Towards MDG 5:
Scaling up the Capacity of Midwives to Reduce Maternal Mortality and Morbidity

Workshop Report
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UNFPA

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Executive Summary

Midwives are vital to preventing the estimated 536,000 maternal deaths and 8 million illnesses and disabilities that occur each year during pregnancy and childbirth. In addition, midwives are crucial to improving newborn health and reducing the estimated three million newborn deaths each year. In countries as diverse as Malaysia, Sri Lanka, Thailand and Tunisia, investments in training, recruiting and retaining midwives, as well as in emergency obstetric care, have reduced maternal death rates.

As documented in the 2005 WHO World Health Report, however, Making Mothers and Children Count, decades of under-investment–and sometimes misguided investment–in human resource development mean that at least 700,000 more midwives are needed today to curb maternal death and illness and to achieve Millennium Development Goal 5–to reduce maternal mortality by 75 per cent by 2015.

It is clear that the lives and health of millions of women and newborns could be saved with greater investments in midwives, emergency obstetric care and family planning. Midwives and others with Midwifery Skills link women, their communities and the health system, ensuring that women and their babies receive vital skilled care during pregnancy and childbirth, and in the important days and weeks after birth.

Urgent support to increase the numbers and skills of midwives would save the lives of 5 million women, prevent 80 million illnesses and disabilities from pregnancy or childbirth and save the lives of countless newborns.

Midwives are also unique in that their competencies[1] also encompass delivery of essential sexual and reproductive health (SRH) services at the primary health care level. Therefore, they can provide pregnancy and delivery care within the full package of SRH services, including family planning to prevent unwanted pregnancies and recourse to abortion. This can contribute to the second MDG 5 target of universal access to reproductive health.

The workshop aimed to contribute to this agenda, and respond to the global focus on human resources for health–the theme of this year's World Health Report. At the workshop, the first of its kind for UNFPA, midwives from developing and industrialised countries, and midwifery

[1] *Core midwifery skills have been defined by the International Confederation of Midwives in the document Essential Competencies for Basic Midwifery Practice (http://www.internationalmidwives.org) see Annex 3 for the full list.*

Midwives – in partnership with women

The barriers are well known. What was new at the workshop… was the recognition that they are rooted in gender inequality. As a primarily female workforce, midwives face many difficulties that their male colleagues do not; because of their sex and associated cultural issues, and also because of their area of work, which in some countries is not yet recognised as a profession. Yet it is the fact that they are women, working in partnership with women, that is valued most frequently by the women they care for, but too often ignored or dismissed by the system in which they work.

advisors working at the international level, discussed with UNFPA staff and UNFPA partners the major barriers to the development of midwifery skills and proposed solutions.

The barriers are well known. Participants at the workshop acknowledged, however, for one of the first times, that these barriers are rooted in gender inequality. As a primarily female workforce, midwives face many difficulties that their male colleagues do not; because of their sex and associated cultural issues, and also because of their area of work, which in some countries is not yet recognised as a profession. The fact that they are women, working in partnership with women, is what is valued most frequently by the women they care for. Yet, too often they are ignored or dismissed by the system in which they work.

"Addressing the shortage of midwives through education, training and deployment to underserved areas would bring us much closer to achieving the Millennium Development Goal of improving maternal health," said Thoraya Ahmed Obaid, UNFPA's Executive Director, in a press release following the workshop. The issue for those countries that have already taken these steps, yet still see too many women and newborns suffer, is quality– poor utilization of midwives' skills, failure to delegate authority, and lack of a supportive policy environment.

1. Background and Rationale for the Workshop

> *"At this defining moment in history, we must be ambitious. Our action must be as urgent as the need, and on the same scale."*
>
> *– Kofi Annan, Secretary General's Report, In Larger Freedom, 2005*

1. At the World Summit of September 2005, 189 Heads of State and Government explicitly accepted universal access to reproductive health as essential for achieving the Millennium Development Goals (MDGs).

2. UNFPA recognises the urgent need to scale up its efforts to make universal reproductive healthcare a reality, and especially to reduce the number of deaths associated with reproduction. This has now become an imperative for the whole organization.

3. The goal cannot be achieved without appropriately skilled health workers. It calls for concerted efforts, in which each partner uses its comparative advantage. UNFPA's Executive Director Thoraya Obaid has pointed out that UNFPA's commitment to work with others to increase investment in the health sector includes joining hands to address human resource shortages, including in reproductive and sexual health. She has pledged UNFPA support for WHO's call in 2006 for a decade of action to address the shortage.

4. As midwives are the healthcare providers closest to where women live, and because they are predominantly women working in partnership with women, the Executive Director acknowledged in her 2006 World Health Day message that midwives hold a very special and central position for UNFPA. As part of its support for professional midwives over many years, UNFPA has been a regular partner with WHO, UNICEF and others, for example in supporting the International Confederation of Midwives' Regional and Triennial Congresses, first launched at the beginning of the Safe Motherhood Initiative in 1987.

5. Many countries need to give more support to skilled primary healthcare providers. UNFPA believes that midwives working at the community level offer the most cost-effective, low-technology, high-quality path to universal access to sexual and reproductive health. High-maternal-mortality countries need more assistance to develop their capacity to recruit, train and support professional midwives. UNFPA recognises that without urgent efforts to address the serious shortage of midwives in many countries, women

and their babies will continue to die needlessly. Women will be left with serious and often life-long disabilities such as obstetric fistulae, and newborns with severe mental or physical disabilities.

"Putting in place the health workforce needed for scaling up reproductive, maternal, newborn and child health services is an urgent task, and we believe that the support of health professional organizations will be crucial."

– Thoraya Ahmed Obaid, Executive Director of UNFPA

6. UNFPA also recognises that midwives' poor working conditions, supplies and support do not reflect their importance. They are also subject to the same gender discrimination as other women.

7. UNFPA decided to hold a consultative workshop to address these issues. The initiative was supported at the highest level of the organization. The Executive Director stated: "Strengthening the capacities of midwives needs to be at the heart of UNFPA business in order to achieve the organization's mandate."

8. The workshop brought together representatives of midwifery, from both North and South, and from countries with transitional economies, with key UNFPA country and HQ staff. Listening to midwives and learning from those who daily face the challenges of providing midwifery care, its purpose was to consider what UNFPA could do at global, regional and national level to help increase the capacities of midwives and reduce maternal mortality. Recommendations from the workshop would help form the UNFPA global strategy for building midwifery capacity, to be implemented at country level and supported and underpinned by regional and global efforts.

9. The workshop focussed on countries facing the most severe shortages of midwifery skills. Shortages were defined as a shortfall in numbers or skills, or both.

10. A background paper set out many of the issues and offered some pointers for UNFPA action. Strengthened by contributions from the workshop, this paper is intended eventually for wide dissemination, including in professional publications. The final version will be available on the UNFPA website.

2. Highlights of the Background Paper

The right to midwifery care - a means to end poverty

Six years after 189 Heads of Sovereign States pledged to halve extreme poverty by 2015[2], the situation for women's reproductive health remains bleak. Efforts to reduce maternal mortality have had little impact. Yet unless women can fully enjoy their right to health, the fight to end global poverty is unlikely to succeed.

Although a few countries have achieved significant reductions the overall number of maternal deaths has not fallen over the last two decades, Lessons learned from these countries have been the subject of many international and regional reviews. Lengthy debates have tried to identify the levers of change.

