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

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Every second, across the 73 developing countries profiled in the *The State of the World’s Midwifery 2014: Towards Universal Access and Effective Coverage* report, another five women become pregnant. This totals three hundred pregnancies each minute, which is well over 400,000 per day. An annual number of 160 million new pregnancies every year, which is not expected to change for many decades.

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 older, 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, essential 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 privacy. Services, in far too many cases, are of poor quality due to insufficient resources for midwifery education, 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.

You — the midwives and providers of midwifery care for whom this toolkit was developed — are at the heart of the solution. You and your colleagues have the training, the skills, and the commitment to provide women and babies with the care they need. Midwives save lives every day.

But you are a key to progress, because midwives — through your midwives’ associations — can be a profound and powerful voice for change in your countries. You understand the health care needs of women and newborns, because you work to meet those needs every day. You see the gaps in the health care system — in resources, staffing, facilities, and policies — because you struggle to fill those gaps, day in and day out. You speak the truth about midwives’ need for training, for support, and for enabling policies — because this is the job to which you have dedicated your life and your livelihood. And you know — in so many countries — more midwives are needed to join this noble profession.

When midwives speak in a united voice, filled with all of your knowledge and passion, policy makers hear you. Now is the time for you to speak up. Change will come. Lives will be saved, and your country will move forward to a brighter, healthier future.

We and our partners pledge to support you in this urgently important work.

FAMILY CARE INTERNATIONAL
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 Organization
NMR  Newborn Mortality Rate
PMNCH  Partnership for Maternal, Newborn & Child Health
RMNCH  Reproductive Maternal, Newborn, and Child Health
SBA  Skilled Birth Attendant
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
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 so 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). They provide comprehensive sexual 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.

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) will not be reached in many countries, change is happening and maternal mortality has declined.

Despite this progress, women and newborns are still dying because they don’t 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 a shared global agenda, inequalities persist across and within countries with regard to realization of these rights, the ability to obtain quality care, and equality of access.

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-trained, well-equipped, well-supported and authorized. The State of the World’s Midwifery 2014: Towards Universal Access and Effective Coverage (SoWMy 2014) report provides data on the availability, accessibility, acceptability and quality of 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 the health systems and the health workforce in order to ensure that all women and families have access to high-quality midwifery care.

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

Now is the time for assertive, effective, evidence-based advocacy: calling upon and mobilizing 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 mobilize leadership and action to strengthen SRMNH services, and to facilitate the provision of quality midwifery services for all.


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.

This year’s report – SoWMy 2014 – describes the current state of the midwifery workforce. It relates the progress that has taken place since 2011 in increasing the number of skilled and competent midwives (and others with midwifery
skills), improving policies and regulations, and expanding the coverage of midwifery services and quality of care, and lays out the remaining challenges and barriers to further progress. 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 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 based on the one used for the SoWMy 2011 report, with key questions repeated to enable analysis of change over time in the 58 countries that took part in both SoWMy 2011 and 2014 reports.

KEY SoWMy 2014 MESSAGE: The SoWMy 2014 report illustrates the disproportionately heavy burden of poor maternal and newborn health that these 73 countries carry (Figure 1). 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

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

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. A “midwife” is a health professional who is educated to undertake the roles and responsibilities of a midwife regardless of their educational pathway to midwifery. This enables analysis of the diverse ways in which midwifery is delivered by a range of health-care profes-
THE MIDWIFERY2030 VISION

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 prioritized 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 healthcare professionals provide and are accountable for delivering respectful, quality care.
10. Professional associations provide leadership to their members to facilitate quality care through collaboration.

Midwifery2030

At the second Global Midwifery Symposium, held in Kuala Lumpur in May 2013, 29 UN agencies, international NGOs, private partners, national governments and donor agencies pledged commitment in a Joint Declaration to “champion the provision of widely available, accessible, acceptable and high quality midwifery services by supporting the education and empowerment of midwives.” In line with the Joint Declaration, the SoWMy 2014 report provides an evidence base for the state of the world’s midwifery in 2014 and shares a vision for midwifery. 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 midwifery 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).

A Toolkit to Help Midwives Create Policy Change

The goal of this toolkit is to enhance your knowledge, skills, and capacity to conduct advocacy for positive policy change to improve the availability, accessibility, acceptability, and quality (AAAQ) of midwifery services utilizing evidence and key messages from the SoWMy 2014 report.

The publication of the SoWMy 2014 report offers an exceptional opportunity to advocate for the positive policy changes that will strengthen SRMNH services and facilitate the provision of quality midwifery services. Midwives are change makers, which is why this toolkit is written specifically for them and their midwives’
associations. Now is the time for you and your midwives’ association to conduct targeted advocacy efforts, mobilizing decision makers to develop and implement supportive policies, remove or reform harmful policies, or ensure proper funding for implementation of policies and programmes.

