, and build up the workforce. It also outlined a series of bold steps tailored for action by governments, regulatory bodies, midwifery schools, and international agencies. Many of these actions have taken place since 2011 and some countries are making progress in moving midwifery forward.[13] Reviewing the progress, or lack of progress, made by your country between 2011 and 2014 can help inform your advocacy efforts.

IMPORTANT CONCEPTS IN THE *SOWMY 2014* REPORT

Throughout the *SoWMy 2014* report and this toolkit, the same key concepts are used. It is important for you to familiarise yourself with them so you can use the evidence appropriately. For further definitions, see the Glossary in Annex 1 on page 205 of the *SoWMy 2014* report.

Midwifery
Midwifery is a key element of SRMNH care and is defined in the *SoWMy 2014* report as: the health services and health workforce needed to support and care for women and newborns, including sexual and reproductive health and especially pregnancy, labour, and postnatal care. Note that other health professionals apart from midwives provide some of the services included in the midwifery service package. When the report refers to the "midwifery workforce" this means all health workers who provide at least part of the spectrum of midwifery services, not just midwives.

Midwife
A midwife is a health professional who is educated to competently undertake the roles and responsibilities of a midwife regardless of their educational pathway. For example, some midwives first undergo nurse training. See the ICM definition for more information. Midwives, if appropriately educated, regulated, and supported, could deliver 87% of the need for midwifery services in the 73 countries.[14]

Effective coverage
Effective coverage is the coverage of health services required in order to fulfil a person's right to health. This implies that services are available, accessible, acceptable, and of high quality. The report explores the extent to which the midwifery workforce is able to provide effective coverage of quality SRMNH services to all women and newborns.

Woman-centered care
The perspectives, needs, and concerns of women should be at the centre of the considerations when discussing and agreeing to the package of SRMNH care.

People-centered health care
People-centred health care sees patients as equal partners in planning, developing, and assessing care to make sure it is most appropriate for their needs. It involves putting patients and their families at the heart of all decisions.

STRUCTURE OF THE *SOWMY 2014* REPORT

Chapter 1 introduces the report.

Chapter 2 updates the evidence base and provides a detailed analysis of efforts to improve the quality of midwifery in the 73 countries included in the report. There is significant evidence of progress, but much more must be done. Challenges and potential solutions are proposed for each component of effective coverage: AAAQ.

Chapter 3 explores the future challenges and opportunities facing midwifery and proposes a people-centered, woman-focused vision that can accelerate progress on universal access by 2030 called *Midwifery2030*.

Two-page "country briefs" are included for each country, providing an innovative mix of 2012 data and needs-based projections through to 2030. These briefs aim to inform policy dialogue and decisions within countries on what actions need to be taken in the near future to ensure progress towards meeting the needs of women and their families. These briefs are based on reported data, and where information was missing, the briefs use uniform assumptions (detailed in Annex 5 of the *SoWMy 2014* report). These briefs should therefore be used, not as a fact sheet, but as a tool to review the quality of data and the policy options within countries. The absence of data is in itself a finding and is an opportunity for action.

UNDERSTANDING THE *SOWMY 2014* COUNTRY BRIEF

The two-page *SoWMy 2014* country brief tells the story of the state of the midwifery workforce in each country. It can guide and inform your discussions about ways that the midwifery workforce can better deliver SRMNH services for all women and newborns. The evidence provided in these briefs is complex and requires careful interpretation in order to understand its implications. You are encouraged to refer back to Chapter 4 of the *SoWMy 2014* report to read the section, *HOW TO USE THE SOWMY 2014 COUNTRY BRIEFS* on page 50. The *SoWMy* annexes also provide valuable information to understand the analysis in these briefs. Annex 3 explains the methodology behind the "met need" number on the first page and the projections on the second page. Annex 4 explains on what basis the "workforce time needed" was estimated for each country, which is an important component of the "met need" number on the first page. Annex 5 explains the standard set of assumptions that was used in the modelling of the projections on the second page.

Universal access to sexual and reproductive

THE MIDWIFERY2030 VISION

Midwifery2030 presents a policy and planning vision to guide the provision of services to women and newborns across the two continuums of SRMNH care: from pre-pregnancy to postnatal care, and from communities to referral hospitals. *Midwifery2030* focuses on increasing the availability, accessibility, acceptability, and quality (AAAQ) of health services and health providers, reaching a greater proportion of the population (increasing coverage), and extending the basic and essential health package (increasing services), while protecting against financial hardship (increasing financial protection). (see Appendix B for the *Midwifery2030 graphic*)

The Midwifery2030 vision states:

1. All women of reproductive age, including adolescents, have universal access to midwifery when needed.
2. Governments provide and are held accountable for a supportive policy environment.
3. Governments and health systems provide and are held accountable for a fully enabled environment.
4. Data collection and analysis are fully embedded in service delivery and development.
5. Midwifery care is prioritised in national health budgets; all women are given universal financial protection.
6. Midwifery care is delivered in collaborative practice with health care professionals, associates, and lay health workers.
7. First-level midwifery care is close to the woman and her family with seamless transfer to next-level care.
8. The midwifery workforce, in communities, facilities, and hospitals, is supported through quality education, regulation, and effective human and other resource management.
9. All health care professionals provide and are accountable for delivering respectful, quality care.
10. Professional associations provide leadership to their members to facilitate quality care through collaboration.

health care and a reduction in maternal and newborn mortality are part of Millennium Development Goals (MDGs) 4 and 5. The *SoWMy 2014* report explores the extent to which a country's midwifery workforce has the time and capacity to deliver universal access to the 46 interventions that are essential for SRMNH. The full list of these 46 interventions can be found on pages 212-215 of the *SoWMy 2014* report and in Appendix D of this toolkit. Effective coverage is defined as the proportion of the population who need an intervention, who then receive that intervention and benefit from it.[15] It can be measured by the AAAQ of health services and of the personnel providing those services.

What is the need?

Each country brief begins with a paragraph explaining some key population characteristics to help you understand the need for the SRMNH workforce and their services:

Table 1.0

WHERE ARE WE NOW? 2012 DATA

- the country's estimated total population
- the number and percentage of the population living in rural areas
- the number and percentage of women of reproductive age
- the total fertility rate

WHERE WILL WE BE? 2030 PROJECTIONS

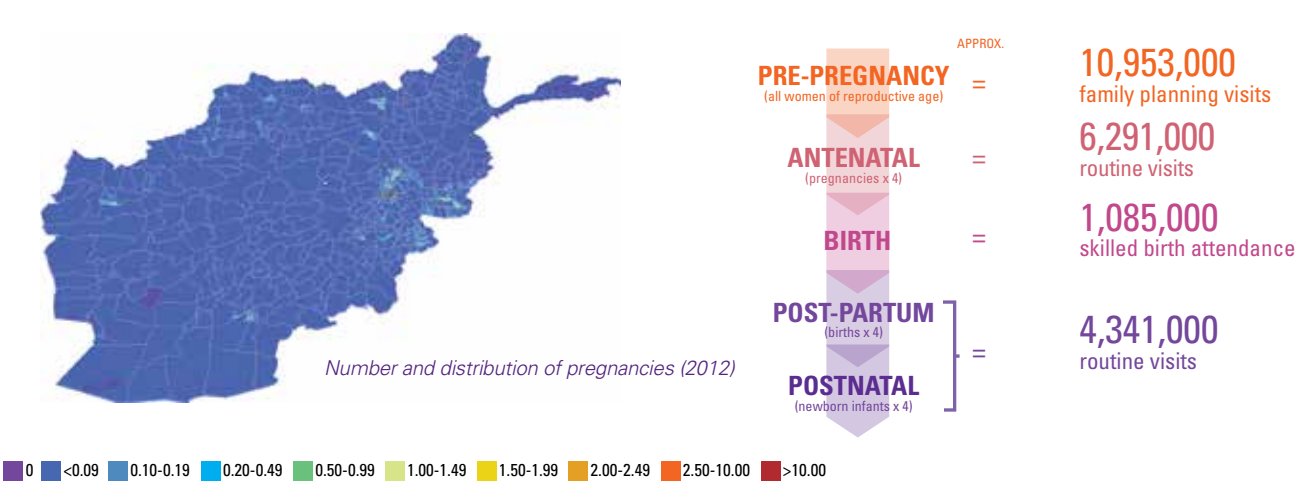
- the country's estimated total population
- the number of pregnancies requiring midwives' services each year by 2030, and the percentage of pregnancies occurring in rural areas
- the number of antenatal visits, births, and postpartum/postnatal visits the SRMNH workforce will need to cover between 2012 and 2030

Following the key population characteristics, there is a graphic showing the level of need that must be met if universal coverage is to be attained. It includes a map of your country with the number and geographic distribution of pregnancies as of 2012, and lists the actual number of SRMNH visits women in your country need from pre-pregnancy to the postnatal period. These visits are referred to in the graphic as "episodes of care."

The graphic below is an example from Sierra Leone's country brief.

The rest of the first page of the country brief provides details and graphics on some dimensions of the other components of effective coverage (AAAQ): availability, accessibility (financial and geographic), and quality. Acceptability, though extremely important, cannot be represented through quantitative indicators in a graphic, however, it is addressed in the *SoWMy 2014* report text. Remember, the first page of the country brief utilises country-reported data from 2012 and indicates the extent to which the workforce is *currently* able to deliver SRMNH services for all women and infants who need them.

As your midwives' association and the organisations interested in using this report analyse and interpret your country's brief, consider the validity of the data overall. Although the data used in your country brief was based on data provided by your country team, you may notice gaps or inconsistencies based on your experience. This provides an opportunity to explore further and potentially advocate for improving the collection of relevant midwifery and health data. Accurate data on the midwifery workforce enables countries to plan effectively and all countries should collect a minimum of 10 key pieces of information: headcount; percentage time spent on SRMNH; roles; age distribution; retirement age; length of education; enrolments into, attrition,



and graduation from education; and voluntary attrition from the workforce.

KEY *SoWMy 2014* MESSAGE: Often, detailed disaggregated data to be able to determine the availability, accessibility, acceptability and quality (AAAQ) of the midwifery workforce are not available.

AVAILABILITY

The first component of midwifery coverage is *availability*:

> **The availability of the health workforce is the sufficient supply of health workers, with the relevant competencies and skill mix, which correspond with the health needs of the population.**

Workforce Availability

The graphic on workforce availability, found on the first page of your country brief, shows the number of all workers reported and the percentage time each one spends on MNH services. These two pieces of information, when taken together, give us a much better picture of the availability of the midwifery workforce than the number of workers alone. Note that the number of health workers in a country is not enough to really understand workforce availability: Availability of the health workforce is best measured by *full-time equivalents* (FTE), a measure that assesses both the number of workers that are involved in the midwifery workforce and how much of their time is actually spent on providing maternal and newborn health services. Rather than counting the number of health workers who provide midwifery services on a part-time basis, it is preferable to measure the time that each worker spends providing midwifery care. For example, two doctors who spend 50% of their time each on MNH services are only equivalent to one doctor working full-time. The technical way of saying the same thing is that there are two doctors by "headcount" but only one doctor by "full-time equivalent".

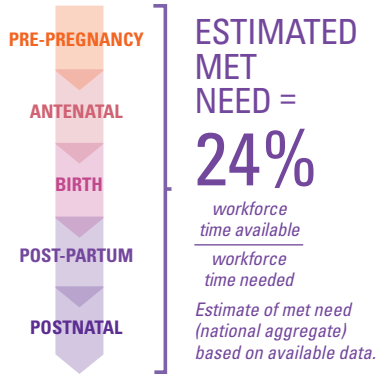
In this graphic, the workers are grouped by global categories and were allocated to the category which the country team thought was the closest match for the country cadre. For example, in Sierra Leone's graphic shown below, the country cadres "maternal and child health aides" are grouped under the "Auxiliary midwives" global category. The country cadre names are provided in footnote 1 at the bottom of the second page of your country brief. Make sure you take a close look at that footnote to understand what the global categories mean in your country context.

Under some categories, "na" will be displayed. This means that category is not applicable in that country. "-" means that the information is missing. This is concerning since knowing the number of workers and the time they spend on MNH is essential to planning the workforce to meet women and babies' needs.

This graphic also provides an estimate of how workforce availability compares with need. An estimated percentage ("estimated met need") summarises the extent to which the available midwifery workforce, taking into account which health workers provide which services, has enough time to deliver the 46 essential SRMNH interventions to all women and newborns who need them (the 46 essential interventions will be explored further in the section on Financial Accessibility and are listed on pages 212-215 of the *SoWMy 2014* report and in Appendix D of this toolkit). Estimated met need takes into account the workforce time available and the workforce time needed. "Workforce time available" starts from the FTE number of workers and considers how many hours they devote to clinical tasks a year, given: hours worked per day, holidays and sick days, and the percentage of time they spend on clinical tasks. "Workforce time needed"

WORKFORCE AVAILABILITY (2012)

Country classification of staff working in MNH[1]		Time spent on MNH %
Midwives	286	90
Midwives, auxiliary	2376	90
Nurse-midwives	*na*	*na*
Nurses	*na*	*na*
Nurses or nurse-midwives, auxiliary	1,018	–
Clinical officers & medical assistants	65	50
Physicians, generalists	45	–
Obstetricians & gynaecologists	7	51



Family Care International

starts from the 46 essential interventions and uses OneHealth estimates to count how much time, in minutes, it takes to deliver each essential intervention. The time needed is then aggregated at the country level based on the number of women of reproductive age, pregnancies, and births, as well as epidemiological information, which tells us what share of women or newborns need each intervention. "Workforce time available" is then matched to "Workforce time needed" depending on the roles and responsibilities of each cadre. For example, the time of an auxiliary midwife cannot be allocated to fill the time needed for Active Management of the Third Stage Labour, but the time of a midwife can be.

KEY *SoWMy 2014* MESSAGE: Only 4 of the 73 countries in the *SoWMy 2014* report have a midwifery workforce that is able to meet universal need for the 46 essential interventions for SRMNH.

HOW TO UNDERSTAND THE MET NEED IN YOUR COUNTRY

1. Check the source numbers
   a. **Check the headcount.** The estimated met need numbers are based on reported country data. Make sure that the number of workers reflects the reality of workers practising on the ground in SRMNH, using Footnote 1, on the bottom of the second page of the country brief, to match the number in the report to your HRH data.
   b. **Check the % time on MNH.** Sometimes different cadres are grouped under a category despite spending different proportions of their time on MNH. For example, if midwives are grouped with nurses in the reported data, and the percentage of time on MNH is 100%, this may overstate the contribution of nurses if they spend less than 100% of their time in MNH.

2. Understand the true meaning of "estimated met need"
   a. **The estimated met need relates to the time needed for the essential interventions only.** This is the only global package for SRMNH for which there is currently a consensus, but what women need and want involves a package of care that is broader than this and which may take more time to deliver. In addition, some countries may deliver less or other interventions than the essential interventions.
   b. **Estimated met need relates to availability only.** While your brief may show 100% met need at the level of the country, there may not be the same level of met need at at all sub-national levels. Lack of geographic or financial accessibility also could mean that not all women truly have access to care. Similarly, issues of acceptability and quality are not included in this estimate.

DISCUSSION GUIDE: AVAILABILITY

Look at the percentage of ESTIMATED MET NEED: this presents an estimate of the extent to which your country's currently available health workforce meets the SRMNH needs of the population.

Are there enough workers providing midwifery services to meet the needs of women and newborns?

If your country's workforce is still far from meeting the population's needs (less than 90%), this may indicate that there are not enough health care professionals providing MNH care (including midwives), *and/or* that these health care professionals are not spending enough of their time carrying out midwifery tasks and services, *and/or* that existing health care professionals do not carry out the roles and responsibilities that are most needed.

If the number of midwives is inadequate, consider these questions:

Is there inadequate planning and investment in education and deployment of MNH workers?
According to the *SoWMy 2014* report, the annual number of pregnancies has increased by 50% in African countries since 1990, which means the midwifery workforce in these countries needs to increase significantly *just to maintain current levels of population coverage*. In order to increase coverage of services and accelerate reductions in mortality and morbidity, the midwifery workforce in Africa needs to increase even more rapidly than the number of pregnancies; new thinking on skill mix and improvements in efficiency are also needed.[16]

Is midwifery considered an attractive profession in your country?
In many countries, a career as a midwife is typically perceived to be more attractive than other professions open to people with a similar level of education, but this is not the case in all countries – in 23% of countries, it is viewed as a less attractive profession.[17] Many midwives work in difficult, unsafe, isolated, and poorly-equipped settings. Midwives often experience gender-based violence, receive poor salaries (among the lowest for health care professionals), work in poor conditions, and have no access to continuing professional development. All of these elements impede high-quality care. Many midwives choose to leave the workforce due to frustration with their position and role or because they reach an arbitrary retirement age.

Are there other reasons why your country may not have enough health care professionals delivering midwifery services?

If midwives and other MNH workers spend too little time performing midwifery tasks and services, consider these questions:

Are health care professionals insufficiently focused on providing midwifery care?
According to the *SoWMy 2014* report, many SRMNH workers, particularly generalist practitioners and nurses, spend much of their work time on non-midwifery tasks. A more in-depth assessment may be required to examine whether it would be more efficient to promote cadres which focus exclusively on midwifery care.