As the World Health Report 2005 Making Mothers and Children Count elaborates, the reasons for lack of progress are complex. The links between poverty and women's health appear cyclical, one impacting on the other. Poor women come last in access to healthcare; Access to maternity care is especially difficult when it is available only at a cost, whether direct or indirect.

From a human rights point of view, a continuing situation where women die from avoidable causes because they have no access to skilled healthcare is a violation of their human right to health.

The UN Special Rapporteur for the Right to Health Paul Hunt has stated "that women continue to die from avoidable factors, contravenes their right to health." It also contravenes many international treaties and conventions, including the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW), and those related to child health, specifically the Convention on the Rights of the Child.

"Rapid Scale-Up of Midwives Is Vital To Saving Lives of Mothers and Newborns"

[2] *The Millennium Declaration gave rise to the eight Millennium Development Goals (MDGs). MDG 5 is cutting maternal mortality by 75 per cent. Indicators, now including reproductive health, track progress towards achieving the ultimate goal of halving global poverty by 2015.*

Maternal mortality – a blight on humanity

"The failure to address the reproductive health needs of women, and particularly to ensure safety during and around childbirth, is an affront to all women and should be seen as one of, if not the greatest, social injustice of modern times".

Starrs A. The 10-year review of the global Safe Motherhood Initiative, Colombo, 1997

Reducing maternal deaths is linked to woman's status and to gender inequities faced by women, both as maternity service users and as female "skilled care"[3] providers – midwives. Many developing countries' major impediment in providing skilled care, especially at and around childbirth, is the lack of skilled professional midwives in sufficient numbers.

Lack of professional midwifery is the result of gender inequities

The gender dimension of the work involved in caring for pregnant women and their babies before, during and after childbirth is only just being acknowledged in development circles. However the subject has been the focus of much social and anthropological debate in countries in the northern hemisphere.

For cultural reasons, midwives are usually women. And, as women, they face the same gender inequities as the women they care for.

For a variety of reasons, often associated with women's lack of political power, there has been a long-standing reluctance to invest in the training and development of professional midwives and the practice of midwifery. Researchers from both feminist and non-feminist perspectives, including historians, contemporary health planners and strategists, consider that one of the major reasons for this reluctance is that midwives are usually women working with and for women, and as such have not caught the attention of politicians and policy-makers.

As if this were not a sufficient challenge, midwives in many countries face the inevitable hierarchical power struggles within a male-dominated health system. It is demoralising for midwives to work in a system which too often favours high technology, facility-based medical care (often at the behest of men) and which invariably makes invisible all non-physician care other than

[3] *"Skilled care" is described by WHO, IAG on Safe Motherhood and others as the provision of quality care by a competent skilled birth attendant, who is backed by an enabling environment (which is understood to mean sufficient supplies, equipment, logistics and supportive supervision, as well as supportive policy, legal and healthcare financing frameworks); and who is linked through an effective referral network and emergency transport system to a functioning facility with capacities to provide emergency obstetric care for managing complications in both women and newborns.*

nursing.[4] It is a reason for many of them to leave the profession.

Despite these challenges, midwives are strong and vibrant individuals. In the absence of other health care providers and physicians, the midwife provides essential care at birth with little support and under the most adverse conditions. The practice of midwifery calls for great stamina, physical and mental strength and the ability to be flexible, ready for the unexpected – an un-booked birth, undiagnosed twins, or complications of pregnancy, to name a few. Many obstetricians and gynaecologists readily acknowledge that they learned their midwifery skills from midwives.

Midwives work at all levels: but those who work at the primary care level, in the community, find the least respect and support from the health system.

Why "professional" midwife?

The Oxford-based medical historian I. Loudon, whose research looked at 100 years of MMR reduction (Loudon, 2000) wrote: "The finding that surprised me most was that no country has managed to reduce their maternal mortality figures without investing in the capacities of midwives working at the community level undertaking home births."

Professional identity–recognition and acknowledgement as the experts of normal midwifery–is important for many reasons. apart from determining who is and is not competent, and for reporting on the MDGs.

In countries where midwives have a strong professional identity–where there is a professional cadre whose job it is to provide midwifery care, supported by the health system–women and the community respect them and there is high demand for and use of their services. The community begins to give serious attention to care for women in pregnancy and childbirth, which further increases demand. Case studies from Sri Lanka, Malaysia and Thailand provide recent examples, even though in Sri Lanka and to some extent in Malaysia, respect and value for midwives has declined as hospital births increase.

This loss of midwifery identity, as in Sri Lanka for example, leads to problems in providing quality midwifery care. Some experts believe that this works against further reductions in maternal and newborn mortality and morbidity. As respect for the skills of midwives fades, families bypass primary care facilities. Central maternity hospitals must then use scarce resources dealing

[4] *It is acknowledged that nursing is a sister profession to midwifery, but often having different roots. Midwifery has a separate and defined universal code of practice. Midwifery is different to nursing, although both professions share some common competencies, depending on the needs of the health system. It is further acknowledged that the core competencies of the two professions may be found in the same person in some countries. However, in the majority of cases, such providers have to undertake separate courses of study and gain a separate (additional) registration/ license to practice. Holding registration for one profession, does not automatically give license to practice the other.*

with normal births rather than being able to concentrate on giving high quality specialised care to women and newborns with complications, or who have identified risk factors. Equipment, supplies and space become major problems.

Further, as Sri Lanka's Minister of Health acknowledged during a regional workshop in 2005, low esteem for midwifery causes staffing problems for maternity services in the major cities. Many nurses and nurse-midwives do not wish to work in maternity areas; and midwives leave the service for nursing or some other professional discipline. This adds to quality issues in maternity hospitals and militates against further maternal mortality reductions. Unless communities regain respect for keeping birth normal, and with it respect for midwives and what midwives do, families will continue to bypass local services. and instead seek care in the tertiary care units, insisting that only care by the most senior specialist is acceptable. In overcrowded and overstretched facilities, they may not receive the quality of care they expect. Decentralisation may exacerbate the problems.

Building a professional cadre of midwives leads to self-reliance and flexibility, and has the potential for midwives to find their own culturally appropriate solutions. It can also allow them to help solve some of the current service provision blockages.

Competent midwives are required in sufficient numbers to perform three essential functions:

- First to supervise and preferably provide hands-on quality care that is acceptable to women and their families, at the point where women need it most–close to where they live and frequently give birth, and within reach of emergency care whenever necessary.
- Second to teach and supervise other health workers who need some midwifery skills, but are not required to be experts.
- Finally to work with, educate and help empower communities to recognise the need and increase demand for skilled midwifery services.

Lack of a critical mass of professional midwives to deliver quality midwifery care within the health system will hold back efforts to provide quality maternity services; to minimise maternal mortality, and to avoid morbidity among women and newborns, which may impoverish their health and increase economic vulnerability for the rest of their lives.

Increasing midwives' contribution to reducing maternal mortality requires investment

UNFPA recognises the need for significant investment to help countries improve both the numbers and the quality of midwives. Investments may take the form of financial, human or technical support; but investments are also needed in time, energy and thoughtful and technically sound planning and implementation. Improving quality calls for strong regulation; the development of strong and credible professional associations and education institutions; supportive supervision of both public and private midwives, and–most important–raising the profile of midwives. Monitoring these results will not be easy, but will be essential for success.