Although this toolkit is geared towards midwives and midwives associations, its broader message can be adapted and utilized by 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 more partners and supporters that take up this toolkit and call to action, the more successful the advocacy movement will be.

Since 2011, midwives’ associations 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

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

The policies that you work to develop or change may include written plans, strategies, laws, regulations, codes of practice, or guidelines; they are supportive when they contribute to improving SRMNH outcomes and reducing mortality. National policies, especially in countries with decentralized 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.

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.

In the years since the 2011 report, 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%) report vigorous attempts to improve retention in remote areas, including the introduction of a bonding system and/or incentives
- 52 countries (71%) have data information systems

These statistics show that the majority of high-burden countries have yet to institute supportive policies and therefore there are significant opportunities for advocacy, policy change, and improvement. Policymakers need midwives' associations to inform them of gaps in and needs of the workforce and health system. Together with other country-level stakeholders, midwives’ associations can hold policymak-
ers 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 better understand the evidence in the SoWMy 2014 report in order to develop an advocacy strategy that leads to positive policy change.

You are encouraged to utilize The Advocacy Progress Planner: An online tool for advocacy planning and evaluationxvii (APP online tool) in conjunction with this toolkit. It is a free online workbook you can access from 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 that you can also securely share with specific individuals and other partners.

How This Toolkit is Organized
The toolkit will help you to identify barriers to availability, accessibility, acceptability and quality (AAAQ) of midwifery services in your country and make suggestions about how you could advocate for change. You will be able to do that 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 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 Your Country’s Midwifery
Part I begins with an overview of the country brief, followed by sections 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 (data in the report is from 2012) and its meaning, and in honing in on an advocacy priority. Each section’s conclusion will focus in on specific problems, the barriers to solving them, and policy changes that can help remove those barriers.

PART II: The Future of Your Country’s Midwifery
Part II guides you through the second page of your country brief, which focuses on evidence-based future predictions of your country’s workforce compared to population need from 2012 through 2030. You will be encouraged to discuss these projections and you may find that the priorities you identified in Part I are supported and strengthened, or that this future-focused discussion brings out new ideas for cross-cutting advocacy approaches.

PART III: Your Opportunity to Improve Your Country’s Midwifery
In Part III, a series of questions will guide a discussion of your country’s policies and plans so you can identify the needed policy change around AAAQ to improve SRMNH care and services. You will also discuss how your midwives’ association can reach policymakers and consider when would be an ideal time to do so. Finally, you will be encouraged to consider how you can leverage global initiatives and involve other stakeholders in advocating for midwifery.

Advocating for policy change is a complex endeavor. 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 organizing 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.
The two-page SoWMy 2014 country brief tells the story of the state of your country’s midwifery. 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 on “HOW TO USE THE SOWMY 2014 COUNTRY BRIEFS” on page 50.

Universal access to sexual and reproductive 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 is prepared to deliver universal access to the 46 interventions that are essential for SRMNH. Effective coverage is defined as the proportion of the population who need an intervention, who then receive that intervention and benefit from it.\textsuperscript{xxviii} It can be measured by the availability, accessibility, acceptability and quality of health services and of the personnel providing those services.

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)

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 (or services) women need from pre-pregnancy to the postnatal period. These visits are referred to in the graphic as “episodes of care.”

The following is an example from Bangladesh’s country brief:

The rest of the first page of the country brief provides details on the four components of

### Table 1.0

<table>
<thead>
<tr>
<th>WHERE ARE WE NOW? 2012 DATA</th>
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<tbody>
<tr>
<td>the country’s estimated total population</td>
</tr>
<tr>
<td>the number and percentage of the population living in rural areas</td>
</tr>
<tr>
<td>the number and percentage of women of reproductive age</td>
</tr>
<tr>
<td>the total fertility rate</td>
</tr>
</tbody>
</table>

### 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 |

### WHAT WOMEN AND NEWBORN INFANTS NEED (2012)

1,573,000 PREGNANCIES A YEAR = HOW MANY EPISODES OF CARE?

- **PRE-PREGNANCY** (all women of reproductive age) = 10,953,000
  - family planning visits
- **ANTENATAL** (pregnant x 4) = 6,291,000
  - routine visits
- **BIRTH** = 1,085,000
  - skilled birth attendance
- **POST-PARTUM** (births x 4) = 4,341,000
  - routine visits

Number and distribution of pregnancies (2012)
effective coverage (AAAQ): availability, accessibility (financial and geographic), acceptability, and quality. Remember, the first page of the country brief utilizes 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.