CASE STUDY A

Improving the Perception of the Midwifery Profession in Tanzania

Although there are supportive policies in place for midwives in Tanzania, the country needs more midwives. The realities of midwives' working conditions and negative public perceptions inadvertently discourage young women and men from pursuing a career in midwifery. In response, the Tanzania Midwives Association worked with the White Ribbon Alliance (WRA) in Tanzania to engage youth to promote the profession.

Together with a broad coalition including civil society, the Tanzania Midwives Association, and WRA Tanzania developed a strategy to promote a career in midwifery among secondary school students in three regions. This effort involved engaging their parents, policymakers, and the community at large in public hearings to increase understanding of midwifery and the need to promote midwifery as a career. Advocacy meetings and presentations reached 16,625 students at 22 secondary schools. Students' awareness and understanding of midwifery, as well as their perception of midwifery as an attractive career path, increased dramatically. The percentage of students indicating an interest in midwifery increased from 7% at the start of the campaign to 83% at its end.

White Ribbon Clubs were also established in schools to provide students with a place to discuss midwifery and receive additional information on the profession. The Tanzania Midwives Association, with WRA Tanzania, continues to visit these clubs to follow up on activities, provide additional materials, and share experiences and address challenges together. Club members are advocating to district authorities to invest in laboratories and science teachers so that students can study science and prepare to pursue a career in midwifery.[18]

CASE STUDY B

Expanding Access to Quality Family Planning Services in Nigeria

Meeting the unmet needs of women for family planning by expanding access to quality services is critically needed in Nigeria. Yet, despite the Nigerian Government's commitments to improve these services, progress is hampered by myriad reasons, including the critical shortage of health workers, insufficient coordination of the health system across government levels, and health care provider policies.

The White Ribbon Alliance Nigeria advocated for the expansion of necessary and quality family planning services to improve maternal health by changing policy. The new policy would allow and enable community health extension workers to provide injectable contraception, one of the more sought-after contraceptive methods among Nigerian women. Currently only higher level health workers have the right to provide the service.

In developing their advocacy strategy, WRA Nigeria examined the national reproductive health and family planning guidelines and service protocols as well as advocacy efforts underway by FHI 360. In conjunction with the Federal Ministry of Health and the Association for Reproductive and Family Health, FHI 360 conducted a pilot project in Nigeria's Gombe State, where it was demonstrated that trained community health extension workers could safely provide injectable contraceptives in communities without complications and that women showed a preference for community-based family planning services as compared to facility-based services. As a result of this pilot project, the Federal Ministry of Health established a technical working group to develop a roadmap for expanding community-based access to family planning. This included a national-level policy change to allow lower level health workers to administer injectable contraceptives.

As this task-sharing policy started gaining traction within the Federal Ministry of Health but faced opposition from higher-level health workers, WRA Nigeria united partners to support these efforts using a two-pronged approach to influence policymakers ahead of the 55th National Council on Health (NCH) Meeting:

Richard Lord

1. The convening of advocacy meetings with the State Commissioners of Health to encourage approval of community-based access to injectable contraceptives in the lead-up to the NCH Meeting. WRA Nigeria held meetings with the Director of Family Health and select State Commissioners of Health to build support for the policy change within the National Assembly. WRA Nigeria was invited to attend and present at the meeting and also was successful at securing a space in the meeting for other influential individuals and maternal health champions to present evidence on the benefits of the policy change.
2. The utilisation of social media to draw national and international attention to the requested policy change in order to build additional support and put additional pressure on the NCH. WRA Nigeria worked with its network and key partners to call on the NCH to approve the policy change. Key members and partners wrote blogs to be shared with the international community and promoted by influential global partners.

WRA Nigeria found that their individual meetings with State Commissioners of Health proved to be adequate advocacy efforts as they were able to champion the issue within the NCH and secure approval for the policy change at the NCH meeting. The advocacy effort resulted in the NCH adopting a new national policy permitting community health extension workers to distribute injectable contraceptives. A next step in this effort is to work at the state level with State Commissioners of Health to develop implementation plans and budgets in order for the new policy to be realised.[19]

Advocating for Availability

Now that you have discussed the *availability* component of midwifery coverage, what can your midwives' association and other partners do to create positive policy change? This depends on your country's political environment, which you will read more about in PART III of this toolkit.

If levels of effective coverage in your country are low, your midwives' association and other partners may want to advocate for changing policies and standards impacting availability.

KEY *SoWMy 2014* MESSAGE: The *SoWMy 2014* report found that midwives can meet almost 90% of the needed essential care for women and newborns if educated and trained to international standards (set by ICM and the International Council of Nurses [ICN]).[20]

If current workforce planning norms in your country are not sensitive to what women and newborns need, there will not be enough health workers available to provide these essential services.

KEY *SoWMy 2014* MESSAGE: Accurate data on health workforce enables countries to plan effectively, ensuring that they have the right people, in the right places, with the right skills, at the right time.

Here are a few advocacy opportunities to increase *availability* of midwifery services in your country:

Improve career pathways: Work with the Ministry of Education, Ministry of Health, or Ministry of Finance to improve the career pathways for midwives and incentivise midwifery education (providing government subsidies for health worker training) while ensuring that available training places are sufficient in both number and quality.

Starting with secondary school, a sufficient number of students must graduate with the skills and motivation needed to enroll in midwifery education programmes. These students need to be exposed to midwifery as an attractive profession to pursue, which can be as simple as ensuring that the profession of midwife is listed in the documents provided by the school. Once individuals have chosen to enroll in midwifery education programmes, these future midwives need to be given an excellent quality of education (including both pre-service and in-service training) within a supportive environment. Education must be incentivised and government subsidies are needed for health worker training. Policymakers may be persuaded to improve career pathways for midwives when they consider that educating midwives results in good value for money.

Improve recruitment policies: Advocate for improved recruitment policies with the appropriate Ministry or professional body in your country. Or consider advocating for the decentralisation of responsibility for recruitment to subnational authorities, such as district management teams. Pathways from education programmes to the workforce must also be improved. Educating health workers for whom there are no jobs or whose postings are severely delayed is a poor use of resources. According to the *SoWMy 2014* report, in more than half of countries there are graduates taking longer than a year to join the workforce, by which time their clinical skills may have deteriorated through lack of application.[21] There needs to be improved funding and enforcement of recruitment policies, and midwives need to be recruited before graduation.

Improve retention policies: Once employed, retention requires that health professionals are happy and satisfied with their jobs. Working with the appropriate Ministry or professional body, advocate for an improved career development pathway with better salaries and incentives, an improved working environment, access to continuing education and training, and improved management and supervision.

Reduce time spent on non-clinical tasks: Work with local authorities and health facility managers to advocate for reductions in the time midwives and other health professionals spend on non-clinical tasks. In their day-to-day work, health workers need to be able to focus their time and energy on health service activities and reduce the time spent on non-clinical tasks. Midwives, together with your professional association, can think creatively of how to work more efficiently within the health system and with other cadres of health workers. Work with health care facility managers and national authorities responsible for workforce planning to improve midwifery workers' skills mix. Determine whether your government has conducted a full workforce assessment to inform your country's model of care. If not, advocate for such an assessment so that the health system can better ensure availability of midwifery services.

According to the *SoWMy 2014* report, the severe deficit of health workers in many countries means that community health workers (CHW) and traditional birth attendants (TBA) will continue to be part of service delivery models in the coming years.[22] CHWs and TBAs can play a significant part in influencing women's use of midwifery care and providing basic health information. Formal and informal links between the traditional birthing services in a community and the professional health services can provide a unique opportunity to effectively use the available resources and to facilitate access to quality, respectful care. New ways of shifting and sharing tasks may potentially be a good way to direct your advocacy efforts.

Keep in mind that although increasing the projected workforce for your country will help increase your percentage of met need, it is still just a first step in improving the effective coverage and the other components of accessibility, acceptability, and quality. Your approach will likely need to take a number of factors into account using a cross-cutting approach in order to better meet the needs of women and newborns in your country.

ACCESSIBILITY

The second component of midwifery coverage is *accessibility*.

Accessibility of the *health workforce* means equitable access to health workers. Important factors regarding accessibility include travel time and transport, opening hours and corresponding workforce attendance, whether or not the infrastructure can accommodate individuals with disabilities, referral mechanisms, and the direct and indirect cost of both formal and informal services.

Even if there are enough health workers, ade-

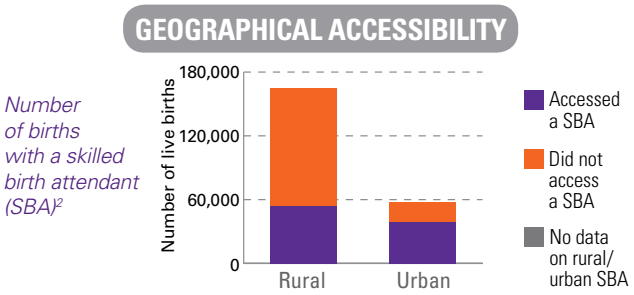
quately paid and with the competencies to provide the continuum of care that women and newborns need, accessing the care that they provide remains a problem for women in many countries.

Geographic Accessibility

Health services and the health workforce should be within safe physical reach for all sections of the population, yet in many cases, health workers and the facilities they work in are not equally distributed geographically, nor are they accessible to all who need them. An accessible health care system must have an adequate geographical spread of facilities and health workers, backed up by good transportation, information, and communication networks.

The following graphic found in your country brief shows two pieces of information. Firstly, the height of the bars indicates the number of births in urban areas versus rural areas to indicate how the geographical need for SRMNH services is distributed. Where recent Demographic Health Survey data were available, the two bars are shaded to show the number of births where a skilled birth attendant (SBA) was reportedly available. This gives you an idea of whether there may be an imbalance in the rural/urban distribution of the workforce compared to the need.

The following is an example from Sierra Leone's country brief:



DISCUSSION GUIDE: GEOGRAPHIC ACCESSIBILITY

Looking at your country's geographic accessibility bar graph, you can assess where the majority of women are giving birth and whether or not the majority of women are accessing an SBA (defined by the WHO as an accredited health professional — such as a midwife, doctor, or nurse — who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth, and the immediate postnatal period, and in the identification, management, and referral of complications in women and newborns[23]). If there is no data on the geographical accessibility for your country, why might that data not be available? What systems and resources need to be put in place in order to obtain the data?

How big is the gap in midwifery service provision between rural and urban areas? To what extent is this a workforce issue?

If women in rural areas are not accessing an SBA when giving birth, consider the following questions:

Is there an uneven distribution of SBAs in your country, with a lack of midwives (or MNH workers in general) living and practising in rural areas?
Midwives need increasing support and both financial and non-financial incentives to work in geographically isolated, underserved, and rural areas. Better planning and investment in the deployment and retention of midwives could also include addressing the uneven geographical distribution of training institutions, requiring compulsory periods of rural service, and aligning an improved career development pathway with opportunities for continued education and training.

Are there enough accessible health facilities in rural areas?
The uneven geographical distribution of health facilities needs to be addressed in line with general improvement of rural facility infrastructure. The provision of maternity homes in especially hard-to-reach areas is an issue to consider. In conjunction with the status of the health facilities, improvements in roads and transportation networks are also needed.

Does your country have poor roads or a lack of transportation in the rural areas, inhibiting women's access to health facilities and SBAs?
Planning, investment, and maintenance of all-weather roads, public transportation, health facility emergency transportation as well as communications in rural areas can help ensure that women can access health facilities in a timely fashion. Women and their families must also be able to afford to use these transportation and communication options in order for access to be increased.

If women in urban areas are not accessing SBAs when giving birth, consider the following questions:

How can women in urban areas be encouraged to access SBAs?
Women among the urban poor may not access an SBA, even if facilities are available near them, if they mistrust facilities and/or health care professionals. New ways of reaching this subset of the population and introducing them to the availability of and benefits of accessing the formal health system, including SBAs, are needed. One strategy is to work with TBAs or CHWs, who also may have migrated from rural to urban areas for work, to introduce women to the available SRMNH services in their area and encourage them to access an SBA.

Are there other factors related to the geographical accessibility of your country's workforce or health services that need improvement?

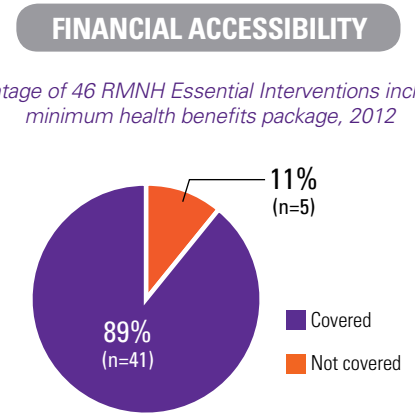
Financial Accessibility

It is widely recognised that women and their families face financial barriers when seeking access to SRMNH care. To combat this, governments are urged to develop and provide a minimum benefits package, as part of universal health coverage that provides all women with access to 46 essential SRMNH interventions free of charge. The 46 essential interventions were identified by the Partnership for Maternal, Newborn & Child Health and Aga Khan University. The essential interventions were selected because there is strong evidence of their efficacy, effectiveness and impact on survival and they are suited to implementation in low and middle-resource settings; a list of the 46 essential interventions is included in Annex 4 of the *SoWMy 2014* report (and Annex D of this Toolkit.)

According to the *SoWMy 2014* report, 70 of the 73 countries profiled have a national minimum guaranteed benefits package of SRMNH services that are supposed to be free at the point of service for all women.[24] However, these benefits packages do not necessarily cover all 46 of the recommended essential interventions. In fact, only a few countries actually include all 46 essential interventions as part of their minimum guaranteed benefits package and not all services may truly be provided free at the point of access.

The following graphic found in your country brief focuses on your country's financial accessibility and the extent to which the minimum guaranteed benefits package covers the recommended 46 essential interventions. The pie chart displays both the proportion and number of the essential interventions that are covered or not covered in the minimum benefits package.

The following is an example from Sierra Leone's country brief:



DISCUSSION GUIDE: FINANCIAL ACCESSIBILITY

Look at the percentage of the 46 key interventions NOT COVERED. Few countries have a package which includes all 46 interventions, but a majority of countries (62%) do offer at least 40 of the 46 interventions.

Does your country's minimum health benefits package guarantee financial accessibility to all essential interventions for all women and newborns? Does your country have a national minimum health benefits package that offers less than the 46 essential interventions (see Appendix D)?

Consider the following questions:

Are there some missing essential interventions to save the lives of women and newborns?
According to the *SoWMy 2014* report, some common gaps in countries' benefits packages deal with antenatal interventions. For example, less than half of the countries provide calcium supplementation to prevent hypertension, intervention for the cessation of smoking, low dose aspirin to prevent pre-eclampsia, or reduction of malpresentation at term with external cephalic version.[25] Given that hypertensive disorders and obstructed labour have been identified as leading causes of maternal death in developing countries, increased access to these interventions can help prevent maternal mortality and morbidity. You can find out the missing interventions by requesting the data submitted for the *SoWMy 2014* report from the UNFPA or WHO focal point. The answer will be in Module 5, Questions 512-515. A full list of country participants from which to request this data, is available on p. 198 of the *SoWMy 2014* report.

Are there other financial barriers to accessibility women and their families face in your country?
Even if services are provided free of charge as part of a package of care, women and their families may still face significant out-of-pocket expenses when accessing SRMNH care. These could include costs related to transportation to and/or between health facilities or additional costs related to laboratory tests or supplies once at the health facility. Women and their families could also be asked to provide informal payments to health workers even though the national health policy says that the SRMNH services should be free of charge.

"She was in a very bad situation when we took her to the hospital.

Thank god, although it was very last minute, she got treatment – she and the baby were okay. She was almost dead.

She was lucky, she survived because that day we were all there and we were able to take her to the hospital. But this doesn't happen in remote villages when there is no one there to give them transport and proper care.

Although a hospital was near and community workers were there, there was lack of awareness of using the systems and lack of awareness of her health and rights. She did not have enough knowledge to use these things.

We have to create this awareness in the rural areas."

SRI LANKAN MIDWIFE

CASE STUDY C

Realising Women's Entitlements to Health Services in India

The Deliver Now India advocacy campaign, organised by the White Ribbon Alliance of India's Orissa Chapter with support from The Partnership for Maternal, Newborn & Child Health, held a rally and public hearing to advocate for women's entitlements to health services in Balangir, Orissa, India.

About 1,300 women — including community members, elected officials, the media, and civil society representatives — participated. The public hearing was chaired by the top administrative official of Balangir district and provided a dynamic public forum for women to question local officials about the state of maternal and child health services. In addition to issues raised regarding the lack of adequate health providers and the need for improving the quality of care, discussions focused on the irregularities in government-issued benefits to women and their families and the prevalence of bribery and corruption in the health system.

As a result of the public hearing an agreement was made on setting up a grievance unit, including a complaint box at the district hospital, and the chief district medical officer agreed to present data on maternal, newborn, and child health service delivery at monthly meetings of the local government council.[26]

Richard Lord

"I am proud of my profession. I like to work as a midwife. Life begins in the hands of a midwife.

Yet a midwife in Malawi has to improvise. We are overworked and we do not have a good reputation.

People say midwives are rude — that we shout; we do this and that. Because they don't know the true situation. They hear talk on the radio about midwives. But they don't know what happens on the ground.

Where I am working there are only four midwives. We cover the maternity ward, the pediatric ward, the female ward, and the children's ward.

Those midwives are trying their best; working day and night to give life to mothers and babies. For them it is a very difficult situation.