The value of such investments extends well beyond the reduction of maternal mortality. There will be added value in overall improvements in basic healthcare at all levels of the health system; better control of infectious diseases such as malaria and sexually transmitted infections, including HIV/AIDS; and better and more healthy families as they become educated about their lifestyle choices. Midwives can also help communities address general public health issues, including environmental health.

Professional midwives can work with communities to improve services for pregnancy, birthing women and newborns. Increased community involvement will open this most important life and family event to men, allowing them to exercise their right to be fully and actively involved.

Finally, by offering employment to women, a larger cadre of professional midwives will help to improve the status of women overall and address gender inequalities. Better economic opportunities for women help to alleviate poverty in the family; increase school attendance and education rates, especially of girls, and improve family health. Many studies show that women entering the waged workforce are more likely than men to invest their wages in their families' health and well-being.

However, to function effectively, midwives need regular supplies and equipment; supportive policy and legal frameworks; constructive supervision; an effective referral network, and, critically, support from and partnership with other professional colleagues.

When they are seen as important and valued members of the community and the health sector, midwives can inspire and offer career opportunities to young women. As such they help promote both women's empowerment, and their economic status.

Midwives - a low-technology, high-quality solution that goes beyond MDG 5

Professional midwives do more than deliver babies, as outlined in the international definition, first drafted in 1976 and endorsed by WHO and FIGO and recently revised and endorsed at the 2005 ICM Council meeting, preceding the Triennial Congress meeting in Brisbane Australia.

Midwives care for women during pregnancy, childbirth and the postnatal period. They also offer pre-pregnancy advice and health education; provide care for the newborn; recognise and respond to problems in the women and newborn before, during and after childbirth, and can refer women and newborns for higher level care when complications arise beyond their scope of practice and capabilities. They can, when properly trained, recognise, stabilise and refer women and newborns with problems, including providing emergency care. In addition, they can offer general health education and promotion.

From a recent ICM study on the core competencies of a midwife, it is clear that in many countries midwives are trained during pre-service to offer basic life-saving skills, as well as manage minor ailments that frequently occur during and after pregnancy–although in a number of situations supporting policies prohibit them from performing such services.

Midwives also assist women to establish successful breastfeeding, and may provide family planning counselling and services.

In some countries the role of the midwife has extended to immunization, child health and development and to certain aspects of gynaecology and woman's health. Midwives practise in clinics, hospitals and other facilities, as well as in the community offering home-care.

In recent years there has been a slow but steady increase in the use of midwifery-led birthing units–facilities where midwives provide care for women in childbirth. Such units offer a halfway point for women who want midwifery care and the security of a facility where links can be made to an obstetric unit and referrals managed efficiently. The 2005 World Health Report recognised that the value of further investments in such facilities. A number of studies, including several from developing countries, some of which were randomised controlled studies and appear on the Cochran library site (see Hodnett et al in reference list), show that midwifery-led birthing units can be as safe as other facilities, but score more highly for women's satisfaction. They have also been shown to be cost-effective, some even cutting costs.

A number of studies demonstrate that women value and will readily seek out care from professional midwives, in some instances preferring such care to that of other healthcare providers. Yet some countries, often those with the highest maternal mortality rates, prohibit or limit midwives from offering needed services, even though they have the necessary skills.

Without such barriers, and with the necessary legal and regulatory frameworks to protect and support them, professional midwives have a huge potential to assist in achieving all the health-related MDGs, including MDG 3, promoting women's empowerment and gender equality; MDG 4, reducing child mortality, and MDG 6, control of HIV/AIDS and other infectious diseases.

None of this however will be possible without carefully-thought-out strategies and collaborative partnerships.

Conclusion – now is the time for action

In summary, there has been much discussion and talk about supporting midwives to help reduce maternal mortality. Records show that as early as 1955, WHO recognised that reducing maternal mortality required investment in and building the capacity of midwives, especially at the community level. However, there has been too little action; or action has been sporadic or not sustained, or has only focused on one aspect of capacity building, and little has been achieved.

For too long, midwives have been relegated to passive participation in the policy dialogue. Others too readily speak for them: and when they have been permitted to speak, they have been ignored.

New ways of working and supporting midwifery must be found. Midwives must be at the policy table and policymakers must hear and respond to their voices. Midwives, along with the women, their babies and families, must be at the centre of discussion. Midwives know what they can do to ensure safer, healthier pregnancy and childbirth, and to make the first days and months after birth safe and happy. They must be allowed to say what they need. Such a dialogue will identify the critical components for the rapid scale-up of skilled care at birth.

UNFPA has a unique opportunity to act as honest broker to encourage and support efforts to build countries' midwifery capacity. UNFPA, with its regional and bi-regional networks and partnerships, can help countries in the same region learn from and support each other. UNFPA can bring to the attention of policy makers and politicians the need to address the gender dimensions of care for and by women, to promote safe and healthy pregnancy and childbirth and to achieve the MDGs.

3. The Workshop

The first UNFPA global workshop on midwives' contribution to reducing maternal and newborn deaths and disabilities

Session 1: Welcome and opening remarks

The welcome and opening remarks were made by Dr. Kunio Waki, Deputy Executive Director of Programmes and Dr. Rogelio Fernandez-Castilla, Director of the Technical Services Division (TSD), who were later joined by the Executive Director Thoraya Obaid. Although the initiative for holding the workshop came from the Reproductive Health Branch, all divisions within the organization supported this landmark event.

In his opening address, Dr Kunio Waki gave a very personal and moving tribute to the position of skilled midwives for making the processes of pregnancy and birth safer for both women and their newborns. He reminded participants that improving women's health through reducing maternal mortality and morbidity (MMM) is at the core of UNFPA's mandate and programme. Dr. Waki, like Dr Rogelio Fernandez-Castilla and the Executive Director Thoraya Obaid, reminded everyone that UNFPA acknowledges the central role of midwives in advancing efforts to achieve the fifth Millennium Development Goal (MDG 5) while also impacting on MDG 3 women's empowerment and gender equality and MDG 4, child health.

In the context of the World Health Day and World Health Report for 2006, the theme of which is "the health workforce", UNFPA has already decided to put emphasis on midwives and other professionals with midwifery skills (MOMS). Midwives, Dr. Waki said, are the often-missing key in the current global context for ensuring safe reproduction. In a context in which best estimates suggest that in 2005 there were approximately 180 million pregnancies in the developing world, of which 70 million were unwanted and where 125 million births took place, midwives and others with midwifery skills are crucial. They form one of the most important resources to ensuring the health of nations and, by caring for newborns, for future generations of the world. According to UN estimates, it is thought that a skilled healthcare worker attends only 50 to 55 per cent of the 125 million births per year. The actual figure for births by a skilled healthcare worker may indeed be much lower, as it is known that some country reports include semi-skilled and community workers not recognised

Participatory workshop – maximising opportunities

All participants were asked to introduce themselves by way of writing on a card what they brought to the workshop to share, and on another card, what they wanted to take away.

The skills and capacities participants brought to share, included: *training, a passion for midwifery and safe maternal and newborn health, programming, information technology, information and knowledge management, expertise of working in resource poor countries to address human resources for health shortages.*

Wanted to take away: ***knowledge, lessons that have worked in other countries for strengthening and capacity building midwives, ways of sharing information and know-how and what are the priorities for action at country level.***

by the most recent UN definition of a skilled attendant.[5] This is despite the fact that this definition has been endorsed by UNFPA, the World Bank and others like the International Council of Midwives (ICM). Indeed, a recent review suggested that less than 40 per cent of women and their newborns globally have the assistance of someone with the requisite midwifery skills to provide quality midwifery care and can assist them if an emergency occurred during or soon after childbirth, the time when most maternal and a high proportion of newborn deaths occur.[6]

Ensuring sufficient numbers and quality of midwives however cannot be achieved by UNFPA alone. All global partners need to join hands in this important process, and the opening speakers were pleased to acknowledge the participation of WHO, UNICEF, the professional association representing midwives worldwide – the ICM and many other partners and donors (see Annex 2 for full list of participants and representation).