On the second page, the country brief moves on to offer projections of the future evolution of the midwifery workforce compared with the future scale of population need. Using sophisticated computer modelling, country-reported data was combined with other published secondary sources for population, demographics, 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. This means you need to be especially careful in your interpretation of the second page of your policy profile. The evidence presented here does not amount to a set of facts, but rather a series of predictions for the future; they are meant to be a starting point for more detailed analysis, investigation, and policy dialogue in-country.

As your midwives’ association analyses and interprets your country’s country brief, consider the validity of the data overall. Although the data used in your country brief was provided by your country, 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.

KEY SoWMy 2014 MESSAGE: Countries are working to expand and deliver equitable SRMNH services, but 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, which has two sub-components: 
- The availability of health services, a dimension of the right to health, requires functioning public health and health-care facilities, goods and services, and programmes in sufficient quantity.
- The availability of the health workforce is the sufficient supply and stock of health workers, with the relevant competencies and skill mix, which correspond with the health needs of the population. 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.

The SoWMy 2014 report focuses primarily on availability of the health workforce.

Workforce Availability
This graphic on workforce availability, found on the first page of your country brief, shows the
number (by headcount) of all workers reported and the percentage time each one spends on MNH services. This information provides the number of available health workers by their FTE (not all of the health workers spend all of their time on SRMNH); health workers are grouped by category.

This graphic also provides an estimate of how workforce availability compares with need. An estimated percentage (“estimated met need”) summarizes the extent to which the available midwifery workforce, taking into account which health workers provide which services, has enough time to deliver the 46 essential SRMNCNCH interventions to all women and newborns who need them (the 46 essential interventions will be explored further in the section on Financial Accessibility).

The estimate of met need is affected by the package of care (e.g. the 46 essential interventions), the number of health workers reported, the percentage of time they spend on SRMNH services, and the roles they perform.

The previous page graphic is an example of what this graphic looks like; this one is from Angola’s country brief.

**Advocating for Availability**

Now that you have discussed the availability 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 levels of effective coverage in your country are low, your midwives’ association may want to advocate for changing policies and standards impacting availability.

**KEY SoWMy 2014 MESSAGE:** The SoWMy 2014 report found that midwives can fill 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]).

If current workforce planning norms in your country aren’t sensitive to what women and newborns need, there will not be enough midwives available to provide these essential services.

**KEY SoWMy 2014 MESSAGE:** Accurate data on 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 MNH workforce meets the needs of the population.

Are the current workforce planning norms in your country sensitive to what women and newborns need?

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.

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 quality and 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.

**Is midwifery considered an unattractive 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. 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 midwives?

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

Are midwives assigned to too many non-clinical tasks or pre-pregnancy care tasks?

According to the SoWMy 2014 report, many midwives and SRMNH workers spend much of their work time on non-midwifery tasks. Task shifting may also result in midwives dedicating more time to the provision of pre-pregnancy care (such as family planning or HIV services).

Are there other reasons why your country’s midwives do not spend enough time carrying out midwifery tasks and services to be effective?

However, if your country’s workforce does meet 100% (or is more than 90%) of the population’s needs, consider the following questions:

If your country had more midwives, would an improved skill mix make SRMNH teams function better?

Imbalances in the skill mix needed for fully functioning SRMNH teams (i.e., the proportion of physicians, nurses and midwives) may limit the health system’s optimal responsiveness to the health needs of the country’s women. A country’s model of care is decided by the government, so you may want to investigate whether your country has conducted a full workforce assessment.

What else could be done to improve service delivery?

**CASE STUDY**

**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 in Tanzania (WRA) 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 percent at the start of the campaign to 83 percent at its end.

**DISCUSSION GUIDE (continued)**

**Are there other reasons why your country may not have enough midwives?**

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

**Are midwives assigned to too many non-clinical tasks or pre-pregnancy care tasks?**

According to the SoWMy 2014 report, many midwives and SRMNH workers spend much of their work time on non-midwifery tasks. Task shifting may also result in midwives dedicating more time to the provision of pre-pregnancy care (such as family planning or HIV services).

**Are there other reasons why your country’s midwives do not spend enough time carrying out midwifery tasks and services to be effective?**

However, if your country’s workforce does meet 100% (or is more than 90%) of the population’s needs, consider the following questions:

**If your country had more midwives, would an improved skill mix make SRMNH teams function better?**

Imbalances in the skill mix needed for fully functioning SRMNH teams (i.e., the proportion of physicians, nurses and midwives) may limit the health system’s optimal responsiveness to the health needs of the country’s women. A country’s model of care is decided by the government, so you may want to investigate whether your country has conducted a full workforce assessment.

**What else could be done to improve service delivery?**
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 incentivize 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 a profession to pursue, which can be as simple as ensuring that the profession of midwife is listed in the documents provided by the school. In order to meet the future needs of women and newborns in your country, midwifery must also be presented as an attractive career option so a sufficient number of students enroll to become midwives. 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 featuring the consistent presence of a professional association. Education must be incentivized 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.