But if there can be a lot more midwives and if resources are made available, midwives can be happy to work in those places. And then the bad name of midwives which has been tarnished can vanish."

MALAWIAN MIDWIFE

Advocating for Accessibility

Now that you have discussed the *accessibility* component of midwifery coverage, what can your midwives' association do to create positive policy change? This depends on your country's political environment, which you will read more about in PART III of this toolkit.

If women are not able to access midwifery services in your country due to geographic or financial barriers, your midwives' association may want to advocate for changing policies that impact accessibility.

Here are a few advocacy opportunities to increase *accessibility* of midwifery services in your country:

Reducing Geographic Barriers to Women Accessing SRMNH Services

Improve your country's workforce planning: According to the *SoWMy 2014* report, most countries deploy their midwifery workforce using facility-based planning or workforce to population ratios.[27] In the case of the former, a specific number of workers of each cadre are allocated to different types of health facilities in the health system (hospital, MNH clinic, etc.). In the case of the latter, planners try to ensure that each region has the same number of health workers per 10,000 population, for example. However, these may be inconsistent with needs and access to care. In the case of facility-based planning, the distribution of health facilities may not match the distribution of need, meaning that the distribution of workers will itself be skewed. In the case of workforce to population ratios, different sub-national populations may have a different scale of need (for example because of higher fertility rates, or higher HIV rates) and sparsely populated areas may need a higher ratio in order to keep a facility open 24 hours 7 days a week. Advocate with the Ministries of Health and Planning for development of a workforce strategy and plan to ensure that the distribution of health workers matches the geographic distribution of pregnant women. Work with the appropriate Ministries to ensure that the workforce strategy addresses how deployment and retention of health professionals will be ensured in rural areas, such as through requiring compulsory periods of rural service, improving distribution of training institutions, or providing financial incentives to health workers who relocate to and remain working in remote rural areas.

Family Care International

Support efforts to improve transportation options for women seeking midwifery care: Midwives associations can lend support to efforts within your country to raise policymakers' awareness of the need to improve transportation to heath facilities. Discuss other options for helping women access affordable, quality care with the Ministry of Health and other authorities who could invest in provision of maternity homes, bicycle ambulance programmes, or other solutions.

Reducing Financial Barriers to Women Accessing SRMNH Services

Improve access to the minimum health benefits package in your country:

- Determine whether your country has a national minimum guaranteed benefits package and review the essential interventions that it covers. You can find out the missing interventions by requesting the submitted data from the UNFPA or WHO focal point. The answer will be in Module 5, Questions 512-515. A full list of country participants from which to request this data is available on p. 198 of the *SoMWY 2014* report. Consider meeting with national health authorities to discuss what is included in your national package and to advocate for coverage of more of the 46 essential interventions.
- Advocate with the Ministry of Health, Ministry of Finance, or other decision makers in health facilities to ensure that the minimum health benefits package is truly guaranteed to all women regardless of their ability to pay.
- Propose that your country consider including transportation costs or drug fees within its minimum benefits package or propose the development of prepayment schemes, financial safety nets, and other social protections for women. You could also propose that community level partners organise co-operative community groups to facilitate transport and share costs.
- Work with the relevant authorities in your country to ensure that salaries are sufficient, improved supervision and monitoring of health services is provided, and equipment and supply demands are met in order to reduce corruption and requests for informal payments.
- Encourage the government to conduct a public awareness campaign – or work with your midwives' association to do so – to inform women about their right to SRMNH services which are free at the point of access, ensuring that this information is made available in women's native languages and on the radio. Such a campaign can increase the public's involvement in holding the government health system accountable for providing these services, and build awareness among health promoters of this basic package of services. Ask that a mechanism be established so that women can voice grievances with respect to accessing free services.

ACCEPTABILITY

The third component of midwifery coverage is *acceptability.*

The acceptability of the *health workforce* includes the ability of the workforce to treat everyone with dignity, create trust, and enable or promote demand for services.

Even if care is available and accessible, effective coverage will be reduced if the care offered is not acceptable to women, their families, and communities. For example, women may not seek care if they feel they are not treated well at the health facility (i.e., lack of confidential, culturally relevant, and respectful woman-centered care) or if they perceive that treatment will be poor (i.e., hearing stories of other women's unacceptable experiences).

Despite a rapidly increasing demand for professional care as evidenced by rising proportions of women giving birth in facilities and with SBAs, there is growing evidence that lack of acceptable and respectful care is a disincentive for women to access care. Midwives' and other health workers' attitudes towards service users matter and provision of women-centered care by all MNH health workers will help prevent disrespect and abuse in health facilities.

Although your country brief does not have a graphic to highlight acceptability of the health workforce and health services in your country, you are encouraged to address the issue of acceptability as you are discussing your country brief. Many countries are working with midwifery and other professional associations to develop policies to promote care which are sensitive to social, cultural, and traditional needs; these policies need to be implemented and monitored. In fact, for the *SoWMy 2014* questionnaire, 79% of countries stated that policies are in place specifically to address how SRMNH care will be delivered in a way that is sensitive to social, cultural, and traditional needs (for example, in relation to age, ethnicity, religion, and language).[28] In addition, in order for midwives to provide care that is acceptable to women and their families, the health facilities where they work must be appropriately staffed and be stocked with the necessary equipment and supplies.

KEY *SoWMy 2014* MESSAGE: In order for midwives to do their job most effectively, facilities need to be equipped to offer the appropriate services, including for emergencies (safe blood, caesarean sections, newborn resuscitation.)

Advocating for Acceptability

Now that you have discussed the *acceptability* component of midwifery coverage, what can your midwives' association do to create positive policy change? This depends on your country's political environment, which you will read more about in PART III of this toolkit.

If lack of acceptable and respectful care is a disincentive for women to access midwifery care in your country, or if your country does not have a policy in place to address how SRMNH care should be delivered, your midwives' association may want to advocate for changing policies and standards impacting availability.

Here are a few advocacy opportunities to increase *acceptability* of midwifery services in your country:

Advocate for the creation of a policy on acceptable SRMNH care: A lack of acceptable and respectful care is a disincentive for women to access care. Work with Ministries of Health, Law and Justice, Social Welfare, Women and Children, and other related divisions of the government, as well as associated Parliamentary Committees, to develop policies to promote care that is sensitive to social, cultural, and traditional needs. You may also want to reach out to the Attorney General, state and local lawmakers, and other health professional associations as appropriate.

Improve implementation of an existing policy: If your country already has a policy in place, discuss with policymakers, health facility managers, and your midwives' association how the policy is implemented and monitored. Advocate for your midwives' association to participate in reviewing the policy (for example, to ensure it includes all seven aspects of the Universal Rights of Childbearing Women Respectful Maternity Care Charter[32]) and making recommendations for improvements in health facilities and workload to make it possible for health workers to comply with the policy.

Advocate for improvements in the working environment for midwives and other health workers: Midwives need to have access to the equipment and supplies necessary to do their jobs; they cannot be overstretched and overwhelmed by the numbers of women needing their attention and help, and they need to be respected as medical professionals and paid an appropriate salary. Advocating for improvements in the working environment — and in mentoring and supervision of all health workers by regulatory bodies, midwives associations and employers — can increase provision of respectful care and ensure that acceptable health services are consistently provided.

Richard Lord

Incorporate respectful care into midwifery training: Work with midwifery training programmes and Ministries of Health that help set the midwifery curriculum to include respectful women-centered care and socio-cultural sensitivity as part of midwifery training and continued education. If a curricula already exist in your country, work with the Ministry of Health to review the curricula to ensure they meet the standards and competencies in ICM tools and guidelines.

Mobilise citizens and providers to demand accountability for respectful care: Raising awareness among women of their right to acceptable care can mobilise citizens to demand greater accountability from those responsible for providing local services, such as facility managers, and can influence governments to deliver on their SRMNH commitments. This can help to ensure the conditions for delivering quality care. Improving acceptability means listening to the voices of women and their communities, and building their preferences into policy and training initiatives for all health workers.

DISCUSSION GUIDE: ACCEPTABILITY

Think about how your country's health workforce and health services can provide care that is more acceptable to women and their families.

Does your country have a policy in place to specifically address how SRMNH care is to be delivered in an acceptable way to women and their families? Is the policy being implemented and enforced?

If a policy is in place, consider these questions:

Could your country's policy be improved?
Review your country's policy. Is it sound and up-to-date? Does it include the seven aspects of the Universal Rights of Childbearing Women Charter (refer to Box 7 on page 22 of the *SoWMy 2014* report)?[29]

Do midwives and other MNH health workers know and understand the policy and apply it consistently in day-to-day work? Does the general public, especially women, know that this policy exists? Do women understand their rights?

Is there a protocol or mechanism for women and their families to file grievances when their rights are violated? If so, is this mechanism understood and available, including in rural areas?

Do women and their families have a negative perception of MNH health workers and/or health facilities that influences their access to care?

If a policy on acceptablity is not in place, consider these questions:

Could a better understanding of women's experiences and public attitudes towards midwives and other MNH workers be helpful in developing a policy on acceptability in your country?
According to the *SoWMy 2014* report, there has been little systematic attempt to study public perception. Studies documenting public attitudes towards the midwifery workforce and their practice are available in only 18 countries; this lack of information limits the understanding of acceptability.[30]

If your country did have a policy in place, what else would need to be done to ensure acceptability of the health workforce and health services in your country?

The White Ribbon Alliance is focusing on promoting Respectful Maternity Care in partnership with the Health Policy Project. Building on their experience in mobilising citizens at the grassroots, the WRA network — which includes thousands of midwives and midwifery organisations globally — aims to make the seven aspects of the Universal Rights of Childbearing Women Charter the basis of maternity care systems around the world; the WRA works with national policymakers to endorse the Charter and hold workshops to help midwives understand their rights and to respect their patients.

In Nepal, the White Ribbon Alliance has supported National Alliance members to ensure the Charter is incorporated into the new National Safe Maternity Bill. In countries such as Kenya, Bangladesh, and Yemen, the WRA has helped create action plans to address disrespect and abuse. In London, regular meetings to raise awareness of Respectful Maternity Care are organised by midwives and health workers.

The WRA published *A Guide for Advocating for Respectful Maternity Care* to equip national-level advocates with the appropriate information, tools, and techniques to generate demand for, increase social accountability for, and secure commitments on the issue of respectful maternity care. The guide also aims to strengthen national-level advocates' capacity to use the Respectful Maternity Care Charter effectively and:

- **Raise awareness and generate demand for respectful maternity care rights from civil society;**
- **Mobilise communities to hold local leaders and service providers accountable for respectful maternity care rights; and**
- **Secure a national-level commitment to institutionalise respectful maternity care as the standard of care.**

For more information, and to access the Universal Rights of Childbearing Women Charter, the guide for advocates, and other supplemental materials (including sample PowerPoint presentations, film, posters, and brochures), go to the WRA website: http://whiteribbonalliance.org/campaigns/respectful-maternity-care/. The charter is available in English, French, and Spanish.

CASE STUDY D

Improving Public Perception of Midwives

The media has a strong influence on all of us. Just one negative news story on an individual case involving midwives can be sensationalised in the media. Stories like this can influence the general public's and policymakers' perception of midwives and can result in a poor opinion of their work and the profession. The WRA National Alliances in both Tanzania and Malawi are working with the media to (1) focus on positive stories and promote the vital work of midwives in saving women and newborns, and (2) clear up any misunderstandings and misconceptions the public may have regarding midwifery.

The media strategies of WRA Tanzania and WRA Malawi, which engages midwives as mothers and advocates, are core tactics in their respective national campaigns to improve the public's perceptions of midwives. For example, WRA Tanzania developed a short film and public service announcement in English and Swahili titled, *What I Want Is Simple*. The film was aired on ITV, a media house viewed by 85% of Tanzanians, and the public service announcement was played on Radio One, which is heard by 35% of Tanzanians at any given time. *What I Want Is Simple* features women describing the conditions of a health facility in which they wish to deliver their children. These women are also midwives; they understand what mothers need because their requests illustrate the environment they want and need in order to perform their job well. Midwives and mothers are one and the same—they all want the best birth experience and outcome possible (to view the film, go to http://bit.ly/13vEQHW).

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WRA Malawi has also developed a film, which features interviews with midwives and Ministry of Health policymakers on the current situation in Malawi and what is needed to improve working conditions and birth outcomes (to view the film, go to http://bit.ly/1bEDBRm). WRA Malawi invited the media to its campaign launch, where it emphasised the media's responsibility to highlight the commendable work of midwives, give midwives and the midwifery profession due recognition, and amplify the community voice in the campaign.[31]

CASE STUDY E

Advocating for Ministry Commitments for Midwives in Malawi

As part of its national campaign to promote midwives, the WRA Malawi is working with the Ministry of Health (MOH) to define improvements in the working conditions of midwives as a key policy priority during planning and budgeting. The goal is for the MOH and professional bodies to take steps to improve client-provider interaction and the provision of respectful maternity care. WRA Malawi's advocacy efforts have led to a commitment by the MOH's Principal Secretary to collaborate with WRA Malawi in reaching its campaign objectives. The Principal Secretary specifically promised that all WRA Malawi recommendations—including those related to midwives' additional qualifications, direct-entry midwifery education, pay, and career path—will be discussed in Ministry meetings.[33]

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QUALITY

The fourth component of midwifery coverage is *quality*:

- The quality of the *health workforce* is assessed by the competencies, skills, knowledge, and behaviour of the health worker according to professional norms and as perceived by users.

Even if the midwifery workforce is available, accessible, and acceptable to the population, delivering poor quality care will substantially limit its effectiveness. Without addressing quality, maternal mortality will not decrease.

Improving quality of care can be achieved through:

- securing an enabling professional environment to support effective education, regulation, and professional associations;
- securing an enabling practice environment that includes access to effective and reliable consultation and referral networks as well as human resources development, management, and capacity building; and

MIDWIFERY EDUCATION[3]

Minimum high-school requirement to start training	Grade 12+
Years of study required to qualify (rounded)	2
Standardized curriculum? Year of last update	Yes, 2010
Minimum number of supervised births in curriculum	20
Number of 2012 graduates/as % of all practising midwives	121/42
% of graduates employed in MNH within one year	99%

MIDWIFERY REGULATION

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

PROFESSIONAL ASSOCIATIONS[4]

Year of creation of professional associations	1969
Roles performed by professional associations:	
Continuing professional development	Yes
Advising or representing members accused of misconduct	Yes
Advising members on quality standards for MNH care	Yes
Advising the Government on policy documents related to MNH	Yes
Negotiating work or salary issues with the Government	Yes

na = not applicable; – = missing data

ICM HAS DEVELOPED A SET OF CORE DOCUMENTS ON THE THREE PILLARS OF A STRONG MIDWIFERY PROFESSION:

- ICM Global Standards for Midwifery Education
- ICM Global Standards for Midwifery Regulation
- The Member Association Capacity Assessment Tool

These ICM Core Documents guide midwives associations and their governments to review, improve, and strengthen the education and regulation of midwives and midwifery. They enable countries to review their midwifery curricula for supporting and retaining a quality midwifery workforce. If your midwives' association needs to be refreshed on the content of these documents, go to the ICM website: http://www.internationalmidwives.org/what-we-do/education-regulation-association/

In addition, if your midwives' association is keen to focus on the quality of midwifery education, regulation, and association following your assessment of factors influencing your country's quality of care, there are excellent tools are available, including:

1. ICM Gap Analysis Documents
   - Pre-Service Education Assessment Tool (2012): English, French , Spanish
   - Regulation Assessment Tool (2012): English, French, Spanish
   - Member Association Capacity Assessment Tool (2012): English, French, Spanish

For more information, and to access these documents, go to the ICM website: http://www.internationalmidwives.org/what-we-do/global-standards-competencies-and-tools.html

2. WHO's Strengthening Midwifery Toolkit

The WHO's 2011 Strengthening Midwifery Toolkit contains nine modules focusing specifically on strengthening the central role and function of the professional midwife in the provision of quality care. The toolkit features guidelines to assist midwives associations in considering strategies by which midwifery services can be strengthened. The guidelines can be used for establishing or reviewing midwifery programmes according to a country's needs and priorities.

For more information and to access the toolkit in its entirety, go to the WHO website: http://www.who.int/maternal_child_adolescent/documents/strenthening_midwifery_toolkit/en/.

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- making respectful teamwork and collaboration a reality by requiring that collaborative SRMNH teams work effectively while keeping the woman and newborn at the centre.

Although your country brief does not have a graphic to highlight all three dimensions of quality, there is a graphic on the first page (as a column on the right-hand side), focusing on the enabling professional environment for quality care and care providers across the three key pillars of midwifery: education, regulation, and association.

The graphic on page 27 is from Sierra Leone's country brief.

An Enabling Professional Environment

Education, regulation, and professional associations are the *Three Pillars* of a strong midwifery profession and are all crucial to support health workers in delivering quality midwifery care.

Looking at your country brief, is data missing from any of the components of your country's three pillars of midwifery? If so, what items are missing and why? What systems might need to be put in place in order to obtain this data?

An Enabling Practice Environment

According to the *SoWMy 2014* report, an enabling practice environment includes access to effective and reliable consultation and referral networks as well human resource development, management, and capacity building.

First-level midwifery care is close to the woman and her family with seamless transfer to next-level care. Midwife-led care can be delivered at community level with access to transport for referral and transfer to reduce unnecessary delays.