To signal the collaborative base of the workshop, the opening speakers were joined by two of UNFPA's partners in this work: Jean Yan, Chief Scientist for Nursing and Midwifery from the World Health Organization in Geneva and Kathy Herschderfer, Secretary General of ICM. Together they gave a resounding call for midwives from North and South, with UNFPA staff from all levels of the organization, including many from high MMR countries, to give serious efforts and share their views, successes and failures and collaboratively propose new strategies and innovative thinking that can help UNFPA in its endeavours.

Introductions were followed by an outline of the UNFPA Strategies for Maternal Mortality Reduction by Vincent Fauveau, Senior Maternal Health Advisor, Reproductive Health Branch, UNFPA, and the background paper

[5] *WHO. Making pregnancy safer: the critical role of skilled birth attendants a joint statement by WHO, ICM and FIGO. World Health Organization, Geneva, 2004*

[6] *Stanton C, Blanc A, Croft T and Yoonjoung C (2006). Skilled care at birth in the developing world: progress to date and strategies for expanding coverage.* Journal of Biosocial Medicine. *Online access March 8, 2006.*

commissioned by UNFPA written by a senior international midwifery advisor and trainer Mrs Della Sherratt.

The remaining sessions were a mixture of plenary sessions and brief presentations from countries followed by small working groups to give each participant maximum opportunity to contribute and share their views. The groups were arranged on a regional basis, except for one session where groups were convened around contextual situations, viz.:

i) very high maternal mortality and morbidity, poverty and low coverage by skilled birth attendant,

ii) high maternal mortality and morbidity in countries with transitional and mixed economy and,

iii) high maternal mortality and morbidity in conflict and complex situations. Small groups allowed opportunities for more focused discussion and to propose specific solutions. (*See Annex 1 for full Agenda*).

Overview and Highlights of Technical Sessions

Day 1: Situational Analysis

Session 2: The UNFPA Strategy for Maternal Mortality Reduction

Vincent Fauveau, Senior Maternal Health Advisor, Reproductive Health Branch, UNFPA outlined the three-pronged strategy that UNFPA has developed to reduce maternal mortality and morbidity–family planning, skilled attendance at birth and access to emergency obstetric care (EmOC) if complications arise

World leaders, recognizing the crucial role of maternal health in broader development, have committed to improving maternal health through MDG 5, to reduce maternal mortality by 75 per cent from 1990 levels by the year 2015. The challenge of reaching the MDGs is particulary exemplified by this target–an area where the deepest disparities exist between rich and poor societies.

An estimated 536,000 women die each year from complications of pregnancy and childbirth, with over ninety per cent in South Asia and sub-Saharan Africa; less than one per cent die in more developed regions. Another 10 to 20 million women annually are estimated to suffer severe health problems as a consequence of pregnancy and childbirth, such as obstetric fistula. Five major

complications account for 70 per cent of maternal deaths, the majority of which occur during labour, delivery and the post-partum period.

Approximately 15 per cent of women will experience a complication during pregnancy or childbirth; most of these cannot be predicted, but almost all can be managed. Most maternal death and disability could be averted if skilled health professionals attended all births and all births took place with access to quality referral facilities. The World Bank estimates that maternal deaths would decrease by 73 per cent if coverage of key interventions rose to 99 per cent.

UNFPA envisages a world where all can fulfil their right to the highest attainable standard of sexual and reproductive health. To achieve this vision, UNFPA is committed to promoting and protecting reproductive rights and ensuring access to quality sexual and reproductive health care as part of basic health. UNFPA considers improving maternal health, including reducing maternal mortality and morbidity, a priority area within sexual and reproductive health.

The UNFPA MMM strategy is based on recent advances in obstetrics and making proven interventions such as active management of the third stage of labour and magnesium sulphate as the drug of choice for the management of eclampsia and prevention of pre-eclampsia, both of which are known and widely available in countries. The MMM strategy also takes account of the need for increased attention to indirect causes of maternal mortality (HIV, TB, malaria, gender-based violence, impact of conflicts), and a renewed emphasis on prevention and management of obstetric fistula, which has been virtually re-discovered in the past five years. The principle of equitable access, including excluded, marginalized and vulnerable populations, such as adolescents, the poor, rural populations and indigenous peoples, guides the strategy.

The challenge for countries is to scale up pilot projects to nationwide programmes using this MMM strategy.

The UNFPA MMM strategy to reduce maternal mortality is based on a continuum of maternal health care focusing on three high impact interventions:

1. Access to contraceptive services for all women, to prevent unwanted pregnancies
2. Access to care by a skilled attendant for pregnancy and childbirth, and
3. Access to emergency obstetric care for all women and newborns with complications.

The UNFPA strategy has been described in the Maternal Mortality Update 2002 *Focus on Emergency Obstetric Care*. Further details on skilled attendance at all births were given in the Maternal Mortality Update 2004, *Delivering into good hands*.

For UNFPA, the skilled attendant is a professional capable of detecting obstetric complications at their onset; performing at least the six basic EmOC (non-surgical) functions in an enabling environment; referring the cases that are beyond their competence, and managing these cases before and during transport to the referral facility.

Concluding the session, participants were reminded that the strategy to scale up the capacities of midwives, including and especially midwifery training, while key to UNFPA's MMM strategy, is not identical with it.

Scaling up the capacities of midwives requires a combination of

- *political advocacy* – to convince those who make the policies, those who allocate budgets and those who regulate the civil service;
- *scientific advocacy* – to demonstrate effectiveness and cost- effectiveness of various options;
- *ethical advocacy* – to apply codes of conduct, rights and gender approaches;
- *technical advocacy* – to review norms and protocols and rules for delegation;
- *support to and partnership with* professional associations and training institutions, and
- *work with* civil society and the community to increase demand.

Participants warmly welcomed the information that the UNFPA Maternal Mortality Update 2006 would focus on midwives, and address the above issues. It would also outline the strategies and thinking that resulted from the workshop and draw on some of the background paper.

Participants noted that scaling-up midwifery is in line with the various strategies and policy briefs issued by many international and non-governmental organizations. For example, WHO and its regional offices; UNFPA; UNICEF; the World Bank; the Safe Motherhood Inter-Agency Group (the secretariat of which is Family Care International); the White Ribbon Alliance; federations of professional associations such as FIGO; ICM; many Universities (including the London School of Health and Tropical Medicine; Columbia University's AMDD project; the Initiative for Maternal Mortality Programme Assessment Aberdeen University, Scotland, UK (IMMPACT); research institutes and donors such as DfID, SIDA, and USAID, and many other organizations, institutions, and countries, have entered into a new partnership for maternal, newborn and child health. Partners are working together to harmonise their views and improve efficiency, to reduce maternal and child mortality and

morbidity. ICM along with other professional associations have an important place in this new partnership.

Session 3 & 4: Midwifery Capacities In The Regions (Regional Working Groups)

It was clear that there were many activities already going on in the regions to which UNFPA could contribute. Equally it was also clear there are many issues still to be addressed.