**KEY SoWMy 2014 MESSAGE:** The SoWMy 2014 report found that investing in midwifery education could yield a 16-fold return on investment with regard to lives saved and cost of caesarean section avoided. xxv

**Improve recruitment policies:** Advocate for improved recruitment policies to the appropriate Ministry or professional body in your country. Or consider advocating for the decentralization 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. xxvi 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 midwives 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 spend on non-clinical tasks. In their day-to-day work, midwives 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 the MNH workers’ skills mix. For example, other cadres like nurses could potentially spend more of their time on the provision of pre-pregnancy care. 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 MNH 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. xxvii 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.
CASE STUDY

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 (WRA) 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:

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 utilization 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 realized.
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, which has two sub-components: 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.

Accessibility of health services – a dimension of the right to health – requires that health facilities, goods and services are accessible to everyone.

Even if there are enough health workers, adequately 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 the number of births in urban areas versus rural areas to indicate the geographical need for SRMNH services. Where data are available, the graph also shows the number of births where a skilled birth attendant (SBA) was reportedly available. This gives you an idea of whether women can access the health workforce in their geographic area.

The following example is from Bangladesh’s country brief:

Financial Accessibility
It is widely recognized 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; a list of the 46 essential interventions is included in Annex 4 of the SoWMy 2014 report.

According to the SoWMy 2014 report, 70 of the 73 countries profiled have a national minimum guaranteed benefits package of SRMNH services that are free at the point of access for all women.

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.
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).xxviii 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 remote, 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 to allow women access to a health facility and an SBA?
Planning, investment and maintenance of all-weather roads, public transportation and health facility emergency transportation 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 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 moved to the city from a rural area where homebirth is the norm and there is mistrust of 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 would be working 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?
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.

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 following is an example from Afghanistan’s country brief:

**DISCUSSION GUIDE: FINANCIAL ACCESSIBILITY**

Look at the percentage of 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 have a national minimum health benefits package that offers an inadequate number of the 46 essential interventions?

Consider the following questions:

- **Could having all 46 essential interventions included in your country’s minimum health benefits package make a significant impact in saving 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. 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.

- **Are there other financial barriers to accessibility women and their families face in your country?**

  Women and their families may face significant legitimate out-of-pocket expenses when accessing SRMNH care. These could include costs related to transportation to/between health facilities or additional costs related to laboratory tests once at the health facility. They may also face unfair and improper out-of-pocket expenses when accessing SRMNH care. For example, women could be asked to provide their own supplies (like gloves or gauze) because the health facility is not well stocked. 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.
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. However, these may be inconsistent with needs and access to care because your country may lack basic information detailing the location and types of health facilities. Advocate with the Ministry of Health for development of a workforce strategy and plan to ensure that the distribution of midwives matches the geographic distribution of pregnant women. Work with the appropriate Ministries to ensure that the workforce strategy addresses how deployment and retention of midwives will be ensured in rural areas, such as through requiring compulsory periods of rural service and improving distribution of training institutions.

**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 health facilities. Discuss other options for helping women access 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. Your midwives’ association may have to do some research to gather this information. 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.

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**CASE STUDY**

**Realizing Women’s Entitlements to Health Services in India**

The Deliver Now India advocacy campaign, organized 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.

Outcomes of the public hearing included: agreement on setting up a grievance unit, including a complaint box at the district hospital; agreement by the chief district medical officer to present data on maternal, newborn, and child health service delivery at monthly meetings of the local government council; and extensive media coverage of the rally and public hearing.
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? 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? xxxiv

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

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 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. xxxv

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?

- 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 organize 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. Such a campaign can increase the public’s involvement in holding the government health system accountable for providing these 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, which has two sub-components:

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.

The acceptability of health services is a dimension of the right to health, which requires that all health facilities, goods, and services are respectful of medical ethics, culturally appropriate, and sensitive to the individual’s needs.
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 and respectful woman-centred 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 evidence that lack of acceptable and respectful care is a disincentive for women to access care. Midwives’ attitudes towards service users matter and provision of women-centred care by all MNH health workers will help prevent disrespect and abuse in health facilities.

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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 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 a role for your midwives’ association in reviewing the policy (for example, to ensure it includes all seven aspects of the Universal Rights of Childbearing Women Respectful Maternity Care Charterxxxvii) 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
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

The White Ribbon Alliance (WRA) 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 organizations 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 policy makers 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 organized 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;
- Mobilize communities to hold local leaders and service providers accountable for respectful maternity care rights; and
- Secure a national-level commitment to institutionalize 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/.

women-centred care and socio-cultural sensitivity as part of midwifery training and continued education.