With this in mind, think about how your country's health workforce and health services can better meet the needs of the population through improved first-level services following a specific protocol or guidelines of consulting with secondary- and tertiary-level services about the processes for referral and transfer of women and/or newborns when needed.

Consider these questions on your country's consultation and referral network:

Do your country's guidelines for consultation and referral need to be reviewed, improved, or developed?

Could midwives' and other MNH health workers' knowledge and understanding of your country's consultation and referral networks and guidelines be improved?

Could women and their families be more engaged to better understand and support the guidelines for transfer?

Respectful Teamwork & Collaboration

Improvement in quality of care requires that SRMNH teams work collaboratively and effectively while keeping the woman and newborn at the centre. With this in mind, think about how your country's health workforce and health services can better meet the needs of the population through improved inter-disciplinary teamwork and collaboration.

Consider these questions with respect to respectful teamwork and collaboration:

How could your midwives' association be more involved with the development and/or implementation of inter-disciplinary teamwork and collaboration in advocacy, education, and practice?

Could there be further clarification and agreement about the roles and responsibilities of each team member/category of cadre?

DISCUSSION GUIDE: MIDWIFERY EDUCATION

Look at your country's MIDWIFERY EDUCATION section: this presents information about the schools and training institutions' standards in your country as well as the number of graduates and their entry into the workforce.

The *SoWMy 2014* report indicates strong evidence of gaps in the infrastructure, resources, and systems that negatively affect midwifery education.[34] There are many factors that can affect the quality of midwifery education, including the inadequacy of secondary education in preparing future midwifery students and the lack of teaching staff and faculty within midwifery schools and institutions. Additionally, poor-quality equipment, lack of classroom space, and insufficient opportunities for practical training are major challenges to strong midwifery education.

Consider these questions on your country's midwifery education curriculum:

Are your country's schools and training institutions aligned with the ICM Global Standards for Midwifery Education?

Do your country's schools have skills laboratories that are adequately equipped with the right type of equipment for all students to learn and practice?

Are there ways to increase the number and quality of opportunities for clinical experience in your country?

For example, this could include access to simulation training and specialised equipment. It could also include increasing the minimum number of supervised births to align with ICM's global standards. According to the *SoWMy 2014* report, the median reported number of supervised births required for midwives is 34, which is significantly fewer than ICM's indicative benchmark of 50 supervised births to ensure that students attain competency before graduation.

How could your country better recruit and retain adequate numbers (recommended student: teacher ratio) of well-qualified faculty and teachers?

For example, could your country do more to introduce faculty development plans, provide regular refresher training and formal qualifications for teachers, and ensure supportive supervision of teachers?

Could the percentage of graduates employed and deployed in MNH and practicising as midwives within one year of graduation be improved?

Richard Lord

CASE STUDY F

Afghanistan Moving Forward with Midwifery Education

The Afghan Midwifery Association is advocating for a professional career path for their colleagues and the advancement of educational opportunities in order to offer the best care to mothers and families.

In 2002, in partnership with the Afghan government, and funded by the U.S. Agency for International Development (USAID), Jhpiego (an international health non-profit and affiliate of Johns Hopkins University) set out to revitalise the Afghan midwifery workforce by developing a national education system to train midwives to provide competent, skilled care to women during childbirth. When the USAID-funded Health Services Support Project concluded in 2011, the state of midwifery in Afghanistan was greatly improved:

- More than 3,000 new midwives had graduated from a network of government-accredited schools, whose curricula and competency-based training were developed in collaboration with the Afghan Ministry of Public Health and other partners;
- The percentage of women giving birth in health facilities had increased from 19% in 2005 to 32.4% in 2011;
- Midwifery programmes had increased from one in 2002 to 30 in 2011;
- 86% of graduates of community midwifery schools obtained jobs;
- The Afghan Midwifery Association was founded and has since grown significantly;
- More than 17,000 health care workers, supervisors, faculty, and health ministry staff have been trained in 28 areas of care, from emergency obstetric and newborn care to family planning and mental health;
- 505 health facilities across 21 provinces are using a new quality improvement and assurance system to provide better services to Afghans; and
- Community health workers have educated more than 10,000 pregnant women living in remote areas on self-administration of misoprostol, a potentially life-saving drug to prevent postpartum haemorrhage; the drug is taken if women cannot reach health facilities to give birth.[36]

The Afghan Midwifery Association continues to grow and strengthen, as evidenced by their recent advocacy for the need for career progression opportunities (particularly higher education) and strengthening the regulatory body for midwives. Advocacy activities were conducted during national forums like the International Day of the Midwife and Annual Midwifery Congresses, as well as individual and group meetings with key stakeholders including the Minister of Public Health, the Minister of Higher Education, the Kabul Medical University Chancellor, and representatives from the private sector and other national and international organisations including UN agencies.

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A major result of these advocacy efforts is that the Ministry of Higher Education agreed to the development of two new educational tracks for midwives at the Kabul Medical College: 1) a post-registered midwifery bachelor of science in midwifery degree (post-RM BScM), and 2) a direct entry BScM degree.

Both programmes are unique and are the first official degrees in the history of the midwifery profession in Afghanistan. These programmes will benefit midwives in moving forward with their profession and improve midwives' opportunities to be involved at the policymaking level.[37]

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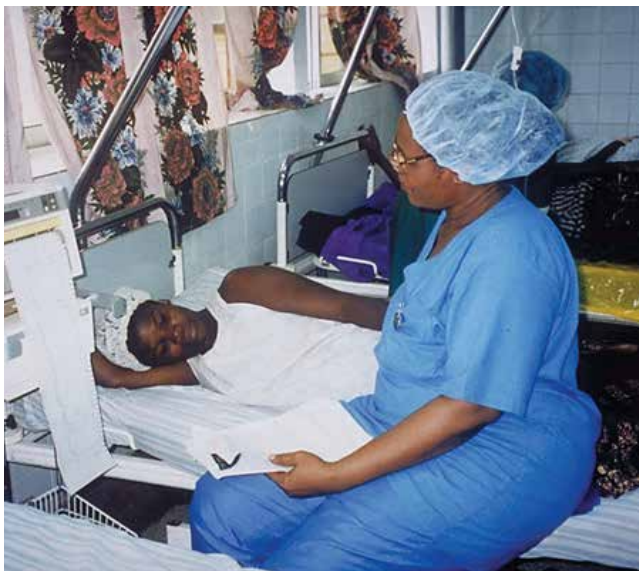
CASE STUDY G

Tracking Policy Implementation of Staffing Levels in Tanzania

White Ribbon Alliance Tanzania members conducted a survey to count the number of skilled medical personnel, including midwives, available at 24 facilities in two Tanzanian districts. They then compared that number with the Ministry of Health and Social Welfare's *"Manning Level Guidelines"* and found huge discrepancies, with facilities severely lacking qualified staff.

WRA Tanzania presented these data to government officials as part of a national advocacy campaign that resulted in the following:

- the President's office issued a letter of permission to hire all graduates of health institutions effective immediately
- the Ministry of Health and Social Welfare was instructed to employ 3,890 workers and deploy them to areas with critical shortages
- this translated into a 33% increase in staffing levels within eight months at the facilities surveyed[38]



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DISCUSSION GUIDE: MIDWIFERY REGULATION

Look at your country's **MIDWIFERY REGULATION** section: this presents information on the extent to which the legal and regulatory environment recognises and protects midwives and the public. Providing midwives with a legal right to practise implies that their scope of practice is recognised and that they and the women they care for are legally protected in case of adverse outcomes. Effective regulation includes licensing and re-licensing midwives which allows for the opportunity to enforce minimum requirements for maintaining excellence through continued professional development and in-service training. According to the *SoWMy 2014* report, nearly all responding countries have at least one regulatory body, but many lack legislation recognising midwifery as a regulated profession, clearly described midwifery competencies and education standards, and effective regulatory processes.[39]

Since 2011, 51 countries (70%) report that regulatory bodies are responsible for setting educational standards, and 39 (53%) report that they are responsible for the accreditation of education providers. Additionally, regulatory bodies reported revising the code of practice, putting in place new legislation and/or establishing mechanisms for re-licensing in 14 countries (19%).[40]

Module 2 of the WHO Strengthening Midwifery Toolkit, "Legislation and regulation of midwifery – making safe motherhood possible" provides an explanation of why legislation and regulation are so important to the quality of care women and newborns need, and of the needs that midwives have to be supported and protected while providing that care.

Consider these questions on your country's midwifery regulation:

Is the regulation of your country's midwifery workforce aligned with the ICM Global Standards for Midwifery Regulation?

Is your country's midwifery practice sufficiently and effectively regulated?
According to the *SoWMy 2014* report, nearly all countries confirmed there is at least one organisation with responsibility for the regulation of midwifery practice. Half (51%) said that midwifery is regulated either by the Ministry of Health or another government department, and a similar proportion (47%) reported that a government-approved regulatory organisation such as a Board or Council exists. A few countries have more than one regulatory body. Just six countries report currently having no regulatory body, and three of those countries indicate that one is being established.[41]

Although the existence of a regulatory body is necessary, it may not be sufficient to ensure effective regulation. The main responsibilities currently held by regulatory organisations are: setting standards for midwifery practice; registration; applying sanctions in misconduct cases; and setting ethical standards. Relatively few countries mentioned accreditation of education providers and protection of the professional title of "midwife." In some countries regulatory organisations do not fulfill these functions effectively, due to issues such as: lack of clear description of midwifery competencies; lack of nationally agreed standards for midwifery education (especially in the private sector); and lack of effective regulatory processes (e.g., due to political instability or insufficient resources).

Consider these questions on your country's legislation and licensing procedures:

Does legislation recognising midwifery as an autonomous profession need to be reviewed, improved, or adopted in your country?
According to the *SoWMy 2014* report, only 35 out of the 73 responding countries (48%) have legislation recognising midwifery as a regulated profession, and in five of these countries the legislation is not applied. Twelve countries report that legislation is being created – but this leaves 26 countries with no such legislation and none being created.[42]

Does a licensing system for midwives need to be reviewed, improved, or adopted in your country?
A licensing system enables regulatory authorities to track who is practising and ensures the quality of their work and may also be a useful source of data for planning purposes. According to the *SoWMy 2014* report, licensing systems for midwives exist in 34 of the 73 reporting countries (47%), and in a further 11 countries (15%) such a system is being created. In all but one of the 34 countries with a licensing system, licensing is compulsory before a midwife can practise. In addition, a register of licensed midwives exists in 48 of the responding countries, 28 of which are electronic.[43]

Among the 54 countries which took part in both *SoWMy 2011* and *SoWMy 2014* there has been a large increase in those with an electronic register. This progress is likely to continue: a further 18 countries reported plans to create a register. Paper-based registers are updated less frequently than electronic ones (10% of countries with a paper-based register and 43% of those with an electronic one say that the register is updated at least once a month).[44]

Keep in mind that a re-licensing system is a crucial first step, but does not guarantee effective regulation. The *SoWMy 2014* report found that only 26 of the 73 countries have a system of regular re-licensing (typically annually or every five years), and only 17 have continuing professional development as a condition of re-licensing.

Consider these questions on midwives' authority in your country:

Does the number of emergency obstetric and newborn care (EmONC) basic signal functions that midwives are allowed to practise need to be reviewed or improved in your country?
The scope of practice for different cadres in the midwifery workforce should be laid down by regulatory mechanisms, but the *SoWMy 2014* reports that these are often ineffective. There are countries in which midwives perform some or all of the seven basic signal functions without being authorised to do so, often because a midwife is the only health care provider present when the need arises. Assisted vaginal delivery stands out as the function with the most significant disparity between authorisation and provision, with 19 countries stating that midwives perform this even though they are not authorised to do so.[46] Conversely, in some countries midwives do not practice signal functions which they are legally allowed to perform, which represents a waste of resources for the health system.

Does the number of family planning methods that midwives are allowed to provide need to be reviewed or improved in your country?
According to the *SoWMy 2014* report, midwives are authorised to provide at least one type of family planning product in 71 out of the 73 reporting countries. In 57 countries midwives are authorised to provide contraceptive injection, contraceptive pill, intra-uterine device, and emergency contraception. Authorisation does not, of course, guarantee availability or quality; at country level there is very little correlation between unmet need for contraception and the number of family planning products that midwives are authorised to provide.[47]

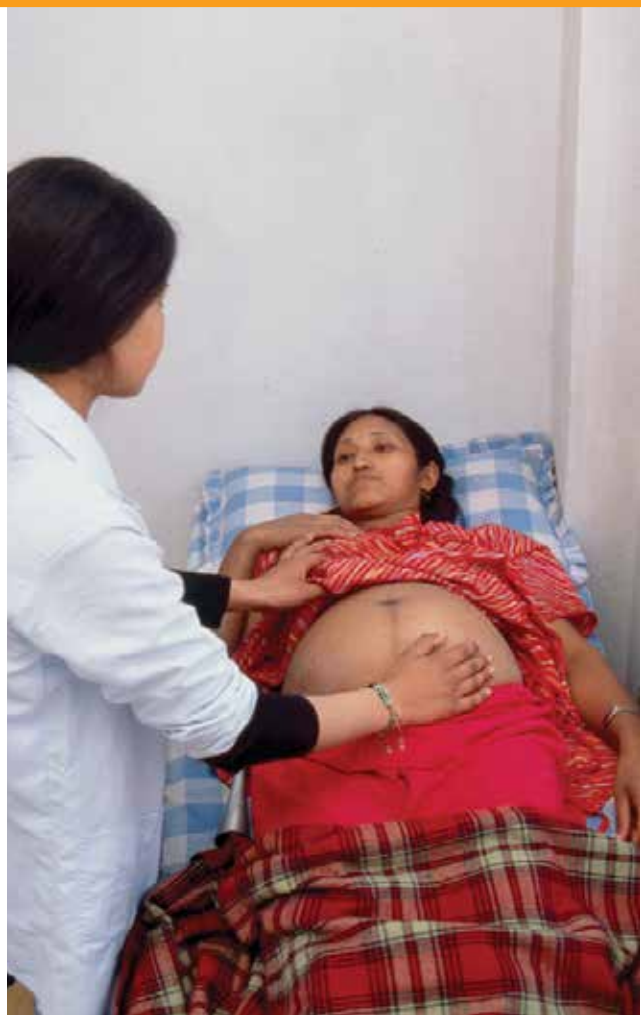
CASE STUDY H

Integrating Midwifery into Emergency Obstetric Care in Nepal

Due to the geography of Nepal, as well as the health system itself, health posts are the highest level of health care accessible to most women. These health posts are staffed by auxiliary nurse midwives, not doctors. Most staff nurses and auxiliary nurse midwives have skilled birth attendant training and are trained to provide at least postabortion care using manual vacuum aspiration. The Ministry of Health and partner organisations now train staff nurses to provide safe, induced abortion with manual vacuum aspiration or medications, and train auxiliary nurse midwives to provide safe, induced abortion with medications.

In Nepal, midwifery training is part of nursing education; abortion is legally permitted and safe abortion care is part of the government's Safe Motherhood programme, aimed at reducing maternal mortality. Safe abortion care, primarily provided by auxiliary nurse midwives, has been fully integrated into EmONC, with tremendous support from the health system.

Nepal's maternal mortality ratio has declined by nearly half — from 415 to 229 per 100,000 live births between 2000 and 2010. Abortion was legalised in Nepal in 2002. Provision of safe abortion services began in 2004. Now, comprehensive abortion care is available in all 75 districts. Midwives have played an important role in increasing access to safe abortion for Nepali women and in reducing the country's maternal mortality.[48]



Richard Lord

DISCUSSION GUIDE: PROFESSIONAL ASSOCIATIONS

Look at your country's PROFESSIONAL ASSOCIATIONS section: this presents information on the roles of your midwives' association. According to the *SoWMy 2014* report, nearly all countries reported having at least one midwives association open to midwives, 80% provided data on the numbers of midwives in membership, and 75% knew how many were currently practicing in-country.[49]

A total of 48 of the 73 countries are represented within the ICM and 45 in the ICN. In a few countries no nursing or midwifery association was mentioned, but other associations were included, such as one for obstetricians which midwives and nurse-midwives are entitled to join.[50]

Since 2011, according to *SoWMy 2014*, professional associations have made great strides in improving midwifery. As mentioned in the Introduction of this toolkit:

- 92% of associations are performing continuous professional development
- 88% of associations advise their members on quality standards for SRMNH care
- 77% of associations have advised the government on the most recent national SRMNH or health policy document
- 53% of associations have negotiated work or salary issues with their government[51]

Consider these questions on the role of your country's midwives' association:

Does your midwives association's role in advising the government on policy documents related to MNH need to be reviewed, improved, or developed in your country?

Does your midwives association have a role in negotiating work or salary issues with the government? If not, who does play that role? How could involvement of the midwives association be increased?

According to the *SoWMy 2014* report, just over half of all associations reported being involved in negotiating work or salary issues with their government.[52]

CASE STUDY I

Strengthening the Midwives Association of Sierra Leone

ICM has been working with and providing support for the Sierra Leone Midwives Association in order to enable midwives to contribute to the reduction of maternal and newborn mortality. A headquarters in Freetown and District branches have been established. Of the 13 Districts, 5 have District Executive Committees representing midwives, working as advocates for improved health outcomes for women and newborn across the country.