With such global efforts the opportunities to succeed have never been greater, the imperative now is to design realistic but innovative strategies

Presentations from the regional working groups expressed many of the same challenges to scaling up midwifery capacity:

- **Lack of numbers** of midwives and in most cases poor quality of midwifery training. Lack of investment meant clinical and theory training were not updated.
- **Lack of funding** for pre-service, in-service and continuing training, and for employment of midwives.
- **Competition and conflicts** between physicians and nurses, physicians and midwives, nurses and midwives – with midwives trying to establish professional space.
- **Lack of incentives** and **lack of polices and plans to develop human resources for health**. There is also need for support for the basics such as housing, light, water, topping up of salaries
- Finally, it was recognised there was a **need for close relationships between women and midwives**. Where midwives worked with women and women's groups the midwifery profession was usually stronger.

Other important issues included the need to extend social security or health insurance payment schemes to cover births attended by a professional midwife.

Africa

- Ensure that maternal health is included in the national health agenda.
- Strengthen professional associations (in Malawi, the professional association gives incentives to midwives).
- Improve documentation of successes.
- Examine how SwaPs are helping and hurting the maternal health agenda.
- Carry out MNH needs assessments, as many countries already do.

- Increase advocacy efforts: MDG 5 gives maternal health global visibility and urgency.
- Expand training institutions and schools.
- Strengthen mid-level providers, who are important to saving lives in many countries.

The Africa Midwives Research Network (AMRN) is increasing in strength and visibility, and increasing midwives' familiarity with current research in the region. More midwives are beginning to undertake research, including operations research, to help find appropriate solutions.

Asia

Lack of supportive policy is the greatest barrier. Current policies impede scaling-up of midwifery. International assistance policies that limit hiring in the health sector are a major challenge.

Each country should:

- Ensure that midwives are clearly included in human resource development policies and plans, with numbers, levels, and the skills set required.
- Revisit existing safe motherhood plans and update where necessary. These plans should be informed by an updated assessment of where and how many professional midwives are needed, and set targets.
- Use modelling to identify what resources are required, with supporting feedback from the lowest level to permit influence on policy (e.g. housing subsidy for assistant nurse-midwives in Uttar Pradesh)
- Link education, health and finance ministries–move early to coordinate efforts among ministries to reduce barriers to certification.
- Agree precisely who is and who is not counted as a skilled attendant. Create a regulatory body linked to the midwifery council.
- Consider intermediate processes such as curriculum revisions to avoid scaling-up before policies are revised. Accelerate action and educate policymakers.

Latin America

- Excellent policies exist and are being integrated into PRSPs, but there is not enough implementation.
- Different models of midwives do exist according to need (primary, secondary and advanced) but not known in all countries (serious problem – there is no Spanish word for midwifery).

- Post training is beginning in many Latin American countries.
- WHO/PAHO's collaborative efforts, especially recent mapping activities, provided a good basis for action.
- Healthcare reform offers potential opportunity, but may also be a threat.
- WHO is currently strengthening midwifery toolkit – currently in Spanish and soon available in English and French.
- Impact of trade agreements needs further investigation: may offer potential for commonality, especially to allow movement of professionals across countries with common agreements. This may also assist common curricula, sharing of training resources, etc.
- Examples of cross training already exist in Dominica and St. Kitts.
- Information technology infrastructure for information sharing is strong, particularly in Bolivia, so distance learning packages via the internet or on CD-ROM are possible.

Summary of day 1: Global Situation Analysis on Midwifery Capacities

1. Lack of investment over a long period currently prevents many countries from building up their midwifery capacity.
2. **Lack of supportive policy environment often places unhelpful and unnecessary limits on the practice of midwives, especially those working at the primary health care level.**
3. **Action is being taken in many countries to build the capacities of midwives – but is hampered by: too few resources; lack of consensus between major stakeholders, and too few models of midwifery that are operating or have been evaluated.**
4. **The current environment provides many opportunities for strategic partnerships to work together on building midwifery capacity**
   a. **Global action on human resources for health – WHO call for decade of action**
   b. **WHO/PAHO regional initiatives on mapping midwifery providers and on translating generic tools for strengthening midwifery, etc.**
   c. **WHO/AFRO has had three regional workshops for strengthening midwifery (one for Anglophone countries, one Francophone and one to bring recommendations together and develop a regional road map for midwifery).**
   d. **In South and Central Asia, WHO and UNFPA have been working jointly on accreditation and regulation of midwives at the community level.**
5. Lack of access to professional midwifery care is a gender issue that needs to be addressed if all men and women are to enjoy the right to health.
6. Lack of professional midwifery care harms women, men and children, including newborns, not just women.

Negative factors

From all regional groups – factors that currently act against capacity building of midwives include:

- lack of visibility for midwifery and midwives.

The midwives considered that visibility of midwives and midwifery has become a greater problem in some places as the skilled attendance at birth agenda has been discussed.

Day 2: Scaling Up Capacities–Solutions

Session 5 & 6: Scaling Up – Different Scenarios Require Different Solutions

Lead Presentations - Examples of what is happening in:

1. South and East Asia with UNFPA support – Saramma Mathai, Atf Gherissi
2. A middle-income country, Tunisia - Atf Gherris
3. Support in conflict and complex situations - Sudan and Afghanistan –Margareta Larsson, Midwife, WHO Geneva (as participant in the Sudan meeting).

Common themes from presentations

- Need for consultation and working with partners at all levels
- Need for national standards regulation and accreditation, to ensure that different actors produce the same product.

Common challenges – finding suitable candidates to enter the midwifery profession, especially in conflicts, where there is civil unrest and in countries with high HIV prevalence rates. In such situations all sectors are disrupted, including primary and secondary education. This will affect ability to recruit. particularly women. At the same time, male midwives may not be acceptable to the community.

Some possible solutions

- working with education sector, adult education and vocational sector to develop bridging courses;
- establishing IQ testing centres.
- **All agreed that it is important not to compromise quality, but rather to find culturally congruent and innovative ways to identify and train midwives.**

One of the participants from UNFPA Africa Region (Dr Diallo) reminded everyone that, while upscaling professional midwives there is also a need to

"up-skill" *all* available human resources in midwifery skills. Especially in Africa there is need to ensure that *all physicians* have core midwifery skills and basic EmOC and, in some instances, complete EmOC skills, as these are often missing in general medical training.

Group work

Three groups were formed to consider scaling up midwifery capacity in three different scenarios,

i) low income,

ii) transitional income and

iii) complex and conflict situations.

Common themes emerging from the group work included:

- The need for new ways of working, as well as new strategic partnerships. For example Cambodia is setting up a Regional Training Centre, and has established a "midwifery forum" (see box).
- The need for increasing visibility and leadership. Some suggested the need for a concerted effort to raise the profile of midwives and advocate for a new vision of the midwife.
- The need for maximizing limited resources–including creation of local, national and regional communities, which will link midwives to the global community of midwives and midwifery research. This will help to reduce midwives' feelings of isolation. especially in countries where numbers are still small. It will enable them to learn from and support each other and build upon accumulated knowledge and experience, instead of finding everything out for themselves.

Increasing midwifery capacities in low-income countries

Although each low-income country has its own challenges and solutions, some common themes emerged.

In **Asia**, one of the major challenges was lack of understanding and traditions of midwifery. Some countries had no tradition of midwifery: a family member or friend attends most births and many women give birth with no assistance.