Mobilizing citizens and providers to demand accountability for respectful care: Raising awareness among women of their right to acceptable care can mobilize citizens to demand greater accountability from local services 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.
The media has a strong influence on all of us. Just one negative news story on an individual case involving midwives can be sensationalized in the media. Stories like this can influence both the general public’s and policymakers’ perception of midwives and can result in a poor opinion of their work and the profession. The White Ribbon Alliance (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 strategy of both WRA Tanzania and WRA Malawi, which engages midwives as mothers and advocates, is a core tactic 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 in the same—they all want the best birth experience and outcome possible (to view the film, go to http://bit.ly/13vEQHW).

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 emphasized 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.

### Quality

The fourth component of midwifery coverage is quality, which has two sub-components:

- **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.

- **The quality of health services** is a dimension of the right to health, which requires that health facilities, goods and services are scientifically and medically appropriate and of good quality.

Even if care and the midwifery workforce are available, accessible and acceptable to the population, poor quality care can 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
- 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 your country brief’s first page (as a column on the right-hand side), focusing on the enabling environment for quality care.
As part of its national campaign to promote midwives, the White Ribbon Alliance in Malawi (WRA) is working with the Ministry of Health (MOH) to make improving the conditions of professional midwifery a 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.

**CASE STUDY**

**Advocating for Ministry Commitments for Midwives in Malawi**

As part of its national campaign to promote midwives, the White Ribbon Alliance in Malawi (WRA) is working with the Ministry of Health (MOH) to make improving the conditions of professional midwifery a 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.

**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 your country’s quality of care, there are excellent tools to consider using. Two such references are:

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/strengthening_midwifery_toolkit/en/.
and care providers across the three key pillars of midwifery: education, regulation and association.

**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.

The following is an example of a graphic found in your country brief that provides information on the strength of the enabling environment within your country; this one is from Azerbaijan:

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?

**Consider these questions on your human resources for health (HRH) strategy:**

- Does your country’s HRH strategy need to be reviewed, improved, or developed in your country?

According to the SoWMy 2014 report, an HRH strategy should include an assessment of a country’s health services packages, national clinical guidelines and curricula. Accurate HRH data and needs-based planning will subsequently inform accurate education planning and financing, including the numbers of students to be accepted into programmes, deployment opportunities, and new graduate posts. Planning must take account of mobility in health labour markets, where regional and global demand for health workers may affect national supply.

**How could your midwives’ association be more involved with the development and/or implementation of the HRH strategy in your country?**
country? What about the HRH data collection process?
Every country needs a minimum HRH dataset with respect to their midwifery workforce; this data should include age, level of education, gender, competency level/educational background, registration status and location. This will enable efficient workforce planning and determination of the appropriate SRMNH team. It will allow the assessment and configuration of the most appropriate skill-mix for the continuum of care, as well as the intake and deployment options to equitably deliver essential SRMNH interventions at scale and quality, and the financing and investment options to achieve universal coverage and access. Reference to basic health geographies, such as districts, may also help improve services in line with need.\textsuperscript{\textsuperscript{16}}

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 your country’s consultation and referral network:
How could your midwives’ association be more involved with the development and/or implementation of inter-disciplinary teamwork and collaboration in education and practice?

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

\textbf{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. There are many challenges to ensuring quality midwifery education, including the inadequacy of secondary education in preparing future midwifery students and the lack of qualified 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:

\begin{itemize}
  \item Are your country’s schools and training institutions aligned with the ICM Global Standards for Midwifery Education?
  \item Could there be ways to improve midwifery students’ educational pathway and provision of opportunities for clinical experience in your country?
  \begin{itemize}
    \item For example, this could include access to simulation training and specialized 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.
  \end{itemize}
  \item How could your country better recruit and retain well-qualified faculty and teachers?
  \begin{itemize}
    \item 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?
  \end{itemize}
  \item Could the percentage of graduates employed in MNH and practising as midwives within one year of graduation be improved?
\end{itemize}
DISCUSSION GUIDE: MIDWIFERY REGULATION

Look at your country’s MIDWIFERY REGULATION 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. Supporting and protecting midwives by law (providing a legal right to practice) is an important recognition of their worth. According to the SoWMy 2014 report, nearly all responding countries have at least one regulatory body, but many lack legislation recognizing midwifery as a regulated profession, clearly described midwifery competencies and education standards, and effective regulatory processes.

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 relicensing in 14 countries (19%).

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 organization 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 organization such as a Board or Council. 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.

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 organizations 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 organizations 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 recognizing midwifery as 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 recognizing 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.xiv

**Does a licensing system for midwives need to be reviewed, improved, or adopted in your country?**
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 practice. In addition, a register of licensed midwives exists in 48 of the responding countries, 28 of which are electronic.xiv

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).xix

Keep in mind that a 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 EmONC basic signal functions that midwives are allowed to practice 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 authorized 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 authorization and provision, with 19 countries stating that midwives perform this even though they are not authorized to do so.