Once the association was established, the National Executive Members were exposed to advocacy for policy change and lobbying so that they could contribute to the revision of maternal and child health policies in the country. ICM also held a workshop with both the National and District Executive teams on regulation and legislation of midwifery education and practice — the role of professional associations. The skills gained enabled the Midwives Association to advocate for the change of name of the regulatory body from the Nurses Board to the Nurses and Midwives Board of Sierra Leone.

Another strategy ICM used to strengthen the Sierra Leone's Midwives Association was twinning. A relationship was established with the Dutch Midwives Organisation, supporting Sierra Leone to further strengthen its associations with the establishment of policies and mechanisms for organisational development. For more information about ICM's Twinning Projects and Programmes, go to: http://www.internationalmidwives.org/projects-programmes/twinning-twinning-projects-programmes.html.[53]

Katy Woods, White Ribbon Alliance

Advocating for Quality

Now that you have discussed the quality component of midwifery coverage, what can your midwives' association do to create positive policy change? This depends on your country's political environment, which you will read more about in PART III of this toolkit.

Quality education, regulation, and associations must be supported to ensure sustainability of quality midwifery services.

KEY *SoWMy 2014* MESSAGE: Investing in quality of care for women and newborns saves lives and contributes to healthier families and more productive communities.

Here are a few advocacy opportunities to improve the *quality* of midwifery services in your country:

Strengthen midwifery education: Midwives' training programmes need well-prepared faculty and to be appropriately resourced; this includes continuing professional development and career pathways with sufficient opportunities for clinical experience. Many countries also highlighted the need to intensify mandatory continuous professional education and to fund and supply in-service learning and capacity building. Targeted midwifery education with a focus on rural areas could also help to address accessibility challenges.

Work with your Ministry of Education, Ministry of Health, and training facilities to develop nationally agreed standards for midwifery education and to strengthen midwifery education through continuing education, improved faculty recruitment, and improved student retention after graduation. Midwives associations may also be able to work with the Ministry of Education to help develop and apply accreditation systems with measurable standards and criteria. Quality initial and ongoing education must ensure that midwives remain competent to do their jobs effectively; it should allow midwives to gain advanced SRMNH clinical skills if desired, or to follow leadership and management training to become SRMNH leaders.

Improve legislation on regulation of midwifery and licensing procedures: Nearly all countries in the *SoWMy 2014* report have at least one regulatory body, but many lack legislation recognising midwifery as a regulated profession, clearly described midwifery competencies and education standards, and effective regulatory processes. Work with the regulatory body in your country to develop or implement legislation to establish strong and functional regulatory systems for midwifery registration and licensing (and relicensing) that incorporate internationally consistent standards and codes while also meeting country-specific needs. Advocate for legislation or updated policies that recognise the autonomous midwife profession and the role, scope of practice, and competencies of midwives.

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KEY *SoWMy 2014* MESSAGE: Legislation to support autonomous midwifery practice allows midwives to provide the care they are educated to deliver and protects public health.

Strengthen your national midwives association so that it is well placed to advise and advocate with the government on quality issues: Vibrant and committed professional associations can provide: a point of leadership and advocacy; lobbying for improved working conditions (including flexible hours, adequate remuneration, leave, housing, transport, safety, and security); opportunities for career development, promotion, and incentives for retention; and access to information and evidence for enhancing practice through continuing education and research. Development, training, and support are required to assist the sustainability of midwives associations and to enable members to work at political and government levels and exercise advocacy both for women generally and for midwives. Consider a twinning relationship with another midwives association as a way to build your association's capacity.

Joey O'Loughlin

PART II: THE FUTURE OF YOUR COUNTRY'S MIDWIFERY

The second page of your country brief focuses on evidence-based projections of the future evolution of the midwifery workforce compared with the future scale of population need for SRMNH services. Using Excel-based modelling, country-reported data was combined with other published secondary sources for population, demographic, epidemiology, and health service delivery data in order to test different scenarios and determine what actions need to be taken in the future in order to improve SRMNH. Keep in mind that some countries reported missing data, and that these analyses use assumptions tailored to a global model. For example, if the proportion of the workforce leaving voluntarily each year was missing from a country's reported data, then a uniform assumption of 4% was used. The full list of assumptions can be found in Annex 5 of the report. This means you need to be especially careful in your interpretation of the second page of your country brief. **The evidence presented here does not amount to a set of facts, but rather a series of predictions for the future; they are to be used as a starting point for more detailed analysis, investigation, and policy dialogue in-country.**

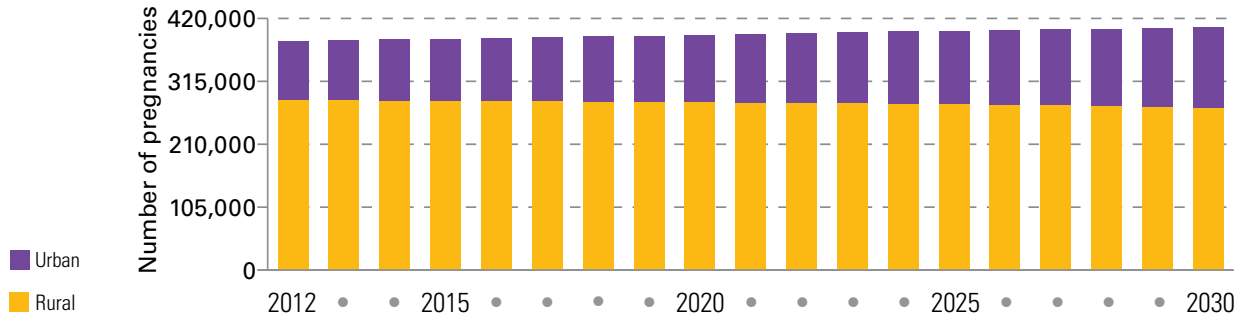
Projection data in action: This data, along with your discussions of your country brief in Part I of this toolkit, can help your midwives' association decide on advocacy priorities. For example, you may have identified the need to improve the geographic accessibility to midwives in your country as a priority during your discussions in Part I. The projection data in Part II can help confirm that improving geographic accessibility should be an advocacy priority, especially if your projection data shows an increasing number of pregnancies in rural areas, where women are likely to face the greatest geographic barriers to accessing midwifery care.

PROJECTED PREGNANCIES AND MORTALITY REDUCTION

Achieving universal coverage of SRMNH services means anticipating and responding to future needs. The first graphic at the top of the second page of your country brief shows one dimension of the evolution of need in your country, expressed as the annual number of pregnancies in urban and rural areas, in the period 2012-2030. The evolution of the need for sexual and reproductive health services will be determined by changes in the number of women of reproductive age, including the number of adolescents. This example below is from Sierra Leone's country brief.

The next graphic in the top portion of the second page of your country brief provides an indication of the targets for reduction in maternal and neonatal mortality, as proposed in the *Ending Preventable Maternal Mortality by 2030* initiative and the *Every Newborn Action Plan*. These proposed targets are subject to national policy priorities and decisions.

PROJECTED NUMBER OF PREGNANCIES BY YEAR: URBAN VS. RURAL



DISCUSSION GUIDE: PROJECTED NUMBER OF PREGNANCIES

Look at the overall number of projected pregnancies in your country.

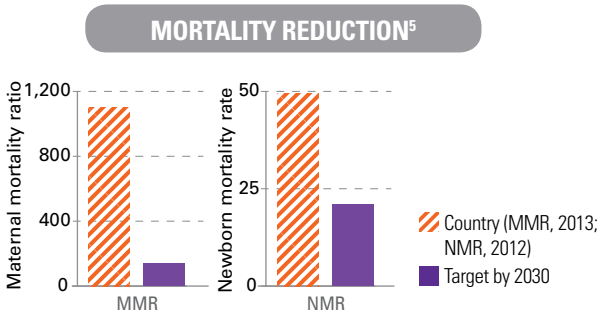
Consider this question looking at both urban and rural pregnancies together:

Is your country's projected number of pregnancies remaining relatively stable, decreasing or increasing towards 2030?

Consider this question based on the projected number of pregnancies towards 2030:

How could the availability, accessibility, and acceptability of the health workforce and health services be improved in order to better meet the needs of women and newborns in the future?

The following is an example from Sierra Leone's country brief.



ESTIMATES AND PROJECTIONS TO 2030

This section illustrates the potential evolution of the midwifery workforce under "business as usual" assumptions, which means that no significant changes are made in the country's current workforce development (no extra midwives, nurses, or doctors educated; no measure taken to decrease attrition; no attention given to increasing productivity; etc.), and compares this with different policy scenarios. The graphic below is an example from Sierra Leone's country brief.

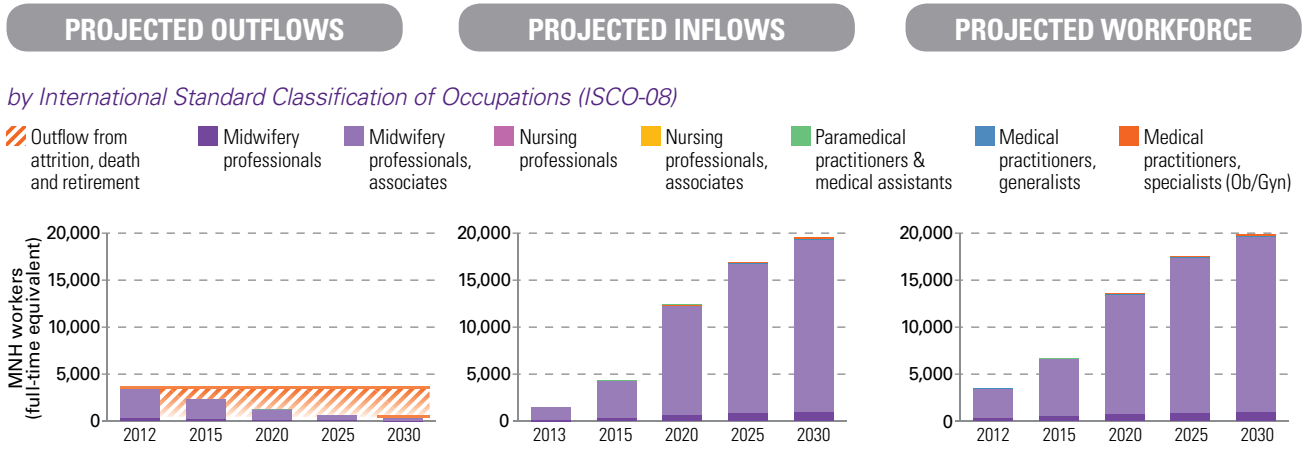
Note that the health workers in these diagrams are classified under different categories than in the Workforce Availability graphic on the first page of your country brief. They are arranged here according to the International Standard Classification of Occupations (ISCO), which takes into account workers' roles and responsibilities. Therefore, only midwives or nurse-midwives with the full midwifery scope of practice will be classified here as "Midwifery professionals". If they do not hold the full scope of practice, they will be classified under "Midwifery professionals, associates". You can find the list of midwifery professionals' tasks according to ISCO in Annex 7, p. 218 of the *SoWMy 2014* report.

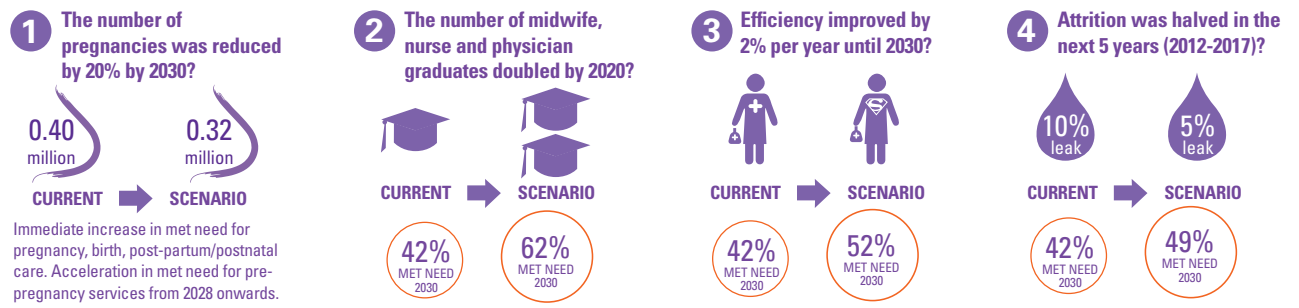
Looking at the graphic, take time to consider each of the three bar graphs, paying particular attention to the items in dark and light purple that indicate "midwifery professionals" and "midwifery professionals, associates", respectively.

The first bar graph (to the left) represents your country's **Projected Outflows**. This graph illustrates how the current health workforce (measured in FTE) will reduce over time as health workers leave. Leading up to 2030, these health workers will leave the workforce for a variety of reasons including attrition, death, and retirement. It is important to look at the rate of reduction of your country's workforce since it can give you information about age distribution (an older workforce will have a faster rate of decline) and the level of attrition (poor working conditions or other negative factors will result in more health workers leaving to find work in another career or country). You can find the level of voluntary attrition, the rate at which workers voluntarily leave the workforce, in the scenario 4 box in the graphic at the top of page 39. For example, in Angola, a 2% attrition rate was reported. In many countries, there was no data on attrition and so the default assumption of 4% was used. Consider how attrition could be better measured in your country.

The second bar graph (in the centre) represents your country's **Projected Inflows**. This graph shows the number of new health workers joining the profession, including the future midwives of your country. Leading up to 2030, these are the new health workers which are expected to enrol and graduate from educational institutions and programmes and become practicing health workers. The graph is cumulative, which means that the number of health workers in 2015, for example, includes all those that entered the workforce between 2013 and 2015. Consider whether this graph represents a realistic evolution of new entries into the workforce in your country.

The third bar graph (to the right) represents your country's **Projected Workforce**. This graph shows the cumulative effect of projected health worker outflows and inflows (exits and entries into the health workforce). This is the end result of combining your current workforce levels with the decline of your country's current health





workforce expected by 2030 and the number of newly trained health workers that are expected to join the workforce over the same period of time. Refer to Annex 5 of the *SoWMy 2014* report on p. 216 to understand which uniform assumptions were used in the event of missing data.

With the information from your projected workforce in mind, take a look at the next graphic (found at the bottom of the second page of your country brief) entitled **WHAT IF... Estimates of met need based on available date**. The four scenarios illustrate the potential impact of policy decisions and demonstrate the changes in met need that could be realised through:

1. reducing the number of pregnancies per year;
2. increasing the supply of midwives, nurses, and physicians;
3. improving efficiency; and
4. reducing voluntary attrition.

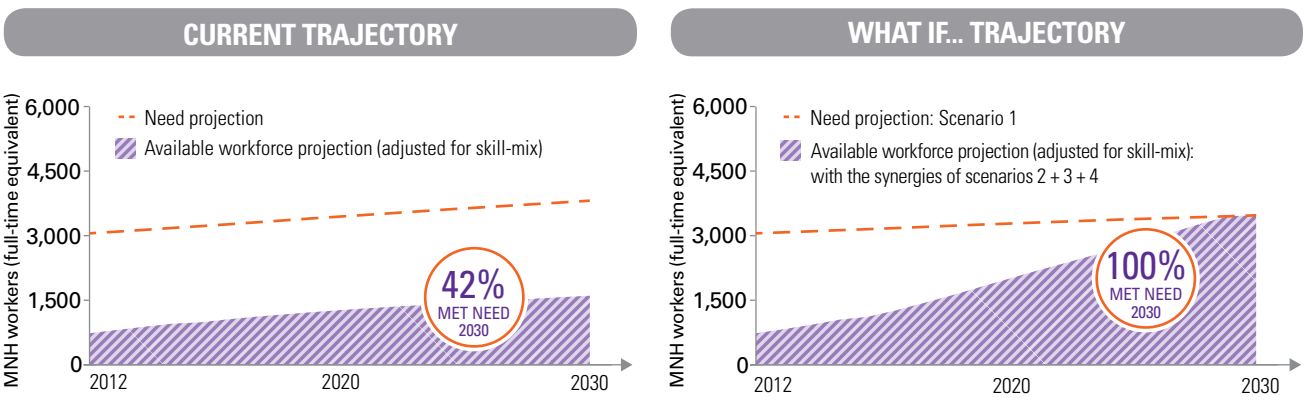
These four scenarios are examples of ways that your country can tailor its approach to improving met need. They were chosen because they are actual efforts that countries have undertaken, which have had a successful impact on improving met need. These "WHAT IF..." scenarios can give your midwives' association an idea of what could be possible in the future based on the priority issues that you have identified as being important to address with your advocacy.

The graphic at the top of the page is an example from Sierra Leone's country brief.

The final graphic provided at the bottom of the second page of your country brief highlights the difference between "business as usual" and the combination of the four scenarios discussed. The **CURRENT TRAJECTORY** graph on the left is based on a number of assumptions and shows the resulting percentage of met need when the projected need, based on future evolution of the population and fertility, is combined with the projected workforce in your country. This is what would happen in the future without any further attention to the workforce. If your workforce remains constant while your population needs increase over the period, met need levels will decrease. Remember that met need only describes the availability of the workforce in relation to an essential package of interventions, and that the model uses reported data from your country.

The **WHAT IF... TRAJECTORY** graph on the right shows the resulting percentage of met need when the projected number of pregnancies is decreased (SCENARIO 1: by reducing the number of pregnancies by 20% by 2030), combined with more graduates entering the workforce (SCENARIO 2: by doubling the number of midwife, nurse, and physician graduates by 2020), an improvement in efficiency (SCENARIO 3: improving efficiency by 2% per year until 2030), and a reduction in voluntary attrition (SCENARIO 4: cutting attrition in half in the next five years [2012-2017]).