- In many of these countries, the development of midwifery is highly related to women's lack of status.
- Women doing "women's work" are not given sufficient attention. There are frequently misconceptions about midwifery as an occupation: midwifery is often seen as low-status work requiring little education.
- The concept of midwifery, whether as an occupation or a profession, is often limited. It is changing slowly, for example in Nepal and Cambodia.

Success story from Cambodia

Cambodia held its first national workshop December 2005 with high level support, including from UNFPA
Cambodia has established a Midwifery Forum led by the Office of Council of Ministers and Ministry of Health, with involvement of:

- **Ministry of Education, Youth and Sport;**
- **The Council for Administrative Reform;**
- **The Secretariat of Public Function;**
- **Ministry of Economics and Finance;**
- **Multilateral and bilateral agencies.**

Cambodia will soon undertake a full assessment of midwifery capacity.
Challenges include:

- **Low enrolment of students in midwifery course;**
- **low numbers of secondary students;**
- **Low motivation to work in rural and remote areas;**
- **Maldistribution of midwives;**
- **Low salary;**
- **Limited resources for retention of midwives in public sector;**
- **Poor social services infrastructure in rural area;**
- **Lack of places for clinical practice.**

Strategies for overcoming these challenges will be the main agenda of the Midwifery Forum.

Presentation by Ms Sam Sochea, Midwife Representative from Cambodia

In **Africa**, professional midwifery is known but often remains invisible. Policy makers see midwifery as part of nursing, and have not made the investments required to build a body of specialised knowledge.

In addition Africa has suffered a loss of trained midwives:

- Most midwives in Africa also have a nursing qualification (nursing is a pre-requisite for entry into midwifery) and can become nurses overseas. Many have been "poached" by developed countries.
- Many have left to work for higher salaries in the private sector (which frequently does not provide midwifery care) or outside the health sector altogether, and are lost to midwifery.

Solutions for Africa

Possible solutions for all low-income countries

- Midwives should have the opportunity to reach senior positions. At present there are few senior midwifery positions, and often no senior midwife at national policy level. There is frequently only one senior nurse in the Ministry of Health, who has responsibility for both nurses and midwives, rendering midwifery invisible.

- Donors should pay the same salaries to midwives as government – possibly by agreeing to enhance government pay, with a commitment that the government eventually take over the enhancement. This may allow government to change the profile of the workforce: review and remove from the system incompetent or surplus staff; and enhance pay for those assessed as performing well or who agree to undertake refresher training.
- Countries should offer refresher courses and registration for midwives currently not working, for whatever reason.
- Ghana managed to increase births by midwives by revitalizing currently practising midwives to attend more births. Midwives expanded their scope of practice to provide family planning and other reproductive health services.
- Countries should encourage and support midwives and nurse-midwives to accept private patients, as in Ghana, Kenya and Indonesia.
- Donors can assist by funding training posts but these must be phased in for absorption by the government. Funders should work with policy makers to ensure that posts are created.
- Countries should challenge IMF to be transparent about how they come up with figures such as caps on numbers of health workers in the public sector.

Midwives from Africa

- *Felt that midwives were often left in isolated positions, with no support and wanted to have a visible community of midwifery practitioners.*
- *Saw midwifery visibility and leadership as key to strengthening capacities in countries and the region*
- *Believed that, unless midwifery was visible and commanded respect, girls and women would not want to enter the profession.*

Scaling-up midwifery capacity in countries in transition and countries with growing economies

The working group for this issue was small and mainly consisted of countries from Latin America and from Tunisia. A number of midwives from the north who had experience of working in countries with transitional economies joined this group.

Midwifery in many countries, including countries in transition, has suffered from a serious lack of investment over the last two decades.

In some countries, both developing and transitional economies, economic policies to reduce healthcare costs have resulted in

1. Replacement of midwives with multi-purpose health workers, who are perceived as cheaper and more cost-effective, and
2. Overall reductions in the hiring and salaries of government health personnel. Midwives find it difficult to work in the private sector, except as assitants to physicans, as births assisted by midwives are often not covered in fee-for-service agreements or insurance schemes.

Tunisa was an exception: the government has in recent years invested in the production of high quality midwives. This is seen as one of the reasons for its success in reducing maternal mortality.

Common barriers

Among the many common barriers in transitional economies are restrictions on midwives' right to practise their skills and work in an enabling environment. Restrictions compromise the quality of care midwives can provide and acts as a disincentive for a potential new generation of midwives. Though midwifery is practised in many Latin American countries, it is often not legally recognised as a profession.

Solutions for Tunisia and other countries

- Regulatory reforms are crucial, to protect midwives' right to practise and the scope of their practice.
- Midwifery should be regulated as a discrete professional area of practice.
- Midwives should be acknowledged as skilled birth attendants, and supported as such.
- Midwives should be recompensed for attending births in the same way as other skilled birth attendants.
- Midwifery professional standards should be set by midwives rather than obstetricians or gynaecologists; although ob/gyns should support the profession and work in partnership with midwives at service level and at the professional association level, as well as in education and research.

Success story from Liberia

Liberia has begun a two-year post-high school certified midwifery programme. Certified midwives (CMs) can add an additional two years of education to become a RN. CMs have recently requested the schools of nursing and midwifery to consider changing from a two-year to a four-year programme awarding a BSc upon completion, similar to the degree that a RN currently receives.

Although undersupplied and working in difficult conditions, professional midwives at outlying clinics are improvising to the best of their ability to deliver services. Clinics are open Monday through Friday during normal working hours. Two professional staff are assigned to each clinic. Most professional staff live near the clinic and provide care for emergencies or deliveries at other times, but the clinics are not staffed for round the clock coverage. Seven of the ten clinics recently visited care for populations over 10,000, with two facilities providing care for populations over 20,000. The CMs supervise the practice of the TBAs in their catchment areas and provide antenatal care for women who deliver at home with a TBA. The CMs hold weekly meetings with the TBAs and provide continuing education and support by acting as a referral centre for complications.

The plan is eventually that as the numbers of CMs increase, they will replace TBAs. It is hoped that the daughters of TBAs will choose to enter the CM programme

Ms. Jodi Lori, Faculty Nurse-Midwife, University of Michigan

- The Ministry of Health should appoint a high-level officer to oversee midwifery and advise on midwifery matters.

Increasing midwifery capacities in complex and conflict situations

Issues during conflict

- Attrition for all healthcare workers will always be high.
- Safety for midwives will be a problem, especially for community-based midwives.
- Midwives, as they are usually women, must stay at home to look after family in unsafe environments.
- Loss or non-operation of facilities.

In the immediate aftermath

- Midwives and nurses with midwifery skills should be involved in immediate technical assessment of available human resources for health. The need for midwifery should be explicit, so that it is not overlooked.
- Include midwives in human resources assessment for minimum integrated service packages (MISP).
- Bring retired staff back into service and provide refresher training.
- Target inputs so that midwifery represents care of the future for the community, in the form of women and their babies. The community may then be willing to contribute to capacity building, giving permission for girls and young women to train as midwives. they may even take it on themselves to provide housing and security in the community.
- Provide security: if posts are not safe, midwives will be discouraged from practising and young people will be discouraged from coming into the profession.
- Make immediate plans to train new midwives, because it takes time to go from plan to action. It is crucial to do this properly – act now but think for the future. Avoid quick fixes that result in poor quality and create obstacles the country may well come to regret.
- Mobilizing the current workforce to work in changed conditions calls for change management
- Scale up all existing midwifery skills, not just professional midwives.