**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 authorized to provide at least one type of family planning product in 71 out of the 73 reporting countries. In 57 countries midwives are authorized to provide contraceptive injection, contraceptive pill, intrauterine device and emergency contraception. Authorization 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 authorized to provide.
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 Free Town and District branches have been established. Of the 13 Districts, five have District Executive Committees representing midwives in those districts, working as advocates for improved health outcomes for women and newborn across the country.

Another strategy ICM is using to strengthen Sierra Leone’s Midwives Association has been through Twinning. A relationship was established with the Dutch Midwives Organization, supporting Sierra Leone to further strengthen its Associations with the establishment of policies and mechanisms for organizational development. For more information about Twinning Projects and Programmes, go to: http://www.internationalmidwives.org/projects-programmes/twinning-twinning-projects-programmes.html.
Integrating Midwifery into Emergency Obstetric Care in Nepal

Due to the nature and geography of Nepal, for many women health posts are the only reasonable level of available health care. 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 post abortion care using manual vacuum aspiration. The Ministry of Health and partner organizations 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 program, aimed at reducing maternal mortality. Safe abortion care, primarily provided by auxiliary nurse midwives, has been fully integrated into emergency obstetric and newborn care, 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 legalized 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.

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 who was currently practising in-country.

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.

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

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’s role in negotiating work or salary issues with the government need to be reviewed, improved, or developed in your country?

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

If midwifery education, regulation, and the role of the midwives’ association could be strengthened in order to address issues with delivery of high quality midwifery services, your midwives’ association may want to advocate for changing policies and standards impacting quality.

Quality education, regulation and associations must be supported to ensure sustainability of midwifery services and to build and sustain momentum for quality maternal and newborn care. Working with government authorities and your midwives’ association to build capacity in midwifery education, regulation, and association can contribute to securing an enabling professional environment.

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

Strengthen midwifery education: Midwives’ training programmes need well-prepared faculty and appropriately resourced programmes; these must include 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, improve faculty recruitment, and improve student retention after graduation. Midwives associations, in conjunction with the government, can also develop and apply accreditation systems with measurable standards and criteria. Quality initial and ongoing education must ensure that midwives remain competent to do their job 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 recognizing 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 re-licensing) that incorporate internationally consistent standards and codes while also meeting country-specific needs. Advocate for legislation or updated policies that recognize the autonomous midwife profession and the role, scope of practice, and competencies of midwives.

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.
The second page of your country brief focuses on evidence-based future predic-
tions of your country’s workforce compared to population need from 2012 through 2030. It
aims to prompt policy discussion on the future evolution of the midwifery workforce com-
pared with the future scale of population need. Remember, these projections are likely future
predictions and not facts. Also, because countries often lack the necessary data in order to
develop these projections, when you review your country brief keep in mind that the analy-
sis should be considered a starting point for policy discussions (including those concerning
the quality of national data).

Projection data in action: This data, along with your discussions of your country brief in Part
I of this toolkit, can help you decide which components of effective coverage (availability, accessibility, acceptability, quality) your midwives’ association may want to advocate for in your country. 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 ser-
VICES means anticipating and responding to future needs. This section shows the evolution of need (expressed as the annual number of pregnancies in urban and rural areas) in the period 2012-2030. Other needs for sexual and reproductive health services will be deter-
 mined by changes in the number of women of reproductive age, including the number of adolescents.

The following graphic is at the top of sec-
don of page of your country brief and focuses on the projected number of pregnancies in your country from 2012 to 2030, distinguishing between rural and urban pregnancies; below left is an example is from Azerbaijan’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 mater-
nal 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.

Below right is an example from Angola’s
country brief:

**KEY SoWMy 2014 MESSAGE:** Investing in quality of care for women and newborn saves lives and contributes to healthier families and more productive communities.
DISCUSSION GUIDE: PROJECTED NUMBER OF PREGNANCIES

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

Consider these questions looking at both urban and rural pregnancies together:

- Is your country’s projected number of pregnancies remaining relatively stable towards 2030?
- Is your country’s projected number of pregnancies decreasing towards 2030?
- Is your country’s projected number of pregnancies increasing towards 2030?

Consider these questions based on the projected number of pregnancies towards 2030:

- Are there ways to improve the availability, accessibility, and acceptability of the health workforce and health services to meet the needs of women and newborns?
- Could there be ways to improve midwives’ contribution to the health workforce and health services, with particular attention paid to the optimal skill mix needed?

DISCUSSION GUIDE: MORTALITY REDUCTION

Look at the mortality reduction targets for your country.