The graphic below is an example from Sierra Leone's country brief.



DISCUSSION GUIDE: WHAT IF…

Look at the first scenario with regard to reducing the number of pregnancies by 20% by 2030, and consider the following question:

What would the impact be on the midwifery workforce if there were 20% fewer pregnancies by 2030 in your country?
What would this mean for the short-term versus the long-term? For example, in the short term it would mean fewer pregnancies, thus less need for a large quantity of health care professionals, and more time for addressing quality and woman-centered care. In the long term, it could mean fewer women, and thus also less pressure on the health system.

Now, looking at the second scenario with regard to the number of midwife, nurse, and physician graduates doubling by 2020, consider the following question:

What is the likelihood that your country could double the number of doctors, midwives, and nurses graduating by 2020?
What are the barriers or challenges to doubling the number of graduates in your country? How could these barriers or challenges be overcome? What would the government's role — or the development partners' role — be in addressing those challenges? And how could your midwives' association contribute to increasing the number of graduates?

Looking at the third scenario with regard to improving efficiency by 2030, consider the following questions:

What are the major issues that contribute to reducing midwives' productivity?
For example, are you always waiting for necessary supplies and equipment? Are there not enough patients seeking care? Is there a large administrative burden?

What changes could take place that would improve midwives' productivity?
For example, would sharing more tasks with CHWs or having a dedicated administrative staff person be helpful? What would the government's role — or the development partners' role — be in addressing those challenges? And how could your midwives association participate in implementing this change?

Looking at the fourth and final scenario on reducing attrition of the workforce, consider the following question:

Why are people leaving the midwifery workforce in your country?
For example, is the age of retirement low? Are working conditions better in other countries or in the private sector? Is it only possible to earn a decent salary by combining work in the public sector with work in the private sector? What would the government's role — or the development partners' role — be in addressing those challenges? And how could your midwives association support this change?

DISCUSSION GUIDE: IMPROVING THE HEALTH WORKFORCE'S ABILITY TO MEET THE NEEDS OF WOMEN AND NEWBORNS

Look at the percentages of MET NEED 2030 from the CURRENT TRAJECTORY graph (on the left) and the WHAT IF… TRAJECTORY graph (on the right) and consider the following questions:

Is the percentage of MET NEED shown in the graph on the right higher than in the graph on the left?
If your country applies policies around reducing the number of pregnancies; increasing the supply of midwives, nurses, and physicians; improving efficiency; and reducing voluntary attrition, how much will this affect the ability of the health workforce to meet the needs of women and newborns?

What are some other ways your country could improve its ability to meet the needs of women and newborns in the future?
Remember that the second page of your country brief mostly focuses on availability. How could your country improve the other components of effective coverage, namely accessibility, acceptability, and quality of both health services and the health workforce in your country over time?

Joey O'Loughlin

UNDERSTANDING THE FUTURE TRAJECTORIES

Here are answers to some common questions about why the future trajectories for your country might not look as you would expect.

- **Why is there no difference between the met need under the current and "what if" trajectories in my country?** This may be because you have already reached 100% met need, or because you are failing to reach 100% due to an inefficient skill mix. None of the scenarios provided address skill mix specifically — therefore if you have "too many" auxiliary midwives but "too few" midwives in the current scenario, you will remain at a less than optimal level in the "what if" scenario.
- **Why is there rapid progress projected under the current trajectory?** These trajectories are based on reported data for future enrolments. We recommend asking the country team that contributed your country data to the *SoWMY 2014* report to share the enrollment data reported, and to examine the assumptions used to convert this data to the number of new entrants into the workforce using Annex 5 on p.216 of the *SoWMy 2014* report.

Family Care International

PART III: MAKING THE CASE FOR MIDWIFERY:

HOW TO DEVELOP AN ADVOCACY STRATEGY FOR USING THE EVIDENCE FROM THE *SOWMY 2014* REPORT TO CREATE POLICY CHANGE AT THE COUNTRY LEVEL

MIDWIVES: PARTNERING FOR ADVOCACY

As midwives, your firsthand experience providing care to women and newborns, combined with the findings of the *SoWMy 2014* report, makes you a strong voice for midwifery in your country. Although your midwifery duties are your first concern, consider how you and your midwives association can engage in changing policies and practices through advocacy to improve the AAAQ of SRMNH services. While you may not have resources dedicated to conducting advocacy activities, there may be partners in your country or at the global level, such as the International Confederation of Midwives, Family Care International, or the White Ribbon Alliance, who are well-positioned to help you address the priority issues you identified in Part I and Part II. Consider making a list of priority issues that your midwives association would like to address and seek out partners who share your interest in changing policies around these priority issues.

Partnering with NGOs, coalitions, other professional associations, and UN agencies who already have experience conducting advocacy will increase your chances of successfully advocating for policy change. These partners may also help you gain access to the policymakers and other key stakeholders who have the power to make decisions about strengthening and investing in midwifery in your country.

This section of the toolkit will provide you with some basic ideas about identifying the need for policy change in your country, your target audience, key messages, and other aspects of developing an advocacy strategy. If you have internet access, there are also many online tools, available free of charge, to help your midwives association develop an advocacy strategy.

Identifying the Needed Policy Change in Your Country

Remember that advocacy is the process of building support for an issue or cause and influencing others to take action. This toolkit focuses on conducting advocacy as a way to achieve policy change.

ONLINE TOOLS FOR DEVELOPING AN ADVOCACY STRATEGY

You are encouraged to utilise *The Advocacy Progress Planner: An online tool for advocacy planning and evaluation*[1] *(APP online tool)*, in conjunction with this toolkit. It is a free online workbook you can access at http://planning.continuousprogress.org/ that will allow you to map out your specific advocacy strategy by guiding you through the process of clarifying your goal, objective(s), target audience(s), activities, and inputs. The progress planner will ask you questions as you insert your ideas to help you focus your strategy. You can also share your strategy electronically with other partners.

In addition to the *APP online tool*, there are a range of excellent training and capacity-building manuals and toolkits your midwives' association can use to walk through the steps of developing an advocacy strategy. Three such resources that are easy to use and provide guidance on aspects of planning an advocacy strategy are:

1. Addressing the Health Workforce Crisis: A Toolkit for Health Professional Advocates
   Created by the Health Workforce Advocacy Initiative, this toolkit is designed to assist you as health professionals and civil society organisations to translate your firsthand knowledge into an effective advocacy strategy. To access the toolkit, go to: http://www.healthworkforce.info/advocacy/HWAI_advocacy_toolkit.pdf.
2. Make a Case for Supplies, Leading Voices in Securing Reproductive Health Supplies: An Advocacy Guide and Toolkit
   Created by the Reproductive Health Supplies Coalition, this guide and toolkit offers general information and guidance on advocacy communication that has been useful to many groups interested in advocating for improved reproductive health policy environments. To access the toolkit, go to: http://www.rhsupplies.org/fileadmin/user_upload/toolkit/Advocacy_Guide_and_Toolkit.pdf.
3. The Spitfire Strategies Smart Chart 3.0: An Even More Effective Tool to Help Nonprofits Make Smart Communications Choices
   Created by Spitfire Strategies, this tool will help you in developing your communications campaign by assessing your strategic decisions to ensure your advocacy and communications strategy delivers high impact. To access the tool, go to: http://www.smartchart.org/content/smart_chart_3_0.pdf.

Advocacy can also help to:

- ensure that key decision makers are informed about existing policies and their responsibility for implementing those policies.
- ensure that sufficient financial resources are allocated for programmes and services.
- create support among community members and generate demand for implementing government policies.
- at the grassroots level, inform the general public and opinion leaders about an issue or problem and mobilise them to apply pressure on decision makers to take action.

It is important to distinguish advocacy from behaviour change communication (BCC), as well as from information, education and communication (IEC). Advocacy, BCC, and IEC are similar in that they are all focused on raising awareness about a particular issue. However, BCC and IEC are ultimately aimed at changing behaviour at the individual level, whereas advocacy activities are aimed at mobilising collective action and promoting social or legislative changes at the national, district, or community levels.

Your advocacy efforts should be based on a clear understanding of the policy change that needs to happen in your country in order to strengthen midwifery and provision of SRMNH

DISCUSSION GUIDE: YOUR COUNTRY'S NATIONAL PLANS AND POLICIES

According to the *SoWMy 2014* report,[54] all of the 73 countries included have at least one plan, policy, or piece of legislation in place for organising, delivering, and monitoring SRMNH services.

Identify your country's existing plans and policies on SRMNH care by considering the following questions:

Does your country have a national health plan? (Keep in mind that it may be referred to by another title.)
Does your country have a national SRMNH plan, strategy, or roadmap?
Does your country have a national HRH plan?
What other policies does your country have on how SRMNH services should be delivered?

Note that the *SoWMy 2014* report found that most countries with national health, SRMNH, and/or HRH plans reported that these are recently developed plans (72% of the plans were published in or after 2009). Most of the plans are still current, covering a period up to or beyond 2014, which means that you have an excellent opportunity now to advocate for implementation of those plans and policies.[55]

Review your country's national plans and policies:

If you do not have access to the plans and policies, work with your midwives association, an NGO advocacy partner, or a regulatory body to request and obtain copies of the plans and policies. Using the questions in each of the respective *Advocating for Availability, Accessibility, Acceptability, and Quality* sections in PART I of the toolkit, review your country's plans and policies.

Are there existing policies that need to be updated or reformed?
You may find that your country has plans and policies in place, but there are gaps that need to be addressed in order to strengthen midwifery and SRMNH service provision. You may want to consider developing an advocacy strategy to fill those gaps, remove outdated aspects of the policy, or to revise the policy to better address realities facing midwives today.

For example, in Uganda, there have been successes in decentralising midwifery licensing and registration to regional centres to take services closer to the people. There has also been a review of the *Nurses and Midwifery Act* and a draft amendment bill is being considered by the Ministry of Health.

Also, refer back to the example of *Expanding Access to Quality Family Planning Services in Nigeria* on page 17 of this toolkit for more information about how a policy was updated to allow community health extension workers to provide injectable contraceptives and decrease the unmet need for family planning.

Is there a need to develop new policies?
If your country does not have a policy in place on the aspect of AAAQ that you are prioritising, you may want to consider developing an advocacy strategy to create a new plan or legislation on your issue, or analyse how your priority issue could be incorporated into existing policies.

For example, in Cote d'Ivoire, a new law establishing the *Ivory Coast Board of Midwives and Male Midwives* was adopted in late 2013 and the passage of this law now recognises midwives in legislation.

Also, refer back to the example of *Afghanistan Moving Forward with Midwifery Education* on page 30 of this toolkit for more information about how the Afghan Midwifery Association advocated for the development and establishment of official midwifery education degree programmes at Kabul Medical College.

Are there harmful policies that should be overturned?

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services. Use the *Discussion Guide* to identify the policy change(s) that would be needed in your country in order to address the priority issues around midwifery that you identified during your discussions of Part I and Part II of this toolkit.

Following your review of your national plans and policies, consider how the following key findings highlighted in the *SoWMy 2014* report pertain to improving AAAQ for women and improving education, regulation, and professional associations in your country. These findings are based on all the *SoWMy 2014* country data gathered and the policy dialogue workshops held; the findings inform and are incorporated into the *Midwifery2030* vision.[56] Consider whether these gaps could be addressed through your advocacy at the country level.

Be prepared to make the case for why a policy must be changed. Gather stories from midwives and others in the health workforce or the communities you serve that highlight why the policy needs to be eliminated. Consider whether a new policy needs to be written to take the place of the policy you are working to overturn.

Does your country have an existing policy which is strong but which is not being implemented? Consider what barriers exist to implementing the policy. Is there a lack of financial resources being allocated to strengthening midwifery services and implementing the existing policy? Is there a lack of awareness of the policy among government officials, regulatory authorities, health facility managers, the general public, and midwives themselves? Lack of implementation of a policy may also be a sign that the policy needs to be updated or reformed to better address the current needs of the SRMNH health workforce.

For example, in Nigeria, midwives' attendance at continuing professional development sessions was recently mandated with the development of specific modules for midwives and this is now a pre-condition for renewal of licences.

Refer back to the example of *Tracking Policy Implementation of Staffing Levels* in Tanzania on page 31 of this toolkit for more information about advocacy efforts to ensure that the number of skilled medical personnel, including midwives, is available at health facilities in accordance with existing Ministry of Health guidelines.

Table 2.0

KEY FINDINGS FROM SoWMy 2014 COUNTRY DATA AND WORKSHOPS	HOW MIDWIFERY2030 RESPONDS TO THE KEY FINDINGS
Lack of data to support HRH policy and planning.	**Highlights** the need for a minimum HRH dataset on a country's midwifery workforce.
Workforce shortages and deficits in relation to projected need.	**Recognises** the importance of making the profession and career of a midwife attractive, having quality midwifery education pathways, deployment strategies, and strategies to improve retention and reduce attrition.
Lack of clarity of roles and tasks and a mismatch between expected roles and readiness, and capacity to undertake the tasks.	**Includes** HRH planning to review roles, tasks, and responsibility and provide clarity. This process can focus on provision of the right SRMNH services by the right provider at the right time and in the right location, and reducing duplication.
Gaps in the provision of antenatal interventions in the benefits packages.	**Recommends** models of practice to ensure that women and their newborns have access to care across the continuum.
Gaps in the capacity for family planning counselling and interventions to be delivered effectively.	**Enables** family planning to be delivered through a collaborative midwifery workforce that includes CHWs or similar cadres.
Cost and geography affects accessibility to care.	**Advocates** for first-level care to be provided close to women's homes and communities, with referral pathways and access to transport.
Disrespect and abuse as drivers of non-acceptability to women.	**Ensures** that education incorporates respectful care and sociocultural sensitivity as part of pre-service and in-service training. **Recognises** that an enabling, sufficiently resourced, safe, and supportive practice environment facilitates respectful care.
Limitations: in the number of midwives educated and retained; in the quality of education — facilities, faculty, standards and clinical exposure; in having either no regulatory authority, or no regulatory authority able to fulfil its role of protecting the public; in the ability of professional associations to advocate effectively for midwifery and SRMNH services.	**Is firmly grounded** in the need for a commitment to education, regulation, and association. **Highlights** the importance of an enabling professional environment to ensure that the midwifery workforce has the readiness, authority, and capacity to undertake the roles for which they have been educated.

Reaching Policymakers and Other Decision Makers

Based on your discussion of your country's national plans and policies, you should have honed in on whether you need to update or reform an existing policy, develop a new policy, overturn a harmful policy, or advocate for implementation of an existing policy. In order for this to happen, you will need to reach policymakers and other decision makers, such as members of regulatory bodies, heads of training institutions, or health facility managers, with your request, either directly or indirectly. You may need to do some research, or enlist the help of other individuals or organisations that have more experience in the policy-making process, to find out the following:

- **Who can make the policy change?** Who are the policymakers, agencies, committees, offices, and/or institutions inside your country's government, or other institutions which have an impact on midwifery in your country, who have a role with regard to your issue? Who specifically can play a role in making the policy change you want to achieve?
- **How will the policy change be made?** Depending on what policy change you want (i.e., creating a new policy, updating a current policy, etc.), there will be different approaches policymakers must take.
- **What messages will persuade policymakers to change policies or to create new policies on midwifery?** The *SoWMy 2014* report key messages appear throughout this toolkit and are included in Appendix A. In addition to evidence from the *SoWMy 2014* report, consider what arguments would be most persuasive to the policymaker you need to influence. For example, policymakers responsible for the national health budget may be persuaded to make policy changes if you tell them about ways that investment in the midwifery health workforce could lead to cost savings within the national health system. Try sharing the **KEY *SoWMy 2014* MESSAGE: Investing in midwifery education, with deployment to community-based services, could yield a 16-fold return on investment in terms of lives saved and costs of caesarean sections avoided, and is a "best buy" in primary healthcare.** The online resources in the text box on page 43 will also help you to identify the best messaging for each of your target audiences for advocacy.

The policymakers you need to reach may be Members of Parliament (MPs). MPs have varying levels of authority to create policy and influence the allocation of funding through their role in the budgetary process. Parliamentarians are the principle vehicles for translating political will into policy. Hence, they are able to hold the government to account for both national and international commitments, create a conducive political environment, and generate media visibility around an issue.[57]

However, it is important to note that many countries are shifting from national to district-level decision making. The decentralisation of policymaking, fiscal authority, and service provision means that local-level individuals and organizations are critical gatekeepers for implementing national government policies.

Based on the following and depending on the policy change you want to achieve and the political environment you are working within, you may need to adapt your advocacy strategy in order for it to have an impact. You may also need to consider a multi-pronged approach of directing your efforts to reach both policymakers and others who can influence policymakers simultaneously.

Katy Woods, White Ribbon Alliance

DISCUSSION GUIDE: WORKING WITH PARTNERS TO REACH POLICYMAKERS

Strong partnerships with other groups and organisations can be essential to creating positive policy change. Forming a broad-based coalition with allies that also hold national-level standing can strengthen and bring further credibility to your effort. Partners can contribute:

- political and media connections,
- expertise in advocacy, communications, and knowledge of opposition within the political landscape, and
- human resources, funding, and other in-kind contributions.