What is needed to make it happen?

- Incentives: monetary but maybe also safe housing, energy, food and water.
- Family permission: reassure families that wives and daughters working as midwives will be safe.
- Education: provide training facilities in the community so trainees will not have to leave the safety of home.

Take advantage of opportunities presented by post-conflict reconstruction funding. These funds will not be available later. Develop innovative proposals early and assure their inclusion in reconstruction plans. Corporate funding can have benefits, if used strategically.

The main post-conflict challenge will most often be cultural: how to help people adjust to the new reality. For example, midwives must provide care for people who may have been enemies. It will be, important to plan approaches to change management.

Session 7 & 8: Strategies for Increasing Numbers and Quality

The groups felt many approaches to scaling up numbers were equally applicable to improving quality.

- New ways of delivering education and new education technologies;
- Strengthening pre-service, in-service and continuing education and training, especially capacities of teachers of midwifery.

Strategies for scaling up capacity development of midwives to improve quality

- Build on existing skills.
- Establish standards and supportive policies.
- Manage brain drain. The loss of health workers from the developing world calls for a collective response. Meanwhile, it must be managed; Information is needed about who is going where and why to do what.
- Build infrastructure and conditions for insertion and retention of staff, including midwives and others with midwifery skills (MOMS).
- Employ appropriate technologies for training MOMS.
- Explore modalities for capacity development such as twinning and South-South and North-South networks. These have been used with great success in other areas such as HIV. ICM and FIGO have joint projects in this area.
- Raise the profile of midwives and the profession of midwife.

- Remind everyone that ICM already has a definition of a midwife, endorsed by WHO and FIGO as long ago as 1976 and updated periodically, most recently during ICM Triennial Congress, Brisbane, Australia 2005.
- Use midwifery competencies developed by ICM. adapted to local situations as necessary. Many countries in Africa and some countries in Asia were involved in developing the ICM competencies, using rigorous scientific methods.

Addressing these issues will enable more MOMS to reach more women, and result in higher-quality sustainable knowledge and practice, and increased knowledge transfer. Capacity development should be the starting point rather than an appendix to programming or country plans.

National action required

- Invest in public-private partnerships and the private sector. Private or semi-private franchised practice would allow some midwives to make their own working arrangements and integrate work with family responsibilities. These midwives should remain part of the health system, especially if they are working in the community as single practitioners, in teams or in group practice.
- Find ways to recompense midwives other than payment for services, which is a major issue, especially for the poor. Develop pension schemes for private midwives.
- Invest in skilled birth attendance through midwives. Make loans and grants to midwives to establish private clinics and practices (where this is in line with national human resources plans).
- Give good midwives public recognition, bringing midwives to the attention of the community.and helping to motivate them.
- Review national plans to include skilled birth attendance and midwifery training.
- Advocate with the community and at national level for midwives; a national focal point for midwifery would signal high-level support.
- Make situational assessments, to show where action is needed.
- Form strategic partnerships for action, going beyond the health sector.
- Ensure strategic buy-ins for stakeholders and partners.
- Learn lessons from scaling-up HIV prevention.
- Address brain drain at national and global levels.

Summary of the first two days

Participants suggested the need for

1. Positioning and global advocacy for midwifery and for midwives; in particular the need for midwives to be visible, and preferably in leadership positions in countries and in international organizations.

2. Recognition of importance of a midwife as the preferred skilled birth attendant at the primary care level.

3. Recognition that midwives are a primarily female workforce, and face gender-specific vulnerabilities and threats to their human rights. This will contribute to empowerment of women, giving respect to women as midwives, as mothers, and as role models in the community.

These actions will give clarity and consistency to strategies; they will also integrate systems and plans within the health sector (including HIV) as well as in education, finance, and other sectors. Innovations such as private-public partnerships will make efficient use of existing resources and amplify the voices of midwives.

Day 3: Strategic Action for UNFPA

Session 9: Donor perspective (presentation by SIDA)

Gunilla Essner, Senior Health Advisor for SIDA, Sweden, gave her personal view on what UNFPA could and should do, and outlined the work on which SIDA and UNFPA had already embarked.

She began by saying that Sweden is committed to ensuring the highest possible level of reproductive healthcare for everyone. Sweden was very proud of their long history of public health. For Sweden, care for pregnant, birthing and postpartum women and their newborns has always been a public health priority. Professional midwives work in collaboration with medical colleagues, such as obstetricians, gynaecologists and other public health specialists to provide this care. This collaboration and model of care contribute to Sweden having one of the lowest maternal mortality ratios in the world.

Sweden's maternal mortality began to fall more than 100 years ago, when the country was very poor – as poor as many developing countries are today. Sweden also had severe infrastructure problems, with many parts of the country inaccessible during the long winter. The solution they chose was to have a properly trained and regulated professional midwife, in every village and community. Even now, although many women give birth in an institution, a midwife provides the care. The obstetrician is called in as required or for specialist care to potentially high-risk cases.

The current programme between UNFPA and SIDA includes supporting three Swedish midwives in UNFPA country offices where there is high mater-

nal mortality. The presentations from the three midwives the previous day showed how successful this support has been. It also showed how pivotal having a professional midwife working in the country office has been for raising awareness and strengthening the countries' capacity to provide quality midwifery care to all their people.

In conclusion, she paid tribute to the innovative work that UNFPA is undertaking in this area**.** She applauded in particular the current initiative to bring midwives from all parts of the world together and listen to them before adopting the UNFPA strategy. She also made clear that SIDA would be willing to receive a proposal from UNFA to support further this work. SIDA would look favourably on any proposal to support more midwives in country offices, if UNFPA thought this would help. She requested however that such a proposal should be drafted as soon as possible, as it would soon be time to finalise SIDA support to UNFPA.

Session 10: Recommendations from the regions for priority actions by UNFPA

Western, Central and Northern Africa

- Make assessments of people, facilities, referral systems and training institutes; prepare action plans based on the results;
- Complement and support existing data; do not make new, separate data sets
- Improve training facilities, including:
- Access to resources
- Clinical sites
- Support supervision

East and Southern Africa

Major challenge: UNFPA's three-year plans can limit inclusion of midwifery issues in plans and work. Make planning more flexible and allow for additions throughout the three-year cycle.

Use UNFPA's global voice:

a. On World Health Day, issue a statement that midwives are essential to MDG 5 on maternal health and achieving the specific maternal health indicator, and contribute to achieving Goal 4 on child health.

b. Disseminate good practices in midwifery capacity-building, and their impact.

c. Stress the importance of midwifery skills for all healthcare workers.

d. Push for ethical recruitment – address rich countries' recruitment from poor countries without compensation.

Strategies to achieve these aims - lessons can be learned from UNFPA's fistula campaign. Consider partnership with UNICEF for marketing and awareness raising.

- Use global perspectives to help other countries share best practices.

Commission and conduct rapid assessments:

- Use AMDD tools to assess current situation to identify gaps, but add midwifery to this
- Use available data.

Support roadmaps at country level to operationalise global strategy:

- Use costing models to cost and plan implementation within country resources.

Promote standards for performance (look at ICM):

- Assess existing midwives and support training for additional areas (EmOC assessments, add human resources dimension, especially midwives).

Promote curriculum review to ensure that standards for midwifery practice are met. ICM has a tool and can assist in this. WHO/ICM *Strengthening Midwifery Toolkit* has guidance and tools to help with this.