Consider these questions:

- How big is the gap between your country’s maternal mortality ratio and its survival target?
- How big is the gap between your country’s newborn mortality rate and its survival target?
- Is the gap between survival targets for maternal and newborn mortality similar? Or does your country have a longer way to go in order to achieve the maternal survival target or the newborn survival target?

Estimates and Projections

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 following is an example from Bangladesh’s country brief:

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 midwives and auxiliary midwives, 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).

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 are expected to enrol and graduate from educational institutions and programmes and become practicing health workers.

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 the decline of your country’s current health workforce expected by 2030 with the number of newly trained health workers that are expected to join the workforce over the same period of time.

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 data. 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 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 is possible based on what you feel are the most important issues to address in your country.

The graphic below is an example from Angola’s country brief:

The final graphic provided in 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 number of pregnancies is combined with the projected workforce in your country. This is what would happen in the future without any further attention to the workforce.

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 an improved projected 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 attrition (SCENARIO 4: cutting attrition in half in the next five years [2012-2017]).

The graphic on the following page is an example from Afghanistan’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 in your country?

Thinking of this, 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 centred care. In the long term, it would 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 increase midwifery education by 50%? What are the barriers or challenges to increasing midwifery education by 50% 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 lead in this change?

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 lead in 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 lead in 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 increase its ability to meet the needs of women and newborns in the future?

For example, would aiming to reduce the number of pregnancies by 30% instead of 20% potentially have a greater impact? Could there be other ways to improve the effective coverage and the other components of accessibility, acceptability, and quality of both health services and the health workforce in your country?
With your knowledge and understanding of the current and future state of midwifery in your country, you are now better prepared to start developing an advocacy strategy to make the case to policymakers for supporting and strengthening midwifery in your country.

If you have not yet accessed The Advocacy Progress Planner: An online tool for advocacy planning and evaluation (APP), please do so now. It is a free, interactive online workbook you can access from 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.

Your midwives’ association will need to collect information, and potentially do some research in assessing your political environment, and make decisions about your policy change approach. The following sections aim to lead your midwives’ association through some discussions to determine how you will advocate to create policy change in your country.

### Identifying the Needed Policy Change in Your Country

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.

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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 organizations 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.
DISCUSSION GUIDE: YOUR COUNTRY’S NATIONAL PLANS AND POLICIES

According to the SoWMy 2014 report, all of the 73 countries included in the report have at least one plan, policy or piece of legislation in place for organizing, 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 human resources for health (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.

Review your country’s national plans and policies:

If you do not have access to the plans and policies, work with your midwives association 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 decentralizing 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 18 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 prioritizing, you may want to consider developing an advocacy strategy to create a new plan or legislation on your issue, or analyse how your priority issued 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 recognizes midwives in legislation.

  Also, refer back to the example of Afghanistan Moving Forward with Midwifery Education on page 32 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?
  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, midwifery 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 licenses.

Refer back to the example of Tracking Policy Implementation of Staffing Levels in Tanzania on page 30 of this toolkit for more information about advocacy efforts to ensure the number of skilled medical personnel, including midwives, is available at health facilities in accordance with existing Ministry of Health guidelines.

Following your review of your national plans and policies, consider how the following key findings in Table 2.0 on page 44 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. Consider whether these gaps could be addressed through your advocacy at the country level.

Reaching Your Policymakers
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 with your request, either directly or indirectly. You may need to do some research, or enlist the help of other individuals or organizations that have more experience in the policymaking 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 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.

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.

However, it is important to note that many countries are shifting from national to district level decision-making. The decentralization of policy-making, 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.
<table>
<thead>
<tr>
<th>KEY FINDINGS FROM SoWMMy 204 COUNTRY DATA AND WORKSHOPS</th>
<th>HOW MIDWIFERY2030 Responds TO THE KEY FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of data to support HRH policy and planning.</td>
<td>highlights the need for a minimum HRH dataset on a country’s midwifery workforce.</td>
</tr>
<tr>
<td>Workforce shortages and deficits in relation to projected need.</td>
<td>recognizes 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.</td>
</tr>
<tr>
<td>Lack of clarity of roles and tasks and a mismatch between expected roles and readiness and capacity to undertake the tasks.</td>
<td>includes HRH planning to review roles, tasks and responsibility and provide clarity. This process can focus on providing the right SRMNH services by the right provider at the right time and in the right location, and reducing duplication.</td>
</tr>
<tr>
<td>Gaps in the provision of antenatal interventions in the benefits packages.</td>
<td>recommends models of practice to ensure that women and their newborns have access to care across the continuum.</td>
</tr>
<tr>
<td>Gaps in the capacity for family planning counselling and interventions to be delivered effectively.</td>
<td>enables family planning to be delivered through a collaborative midwifery workforce that includes CHWs or similar cadres.</td>
</tr>
<tr>
<td>Cost and geography affects accessibility to care.</td>
<td>advocates for first-level care to be provided close to women’s homes and communities, with referral pathways and access to transport.</td>
</tr>
<tr>
<td>Disrespect and abuse as drivers of non-acceptability to women.</td>
<td>ensures that education incorporates respectful care and sociocultural sensitivity as part of pre-service and in-service training.</td>
</tr>
<tr>
<td><strong>Limitations:</strong></td>
<td>recognizes that an enables, sufficiently resourced, safe and supportive practice environment facilitates respectful care is firmly grounded in the need for a commitment to education, regulation, and association.</td>
</tr>
<tr>
<td>in the number of midwives educated and retained;</td>
<td>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.</td>
</tr>
<tr>
<td>in the quality of education: facilities, faculty, standards and clinical exposure;</td>
<td></td>
</tr>
<tr>
<td>in having either no regulatory authority, or no regulatory authority able to fulfil its role of protecting the public;</td>
<td></td>
</tr>
<tr>
<td>in the ability of professional associations to advocate effectively for midwifery and SRMNH services.</td>
<td></td>
</tr>
</tbody>
</table>
DISCUSSION GUIDE: WORKING WITH PARTNERS TO REACH POLICYMAKERS