Also, when working to influence and change policy, policymakers may prefer to give their support on an issue to a larger alliance that represents the voices of many so they are not viewed as favouring one single association or a particular agenda.

With this in mind, consider the following questions:

How can you best work with policymakers?
This may be as simple as requesting a formal meeting with a policymaker to share the *SoWMy 2014* findings about midwifery in your country and requesting their support in making policy changes or increasing investment in midwifery. There may also be public forums or hearings where you can engage with policymakers. Work with your midwives association and other partners to determine the best way to work with and inform policymakers in your country.

Does your midwives' association know of other groups that have a direct relationship with the policymakers you need to reach?
There may be other individuals, health worker associations, organisations, or alliances/coalitions, including community-based organisations and women's groups, that already have relationships or influence with policymakers in your country. Do some research to find out if their work aligns with the policy change you want to achieve. Reach out to these potential partners/allies to ask whether you can work with them on joint advocacy. Also consider working with groups that are affected by the SRMNH policies you are advocating to change, for example, organisations of mothers or other health professional associations.

Who else can your midwives' association directly influence, who can then, in turn, influence the policymakers you need to reach?
Sometimes it is not possible to reach policymakers directly. When this is true, try to identify who might be able to reach and influence policymakers responsible for SRMNH policies. These individuals could be staff members of policymakers, other politicians or decision makers, religious or community leaders, heads of health facilities, etc. Request meetings with these specific individuals, share the findings from *SoWMy 2014* with them, and request their help in advocating for support of midwifery with key policymakers. Also consider how public opinion and the media can play a part in influencing the policymakers. Joining partners in a campaign to draw public attention to the life-saving role that midwives play in providing SRMNH services and the need for further investment in midwifery, using findings from the *SoWMy 2014*, may motivate policymakers to take action.

Katy Woods, White Ribbon Alliance

Timing the Delivery of Your Effort

In addition to identifying who can help you achieve your advocacy strategy to improve the AAAQ of SRMNH services in your country, it is important to consider the timing of your advocacy efforts.

Connecting with Global Initiatives Advocating for Midwifery

The *SoWMy 2011* report encouraged international organisations, global partnerships, donor agencies and civil society to get involved and play their part to improve midwifery services by encouraging international forums and facilitating exchanges of knowledge, good practices, and innovation as well as encouraging the establishment of a global agenda for midwifery research and support for the agenda's implementation at the country level. The *SoWMy 2014* report highlights a number of global efforts that have been launched to draw attention to improving midwifery:

- The Second Global Midwifery Symposium (May 2013) brought together midwives; policymakers; and representatives of NGOs, donor partners, and civil society to discuss various issues around midwifery strengthening, showcase results, and innovations and address challenges.
- *The Lancet* Special Issue on Midwifery (June 2014): aims to consolidate and improve the available knowledge on midwifery to facilitate evidence-based decision making at country level in support of effective RMNCH services.
- The H4+ including UNFPA and WHO, is providing technical support to regions and countries on midwifery workforce assessments, quality of care, and national policy. Countries where these assessments are currently underway include Afghanistan, Bangladesh, Benin, Democratic Republic of Congo, Guinea, Mozambique, Tanzania, and Togo, with an assessment starting soon in Nigeria.
- Civil society organisations are active participants in global, regional, and national forums on midwifery.[58]

How do these efforts affect your midwives' association? What can you do to connect with these stakeholders?

As you move forward, consider how your advocacy efforts can leverage and connect with other global initiatives for midwifery. The *SoWMy 2014* report lists the following campaigns and guidelines that you can learn more about. Consider whether your advocacy efforts at the country level can help your country achieve the actions and targets set out by these global initiatives.[59]

DISCUSSION GUIDE: TIMING YOUR ADVOCACY EFFORT FOR MAXIMUM IMPACT

Depending on your government's policy cycle, you will want to find out if there are any upcoming key moments for advocating on your priority issues. Consider the following:

Are policymakers currently working on other legislation related to SRMNH services?
Use the opportunity to draw attention to the importance of midwives and the health workforce in providing SRMNH care that is available, accessible, acceptable, and of high quality. Request that the SRMNH-related legislation currently under consideration includes support for strengthening the midwifery health workforce in order to improve SRMNH outcomes.

When is your country's budget cycle starting?
If not enough resources are being invested in midwifery, consider timing your advocacy efforts to coincide with the time period when the government is developing its budget for the next fiscal year. If policymakers are considering making cuts to the budget lines that support midwifery services, make sure that your voice is heard during the debate by partnering with organisations who are already advocating around the national budget. Share messages from the *SoWMy 2014* report to make the case for investing in midwifery.

Are there global days coming up, such as the International Day of the Midwife, that could help draw attention to your advocacy asks?
The International Day of the Midwife is observed each year on 5 May. Other global days to consider include International Women's Day observed 8 March and International Day of the Girl observed 8 October. Your country may also observe special days which would provide a good opportunity for highlighting your advocacy to strengthen midwifery and provision of SRMNH services.

When will the national launch of the SoWMy 2014 report take place in your country?
The release of the *SoWMy 2014* report is itself an exceptional key moment and opportunity for advocacy. National midwives associations should play a key role in national launches which can be coordinated in partnership with UNFPA, WHO, and other national partners. Visit the *SoWMy 2014* report page at www.sowmy.org for updates on country launches. Also consider other opportunities such as upcoming political events or elections, holidays, or significant anniversaries related to your issue.

Table 3.0

GUIDELINES / CAMPAIGN	TARGET YR	ACTIONS / TARGETS
Stillbirths	2000	For countries with a current stillbirth rate of more than 5 per 1,000 births, the goal is to reduce their stillbirth rate by at least 50% from the 2008 rate. For countries with a current stillbirth rate of fewer than 5 per 1,000 births, the goal is to eliminate all preventable stillbirths and close equity gaps.
Preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries		To improve sexual and reproductive health outcomes among adolescents by reducing the chances of early unwanted pregnancy which can result in poor health outcomes, by: • reducing pregnancy before the age of 18 years; • eliminating early and forced marriage; • addressing sexual abuse and violence against women and girls; • increasing the availability and use of contraception among adolescents who want to prevent pregnancy; • reducing unsafe abortion among adolescents; • increasing the use of skilled antenatal, childbirth, and postnatal care among pregnant adolescents; • preventing sexually transmitted infections, including HIV.
Global plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive	2015	The estimated number of new HIV infections in children is reduced by at least 85% in each of the 22 priority countries. The estimated number of HIV-associated pregnancy-related deaths is reduced by 50%.
Family Planning 2020	2020	To make available affordable, lifesaving contraceptive information, services, and supplies to an additional 120 million women and girls with unmet need for contraceptives in the world's poorest countries.
Global targets 2025 to improve maternal, infant, and young child nutrition	2025	• 50% reduction of anaemia in women of reproductive age. • 30% reduction in low birth weight. • increase the rate of exclusive breastfeeding in the first 6 months to at least 50%.
A Promise Renewed	2035	All countries to lower child mortality rates to 20 or fewer deaths per 1,000 live births.
Ending Preventable Maternal Mortality	2030	To reduce maternal mortality ratios to less than 70 per 100,000 live births.
Every Newborn Action Plan	2030 and 2035	To reduce neonatal deaths to fewer than 12 per 1,000 live births by 2030 and fewer than 10 per 1,000 live births by 2035. To reduce stillbirths to fewer than 12 per 1,000 total births by 2030 and fewer than 10 per 1,000 total births by 2035.

Conclusion

Joey O'Loughlin

According to the *SoWMy 2014* report, almost all countries have made progress in reducing their maternal mortality ratios.[60] This progress can be attributed to the fact that many low-income countries have improved access to midwifery care.[61]

As midwives, you can be the most appropriate care providers to attend women during pregnancy, labour, birth, and the postnatal period. Midwifery care takes place in partnership with women and is personalised, continuous, and non-authoritarian. As a result, midwifery care actively promotes and protects women's wellness, supports women's reproductive rights, and respects ethnic and cultural diversity.[62]

As experts in woman-centered care, you are well positioned to raise your collective voice to advocate for strengthening the midwifery workforce and services in your country. The knowledge and understanding you have of the state and future of your country's midwifery provides you with a valuable opportunity to make a difference and create the positive policy change necessary for women and newborns.

Your country has a unique opportunity to make rapid progress towards realising the universal right of access to high-quality SRMNH services, with midwifery as one of its core components. Together, with partners, allies, policymakers, and community leaders, individual midwives and national midwives' association can forge a new future for the profession of midwifery, advocating to ensure that life-saving services are provided to women and newborns by a well-equipped and supported midwifery workforce.

Appendices

Appendix A – *SoWMy 2014* Report Key Messages

Appendix B – Midwifery2030: A Pathway to Health

Appendix C – *SoWMy 2014* Report Infographic

Appendix D – Estimating Women's and Newborns' Need for the 46 Essential Interventions

Appendix A

KEY MESSAGES

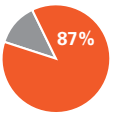
The report shows that:

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

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

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

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



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

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

7 Legislation, regulation and licensing of midwifery allow midwives to provide the high-quality care they are educated to deliver and thus protects women's health. High-quality midwifery care for women and newborns saves lives and **CONTRIBUTES TO HEALTHY FAMILIES AND MORE PRODUCTIVE COMMUNITIES.**

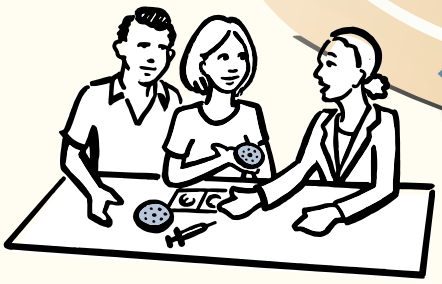
8 The returns on investment are a "best buy":

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

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

MIDWIFERY2030

A PATHWAY TO HEALTH

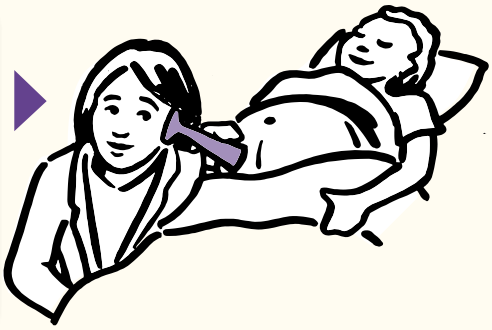


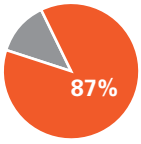
PLANNING AND PREPARING *means:*

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

ENSURING A HEALTHY START *means:*

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



CHALLENGE	SOLUTION	IMPACT	PROGRESS
Only 4 of the 73 countries have a midwifery work-force that is able to meet universal need for the 46 essential interventions for SRMNH.	Midwives can provide **87% of the needed essential care** for women and newborns if educated and regulated to international standards. 	Investing in midwives could give a **16-fold return** on investment. 	Bangladesh is educating **500 midwives** who can potentially save around **36,000 lives.** 

WHAT MAKES THIS POSSIBLE?

1. **All women of reproductive age,** including adolescents, have universal access to midwifery care when needed.
2. **Governments** provide and are held accountable for a supportive policy environment.
3. **Governments** and health systems provide and are held accountable for a fully enabled environment.
4. **Data collection and analysis** are fully embedded in service delivery and development.
5. **Midwifery care** is prioritized in national health budgets; all women are given universal financial protection.

SUPPORTING A SAFE BEGINNING *means:*

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

CREATING A FOUNDATION FOR THE FUTURE *means:*

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

6

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

7

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

8

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

9

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

10

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

STATE OF THE WORLD'S MIDWIFERY 2014 REPORT

CHALLENGES

The 73 countries profiled in the 2014 report account for:

96% of all maternal deaths

91% of all stillbirths

93% of all newborn death

but only have 42% of the world's midwives, nurses, and doctors.

Millenium Development Goals (MDG) 4, 5: Reduce child and maternal deaths by 3/4

In 2013, **289,000** women died from childbirth complications. Nearly **3 million** newborns die in the first month of life and **2.6 million** newborns are stillborn each year.

In sub-Saharan Africa a woman is **100 X MORE LIKELY** to die in pregnancy or childbirth than a woman from an industrialized country.

To help health systems provide effective coverage, actions in the four key areas of impact can be:

AVAILABILITY + **ACCESSIBILITY** + **ACCEPTABILITY** + **QUALITY**

- Educate more midwives and use international standards
- Ensure financial protection for access to basic health services
- Provide respectful care
- Close gaps in infrastructure and resources for maternal and newborn health
- Ensure that midwives can focus on midwifery practice
- Bring midwifery services close to women
- Dispel common misperceptions about midwives
- Regulate, register and re-license midwives

Implementing quality midwifery services could prevent about TWO THIRDS of women's and newborns' death globally.

IMPACT

Investing in educated and well-trained midwives can save **MILLIONS** of lives each year.

Contribute to healthier families and communities

Help **end** preventable child and maternal deaths

Can yield a **16x return** on investment

87% of the essential care for women and newborns can be performed by an educated midwife.

BANGLADESH CASE STUDY

- 500 educated and deployed midwives can reduce maternal mortality by **over 80%**
- Decrease infant mortality by **75%**
- Over the course of a 30-year career, **save over 36,000 lives**

#SoWMy2014

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Appendix D

ANNEX 4: ESTIMATING WOMEN'S AND NEWBORNS' NEED FOR THE 46 ESSENTIAL INTERVENTIONS

Essential intervention (SRMNH)	Need (defined as number of contacts with a health care worker by the population in need)	Data requirements and sources
PRE-PREGNANCY		
1. Family planning advice	All WRA (i.e. women aged 15-49), one contact per year.	**Indicator:** Number of WRA (2012-2030). **Source(s):** United Nations population database, medium fertility, 2012 revision (available from: http://esa.un.org/wpp/unpp/panel_indicators.htm).
2. Family planning methods – delivery	All WRA who use one of the following contraception methods: condoms/ pills/ injectables/ IUD/ female sterilization. For each year y, need is defined for each method as follows: 1. Need for condoms (y) = WRA (y) x (CPR + unmet need) x condom method mix x 3. 2. Need for pills and injectables (y) = WRA (y) x (CPR + unmet need) x method mix (pills + injectables) x 3. 3. Need for IUD = [WRA (y) x (CPR + unmet need) x IUD method mix] / 5. 4. Need for female sterilization (y) = [WRA (y) – WRA (y-1)] x (CPR + unmet need) x sterilization method mix.	**Indicator:** CPR (latest available figure) **Source(s):** WHO Global Health Observatory (available from: http://apps.who.int/gho/data/node.main.531?lang=en).
		Indicator: Unmet need for family planning. **Source(s):** United Nations Statistics Division, Millennium Development Goals Indicators (latest year available); WHO Global Health Observatory (latest year available) (available from http://unstats.un.org/UNSD/MDG/Data.aspx); DHS StatCompiler (available from: http://www.statcompiler.com/); Partnership in Action 2012-2013 Report (available from: http://www.familyplanning2020.org/images/content/documents/FP2020_Partnership_in_Action_2012-2013.pdf); Angola, Botswana: Alkema L, Kantorova V, Menozzi C, Biddlecom A. National, regional, and global rates and trends in contraceptive prevalence and unmet need for family planning between 1990 and 2015: a systematic and comprehensive analysis. *Lancet* 2013; 381:1642–52.
		Indicator: Prevalence of contraceptive method mix. **Source(s):** Seiber E, Bertrand J, Sullivan T. Changes in contraceptive method mix in developing countries. *International Family Planning Perspectives 2007;* 33(3). (available from: http://www.guttmacher.org/pubs/journals/3311707.pdf). **Note:** Information in this source for our purposes is only available for the following methods: IUD/ pill/ injectable/ condom/ female sterilization. Implants are apparently excluded from method mix because they account, across countries, for less than 1% of all contraception methods.
3a. Prevention and management of STIs and HIV in all WRA: prevention of STIs and HIV	All WRA, one contact per year.	**Indicator:** Number of WRA (2012-2030). **Source(s):** United Nations population database, 2012 revision (available from: http://esa.un.org/wpp/unpp/panel_indicators.htm).
3b. Prevention and management of STIs and HIV in all WRA: management of STIs	All WRA with syphilis, gonorrhoea, chlamydia or trichomoniasis. For each year y, calculated as follows: 1. Need for management of syphilis (y) = WRA (y) x incidence of syphilis. 2. Need for management of gonorrhoea (y) = WRA (y) x incidence of gonorrhoea. 3. Need for management of chlamydia (y) = WRA (y) x incidence of chlamydia. 4. Need for management of trichomoniasis (y) = WRA (y) x incidence of trichomoniasis.	**Indicator:** Incidence of STIs in WRA. **Source(s):** WHO. Global incidence of selected curable sexually transmitted infections by region. Geneva: WHO, 2008 (available from: http://apps.who.int/iris/bitstream/10665/75181/1/9789241503839_eng.pdf?ua=1).
3c. Prevention and management of STIs and HIV in all WRA: management of HIV	All WRA needing ART, calculated as follows: Number of WRA needing ART in 2012 / WRA in 2012 x WRA (y).	**Indicator**: % of WRA needing ART (number of adults needing ART x % of HIV positive adults who are women). **Source(s):** Number of adults needing ART (available from: http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/); some countries' individual sources; % of HIV positive adults who are women (number of female adults who are HIV positive / number of all adults who are HIV positive) from UNAIDS AIDSinfo database (available from: http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/); some countries' individual sources.
4. Folic acid fortification/ supplementation	All WRA, one contact per year.	
PREGNANCY		
5. Iron and folic acid supplementation	All PW, one contact per year.	
6. Tetanus vaccination	All PW, one contact per year.	
7a. Prevention and management of malaria with insecticide-treated nets and antimalarials: prevention	All PW living in areas of high malaria transmission, calculated as follows: Need for prevention of malaria (y) = PW (y) x % population in the country living in areas of high malaria transmission.	**Indicator:** % population living in high malaria transmission areas (number of people living in high risk areas (or if not available, used living in active foci)/total population). **Source(s):** WHO. Annex 6A of the World Malaria Report 2013. Geneva: WHO, 2013 (available from: http://www.who.int/malaria/publications/world_malaria_report_2013/en/).