Strong partnerships with other groups and organizations 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 favoring 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 policymakers 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, organizations, or alliances/coalitions that already have a relationship 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 with an invitation to join you in developing a joint strategy. Also consider working with groups that are affected by the SRMNH policies you are advocating to change, for example, organizations 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.
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.

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 key moments for advocating on your priority issue coming up. 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 to provide available, accessible, acceptable, and quality SRMNH care and to push for reforms of existing policies.

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 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. 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?

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. Now is the perfect time to raise your voice as the expert of the discussion. Visit the SoWMy 2014 report page at www.unfpa.org for updates on country launches. Also consider other opportunities such as upcoming political events or elections and holidays or significant anniversaries related to your issue.

Connecting with Global Initiatives Advocating for Midwifery

The SoWMy 2011 report encouraged international organizations, 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 its implementation at 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.

- Civil society organizations are active participants in global, regional, and national forums on midwifery.

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.
<table>
<thead>
<tr>
<th>GUIDELINES / CAMPAIGN</th>
<th>TARGET YR</th>
<th>ACTIONS / TARGETS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stillbirths</td>
<td>2000</td>
<td>For countries with a current stillbirth rate of more than 5 per 1,000 births, the goal is to reduce their stillbirth rates by at least 50% from the 2008 rates. 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.</td>
</tr>
<tr>
<td>Preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries</td>
<td>2015</td>
<td>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.</td>
</tr>
<tr>
<td>Global plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive</td>
<td>2015</td>
<td>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%.</td>
</tr>
<tr>
<td>Family Planning 2020</td>
<td>2020</td>
<td>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.</td>
</tr>
<tr>
<td>Global targets 2025 to improve maternal, infant and young child nutrition</td>
<td>2025</td>
<td>• 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%.</td>
</tr>
<tr>
<td>A Promise Renewed</td>
<td>2035</td>
<td>All countries to lower child mortality rates to 20 or fewer deaths per 1,000 live births.</td>
</tr>
<tr>
<td>Ending Preventable Maternal Deaths (Draft)</td>
<td>2030</td>
<td>To reduce maternal mortality ratios to less than 70 per 100,000 live births.</td>
</tr>
<tr>
<td>Every Newborn Action Plan (Draft)</td>
<td>2030 and 2035</td>
<td>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.</td>
</tr>
</tbody>
</table>
According to the SoWMy 2014 report, almost all countries have made progress in reducing their maternal mortality ratios.\textsuperscript{\textit{lxvii}} This progress can be attributed to the fact that many low-income countries have improved access to midwifery care.\textsuperscript{\textit{lxviii}}

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 personalized, continuous, and non-authoritarian. As a result, midwifery care actively promotes and protects women’s wellness and supports women’s reproductive rights and respects ethnic and cultural diversity.\textsuperscript{\textit{lxix}}

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 realizing 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.
End Notes


7 Ibid., p. 14.

8 Ibid., p. 34.


Ibid., p. 46.


Ibid., p. 38.


Ibid., p. 18.


Ibid., p. 23.


Ibid., p. 6.

Ibid., p. 27.

Ibid., p. 27.

Ibid., p. 29.
Ibid., p. 29.

Ibid., p. 29.

Ibid., p. 28.

Ibid., p. 28.

Ibid., p. 28.


Ibid., p. 29.

Ibid., p. 6.

Ibid., p. 30.


Ibid., p. 41.

Ibid., p. 30.

Ibid., p. 31.

Ibid., p. 42.


Ibid., p. 48.

Ibid., p. 5.

Ibid., p. 5.