ANC=antenatal care; ART=antiretroviral therapy; CPR=contraceptive prevalence rate; IUD=intrauterine device; PMTCT=preventing mother to child transmission; pPROM=pre-term premature rupture of membranes; PW=pregnant women; STIs= sexually transmitted infections; WRA=women of reproductive age.

Essential intervention (SRMNH)	Need (defined as number of contacts with a health care worker by the population in need)	Data requirements and sources
PREGNANCY (continued)		
7b. Prevention and management of malaria with insecticide-treated nets and antimalarials: management	All PW with presumed and confirmed malaria, calculated as follows: Need for malaria management (y) = PW (y) x incidence of presumed and confirmed malaria cases.	**Indicator:** Incidence of resumed and confirmed malaria cases in PW, (Number of presumed and confirmed malaria cases/Total United Nations population estimates). **Source(s):** WHO. Annex 6A of the World Malaria Report 2013. Geneva: WHO, 2013 (available from: http://www.who.int/malaria/publications/world_malaria_report_2013/en/).
8a. Prevention and management of STIs (as part of ANC): prevention of STIs and HIV	All PW, one contact per year.	
8b. Prevention and management of STIs (as part of ANC): management of STIs	All PW with gonorrhoea, chlamydia or trichomoniasis (note syphilis is addressed separately below). For each year y, calculated as follows: 1. Need for management of gonorrhoea (y) = PW (y) x incidence of gonorrhoea. 2. Need for management of chlamydia (y) = PW (y) x incidence of chlamydia. 3. Need for management of trichomoniasis (y) = PW(y) x incidence of trichomoniasis.	**Indicator:** Incidence of STIs in PW. **Sources(s):** WHO. Global incidence of selected curable sexually transmitted infections by region. Geneva: WHO, 2008. (available from: http://apps.who.int/iris/bitstream/10665/75181/1/9789241503839_eng.pdf?ua=1).
8c. Prevention and management of STIs (as part of ANC): management of HIV	All PW needing ART to avoid mother-to-child transmission, calculated as follows: Need for management of HIV (y) = % (number of pregnant women needing ART for PMTCT in 2012/ PW in 2012) x PW (y).	**Indicator:** % of HIV positive PW needing effective ART for PMTCT. **Source(s):** For Africa: USAID AIDSinfo (available from: http://www.unaids.org/en/data-analysis/datatools/aidsinfo/); For other regions: UNAIDS. Global Report: UNAIDS report on the global AIDS epidemic 2013. (available from: http://www.unaids.org/en/media/unaids/contentassets/documents/epidemiology/2013/gr2013/UNAIDS_Global_Report_2013_en.pdf); Some countries' individual sources. **Note:** Where value is <500 or <1000, 500 and 1000 values were assumed, respectively; where value is not available for country, the following data were used: HIV positive PW needing ART for PMTCT {region} x (HIV infected females {country}/ HIV infected females {region}).
9. Calcium supplementation to prevent hypertension	All PW, one contact per year.	
10. Interventions for cessation of smoking	All PW who smoke, calculated as follows: Need for smoking cessation interventions (y) = PW x prevalence of smoking in women aged over 15 years.	**Indicators**: Current smoking of any tobacco product (age-standardized rate), all females **Source(s):** WHO Global Health Observatory (available from: http://apps.who.int/gho/data/node.main.1250?lang=en). **Note:** If no data were found for a particular country, used WHO regional average for the countries in the dataset.
11a. Screening for and treatment of syphilis: screening	All PW, one contact per year.	
11b. Screening for and treatment of syphilis: treatment	All PW with syphilis. For each year y, calculated as follows: 1. Need for management of syphilis (y) = PW (y) x incidence of syphilis.	**Indicator:** Incidence of syphilis in PW. **Sources(s):** WHO. Global incidence of selected curable sexually transmitted infections by region. Geneva: WHO, 2008 (available from: http://apps.who.int/iris/bitstream/10665/75181/1/9789241503839_eng.pdf?ua=1).
12+13: Antihypertensive drugs to treat high blood pressure (including low-dose aspirin to prevent pre-eclampsia)	All PW with raised blood pressure and all PW with pre-eclampsia, calculated as follows: Need for antihypertensive drugs (y) = [WRA x (incidence of pre-eclampsia)] + [live births x (incidence of pre-eclampsia)].	**Indicator:** Incidence of high blood pressure and pre-eclampsia in PW. **Source(s):** Dolea C, AbouZahr C. Global burden of hypertensive disorders of pregnancy in the year 2000. Evidence and Information for Policy. Geneva: WHO, 2003 (available from: http://www.who.int/healthinfo/statistics/bod_hypertensivedisordersofpregnancy.pdf). **Note:** Only half of all hypertensive disorders presented in Table 6.1 in the reference paper were considered for the analysis.
14. Magnesium sulphate for eclampsia	All PW with eclampsia and pre-eclampsia, calculated as follows: Need for magnesium sulphate (y) = live births x (incidence of eclampsia + incidence of pre-eclampsia).	**Indicator:** Incidence of pre-eclampsia and eclampsia in PW. **Source(s):** Dolea C, AbouZahr C. Global burden of hypertensive disorders of pregnancy in the year 2000. Evidence and Information for Policy. Geneva: WHO, 2003 (available from: http://www.who.int/healthinfo/statistics/bod_hypertensivedisordersofpregnancy.pdf); Regional rates used according to WHO regions. **Note:** Total eclampsia incidence rates calculated as percentage of pre-eclampsia. Regional rates by WHO regions.

(continued)

Essential intervention (SRMNH)	Need (defined as number of contacts with a health care worker by the population in need)	Data requirements and sources
PREGNANCY (continued)		
15. Antibiotics for pre-term premature rupture of membranes (pPROM)	All cases of pPROM, calculated as follows: Need for antibiotics for pPROM (y) = all births including stillbirths (y) x incidence of pPROM.	**Indicator:** Incidence of pPROM **Source(s):** WHO global survey on maternal and perinatal health, 2005 (available from: http://www.who.int/reproductivehealth/topics/best_practices/GS_Tabulation.pdf?ua=1). **Note:** Where country rate not available used regional rate; where regional rate not available used world total rate.
16. Corticosteroids to prevent respiratory distress	All preterm births (including stillbirths), calculated as: Need for corticosteroids (y) = all births, including stillbirths (y) x preterm birth rate.	**Indicators:** Prevalence of preterm births. **Source(s):** Healthy Newborn Network. Global and national newborn health data and indicators (available from: http://www.healthynewbornnetwork.org/resource/database-global-and-national-newborn-health-data-and-indicators).
17. Safe abortion	All safe abortions, calculated as follows: Need for safe abortions (y) = WRA (y) x rate of safe abortions.	**Indicator:** Rate of safe abortions. **Source(s):** Sedgh G, Singh S, Shah IH, et al. Induced abortion: incidence and trends worldwide from 1995 to 2008. *Lancet* 2012; 379:625-32 (available from: http://www.thelancet.com/journals/lancet/article/PIIS0140673611617868/table?tableid=tbl2&tableidtype=table_id&sectionType=red). **Note:** Where the value was <0.5 used 0.5.
18. Post-abortion care	All unsafe abortions, calculated as follows: Need for post-abortion care (y) = WRA(y) x rate of unsafe abortions.	**Indicator:** Rate of unsafe abortions. **Source(s):** Sedgh G, Singh S, Shah IH, et al. Induced abortion: incidence and trends worldwide from 1995 to 2008. *Lancet* 2012; 379:625–32 (available from: http://www.thelancet.com/journals/lancet/article/PIIS0140673611617868/table?tableid=tbl2&tableidtype=table_id&sectionType=red). **Note:** Where the value was <0.5 used 0.5.
19. Reduce malpresentation at birth with external cephalic version	All breech births (including stillbirths), calculated as follows: Need for external cephalic version (y) = all births, including stillbirths (y) x incidence of breech births (including stillbirths).	**Indicator:** Incidence of breech presentations. **Source(s):** WHO. Global survey on maternal and perinatal health. Statistics on breech presentations, 2005 (available from: http://www.who.int/reproductivehealth/topics/best_practices/GS_Tabulation.pdf?ua=1). **Note:** Where country rate not available used regional rate; where regional rate not available used world total rate.
20. Induction of labour to manage pre-labour rupture of membranes at term	All cases of pPROM, calculated as follows: Need for antibiotics for pPROM (y) = all births, including stillbirths (y) x incidence of pPROM.	**Indicator:** Incidence of pPROM. **Source(s):** WHO. Global survey on maternal and perinatal health. Statistics on breech presentations, 2005 (available from: http://www.who.int/reproductivehealth/topics/best_practices/GS_Tabulation.pdf?ua=1).
CHILDBIRTH		
23. Normal labour and delivery management and social support during childbirth	All births (including stillbirths), one contact.	
21+22+24. Active management of third stage of labour (to deliver placenta) to prevent post-partum haemorrhage (including uterine massage, uterotonics and cord traction)	All births (including stillbirths), one contact.	
26a. Screen and manage HIV during childbirth – screen if not already tested	All births (including stillbirths) except in those cases when there have been 4 ANC visits, calculated as follows: Need for screening for HIV during childbirth (y) = all births including stillbirths (y) x (1 - % of cases with 4 ANC visits).	**Indicator:** % of antenatal care coverage (4 visits). **Source(s):** United Nations Statistics Division. The official United Nations site for the MDG indicators (available from: http://mdgs.un.org/unsd/mdg/Default.aspx).
26b. Screen and manage HIV during childbirth – treat	All births (including stillbirths) of HIV positive women who have not had 4 ANC visits, calculated as follows: Need for screening for HIV during childbirth (y) = all births, including stillbirths (y) x (% of cases without 4 ANC visits) x % HIV prevalence in all adults.	**Indicator:** % of antenatal care coverage (4 visits) of HIV positive women. **Source(s):** United Nations Statistics Division. The official United Nations site for the MDG indicators (available from: http://mdgs.un.org/unsd/mdg/Default.aspx); UNAIDS AIDSinfo (available from: http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/); some countries from individual sources.
27+28. C-section for maternal/foetal indication (including prophylactic antibiotics for c-section)	All births, including stillbirths, which require c-section, calculated as follows: Need for c-section (y) = all births, including stillbirths (y) x fixed assumption on need for a c-section.	**Note:** Assumption = 0.05 x all births (including stillbirths).

Essential intervention (SRMNH)	Need (defined as number of contacts with a health care worker by the population in need)	Data requirements and sources
CHILDBIRTH (continued)		
29. Induction of labour for prolonged pregnancy (midwife or nurse)	All births including stillbirths that occur after 41 weeks, calculated as follows: Need for induction of labour (y) = pregnancies (y) x % of pregnancies which go beyond 41 weeks.	**Indicator:** % pregnancies terminated after 42 weeks. **Source(s):** OneHealth Model: Interventions treatment assumptions, 2013 (available from: http://futuresinstitute.org/Download/Spectrum/Manuals/Intervention%20Assumptions%202013%209%2028.pdf). **Note:** Assumption = 0.05 x pregnancies.
30+25. Management of post-partum haemorrhage (manual removal of placenta and/or surgical procedures and/or oxytocics)	All births, including stillbirths, where there is post-partum haemorrhage, calculated as follows: Need for management of post-partum haemorrhage (y) = WRA (y) x incidence of post-partum haemorrhage (per 1000 women aged 15-49).	**Indicator:** Incidence of post-partum haemorrhage cases. **Source(s):** Dolea C, AbouZahr C, Stein C. Global burden of maternal haemorrhage in the year 2000. Evidence and information for policy. Geneva: WHO, 2003 (available from: http://www.who.int/healthinfo/statistics/bod_maternalhaemorrhage.pdf).
POSTNATAL CARE		
31-34 and 36-38. Postnatal preventive care	All births (including stillbirths), 4 contacts.	
35. Detect and treat post-partum sepsis (PPS)	All cases of post-partum sepsis, calculated as follows: Need for detecting and treating post-partum sepsis (y) = WRA (y) x incidence of post-partum sepsis per 1000 WRA.	**Indicator:** Incidence of post-partum sepsis. **Source(s):** Dolea C, AbouZahr C, Stein C. Global burden of maternal sepsis in the year 2000. Evidence and information for policy. Geneva: WHO, 2003 (available from: http://www.who.int/healthinfo/statistics/bod_maternalsepsis.pdf).
39. Neonatal resuscitation with bag and mask	All newborns requiring resuscitation, calculated as follows: Need for neonatal resuscitation (y) = live births (y) x 0.01.	**Indicator:** % of newborns requiring resuscitation. **Source(s):** OneHealth Model: Interventions treatment assumptions, 2013 (available from: http://futuresinstitute.org/Download/Spectrum/Manuals/Intervention%20Assumptions%202013%209%2028.pdf). **Note:** around 1% of newborns require resuscitation
40. Kangaroo mother care	All newborns with low birth weight, calculated as follows: Need for kangaroo mother care (y) = live births (y) x % of newborns with low birth weight.	**Indicator:** % of newborns with low birth weight. **Source(s):** UNICEF and WHO. Low birth weight: country, regional and global estimates. New York: UNICEF, 2004 (available from: http://www.unicef.org/publications/files/low_birthweight_from_EY.pdf).
41. Extra support for feeding small and preterm babies	All preterm births (including stillbirths), calculated as follows: Need for extra feeding support (y) = all births including stillbirths (y) x preterm birth rate.	**Indicators:** % of preterm birth. **Source(s):** Healthy Newborn Network. Global and national newborn health data and indicators. (available from: http://www.healthynewbornnetwork.org/resource/database-global-and-national-newborn-health-data-and-indicators).
42. Management of newborns with jaundice	All newborns with jaundice, calculated as follows: Need for management of jaundice (y) = live births (y) x % of newborns with jaundice requiring phototherapy.	**Indicator:** % of newborns with jaundice. **Source(s):** Teune MJ, Bakhuizen S, Gyamfi Bannerman C, et al. A systematic review of severe morbidity in infants born late preterm. *Am J Obstet Gynecol* 2011; 205:374.e1-9. **Note:** Uniform assumption. Sum of incidence in late preterm infants (1245/26,252) and in full-term infants (2033/150,700).
43. Initiate prophylactic ART for babies exposed to HIV	All births, including stillbirths (except when there have been 4 ANC visits) in women who are HIV positive, calculated as follows: Need for prophylactic ART (y) = all births including stillbirths (y) x (1 - % of cases with 4 ANC visits) x % HIV positive adults.	**Indicator:** % of newborns, born from a HIV positive woman, who received prophylactic ART. **Source(s):** United Nations Statistics Division. The official United Nations site for the MDG indicators (available from: http://mdgs.un.org/unsd/mdg/Default.aspx); UNAIDS AIDSinfo (available from: http://www.unaids.org/en/dataanalysis/datatools/aidsinfo/).
44. Presumptive antibiotic therapy for newborns at risk of bacterial infections	All newborns at risk of bacterial infection, calculated as follows: Need for presumptive antibiotic therapy (y) = live births (y) x incidence of bacterial infection in newborns.	**Indicator:** Incidence of bacterial infection in newborns. **Source(s):** Singh S, Darroch JE, Ashford LS. Adding it up: the need for and cost of maternal and newborn care – estimates for 2012. Guttmacher Institute, 2013 (available from: http://www.guttmacher.org/pubs/AIU-MNH-2012-estimates.pdf). **Note:** Uniform assumption of 20%.
45. Surfactant to prevent respiratory distress syndrome in preterm babies	All preterm births (including stillbirths), calculated as follows: Need for surfactant (y) = live births (y) x preterm birth rate.	**Indicator:** % of preterm births. **Source(s):** UNICEF and WHO. Low birth weight: country, regional and global estimates. New York: UNICEF, 2004 (available from: http://www.unicef.org/publications/files/low_birthweight_from_EY.pdf).
46. Continuous positive airway pressure (CPAP) to manage babies with respiratory distress syndrome (RDS)	All newborns with respiratory distress syndrome, calculated as follows: Need for surfactant(y) = live births (y) x incidence of respiratory distress syndrome in newborns.	**Indicator:** Incidence of respiratory distress syndrome in newborns. **Source(s):** Rodriguez RJ, Martin RJ, Fanaroff AA. Respiratory distress syndrome and its management – Chapter 19. In Fanaroff AA, Martin RJ. Neonatal-perinatal medicine: diseases of the fetus and infant. St Louis: Mosby, 2010. (available from http://www.thoracic.org/education/breathing-in-america/resources/chapter-19-respiratory-distress-syndr.pdf). **Note:** Uniform assumption of 1%

End Notes

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