Rebuild basic health system, instead of supporting action that will lead to bypassing basic facilities.

Look to HIV/AIDS infrastructure scale-up models to guide possible action. Including looking at (gains) to address linkages between HIV and maternal mortality. To put PMTCT in place South Africa needs more than new midwives – but without midwives, efforts are unlikely to succeed.

Support planning and procurement of supplies for women's health. Skilled personnel cannot do much without supplies.

- Make sure there are line items in budgets for supplies.

Participatory programme planning and advocacy training for UNPFA staff to understand the "what, why and how" of scaling-up midwife capacity. Include country counterparts and midwife associations in these courses, so they can learn from and listen to each other.

Advocate international regulation of training and recruitment, to stop "poaching" from public service sector

a. UNFPA global forum on ethical recruitment, scaling up the national workforce and support for retention

b. WHD joint statement on human resources message.

Asia

UNFPA at HQ and Regional level:

- Advocate with UNFPA geographical divisions and the Technical Support Division to strengthen the three-pronged strategy to reduce maternal mortality and morbidity in all activities including FP, skilled care and EmOC

UNFPA at Country level:

- Advocate with UNFPA country offices to keep the three pillars centre stage.
- Among the three pillars, focus on skilled care and EmOC (one is not useful without the other).
- Strengthen capacity of UNFPA country offices to support implementation of UNFPA MMM strategy, including integrating human resources dimension and stressing need for midwives.
- Build capacity to negotiate increased resources allocated to SWAp process, with budget lines for skilled care and EmOC.
- Advocate for evidence-based basic maternity care.
- Mobilise additional resources by using evidence-based dialogue with bilateral and multilateral agencies.
- Use examples, e.g. Bangladesh, to show what can be done where there are no or very few midwives, as first step towards building midwifery capacity.
- Draft needs-based action plan.
- Train community-based skilled birth attendants in basic maternity care including selected country-specific basic EmOC procedures.
- Upgrade peripheral facilities to EmOC to offer 24/7 service.

Latin America

There were few participants from Latin America at the workshop. However, they agreed UNFPA should:

- Support existing programmes, particularly with supplies
- Help establish midwifery associations
- Enhance communication among professionals to decrease isolation and help create communities of practice and practitioners
- Refer to skilled birth attendants (SBAs) as “midwives and others with midwifery skills” (MOMS). The term SBA was confusing; especially as the terms midwife and midwifery were also new in the

region and there was no equivalent Spanish word for either. It is important to establish the terms carefully: ICM Americas Region is working closely with WHO/PAHO and others to help develop a known and accepted terminology.

Session 11: UNFPA's advantage in assisting scaling up midwifery capacity in countries

Groups were formed to look at some very specific and more technical issues required for scaling up midwifery capacity:

1. Regulation and accreditation of midwifery;
2. Delegation of authority;
3. Creating a professional identity (professional associations);
4. Creating a community of practice around midwifery, and
5. Strengthening the relationship between midwives and the community, to identify possible UNFPA roles, potential action points and added advantage for being involved in these issues.

1. Regulation and accreditation of midwifery

- In many countries this is the major barrier to scaling-up. UNFPA has not traditionally been involved, assuming WHO and others were addressing it; but they have not, or not sufficiently, so UNFPA must now take action.

2. Delegation of authority

- A sensitive subject in most countries, but must be addressed. In many countries midwives are prohibited from practising essential life saving skills, though they are taught in the pre-service programme. UNFPA should advocate for delegation and press for action by all stakeholders, especially in countries where women's lack of empowerment is an issue,

3. Creating a professional identity and professional associations

- UNFPA has supported ICM at global level, but has offered little support to strengthening professional associations at country level, only sponsoring individual midwives.
- UNFPA should recognise the value and benefits of a vibrant civil society, including professional associations as legitimate actors and stakeholders.
- Midwifery professional associations are crucial for women's health, including sexual and reproductive health. This is central to UNFPA's

mandate, to ending gender inequality and eliminating poverty. Support for midwifery professional associations should be part of UNFPA country activities.

4. Creating a community of practice around midwifery

- A constant theme running through the workshop was the need for identity and networking.
- The WHO initiative to establish communities of practice supported by appropriate information technology including an electronic platform, should be explored further.
- UNFPA should explore a variety of strategies for establishing and supporting communities of practice at local, provincial, national, regional and global level.
- WHO and ICM have examples of how this can be done and would be happy to partner with UNFPA at regional, global and in-country level.

5. Relationship between midwives and the community

- In many developing countries few professional midwives are found in the community. Those who are there are often not fully used.
- Strategic choices will have to be made if it is desired to increase the number of professional midwives at the community level. It is essential to have cultural congruence and acceptability.
- Incorporate the "midwifery model of care" in all curricula and in plans and community programmes.
- Change attitudes of formal care providers in the health system Often everything perceived as traditional such as the TBA, is perceived as bad, in all respects, and treated accordingly.
- Health committees' capabilities, especially for making and maintaining priorities, are not always adequate.
- Capitalise on community assistance and get community buy-in for example in Kenya.
- Strengthen the roles of the midwife in the community, in order to increase trust, confidence and respect for the midwife and the care she provides.
- Educate women, starting with boys and girls in school, to seek midwifery care before during pregnancy, for childbirth and for after birth.
- Education for all midwives must include community practice – even if they will work primarily in a hospital or other facility so they can keep empathy with women and develop good attitudes.

4. Summary of Workshop Recommendations to UNFPA

All regional working groups requested

1. UNFPA should take a global role in saving women's lives
2. UNFPA, ICM and FIGO should work together with others, such as WHO, to take a stand on the definition of a midwife, including, where possible, use all opportunities to refer to midwives and midwifery.
3. Rather than "skilled birth attendants" UNFPA should always refer to Midwives and Others with Midwifery Skills (MOMS) or if referring to SBA should clarify that for UNFPA this means MOMS
4. UNFPA should establish key messages for wide dissemination within the organization, which include:
   - The term "skilled birth attendant" means MOMS
   - Avoid short term goals taking away from systems building and infrastructure
   - EmOC is only one issue for MMM and should not be addressed in isolation. It is important not to let EmOC divert attention from the essential understanding that all women need skilled care, even if they do not have a problem; this can only be achieved by creating/ building and or strengthening the midwifery cadre.

     Consideration should be given to holding similar workshops in the regions to disseminate these messages and gain more insights and inputs for regional action.
5. UNFPA needs to coordinate activities with all partners at country levels, including professional associations
6. UNFPA needs to take a leadership role and to stand firm in global health forum; to demand attention be given to women and the position of women health providers, as well as the role of individuals in saving lives.
7. UNFPA to promote the need for woman-centred care, whether facility or community care
8. UNFPA should write formally to WHO and to countries, to request that nurses and midwives are included in all emergency assessments,

both in making assessments and in terms of data to be collected - assess midwifery capacity needed to ensure skilled care is possible immediately after the emergency

9. UNFPA should include strengthening capacity of midwifery in the MISP (Minimum Integrated Standard Package)

10. In the internal one-day working session for key UNFPA staff following this workshop, UNFPA should give serious consideration to the recommendations from the workshop and begin immediately to draft a strategy for capacity development of midwives to enable them to contribute to reducing maternal mortality and morbidity. The strategy should focus on country implementation underpinned by regional and HQ action.

Appendix 1: Agenda

Day 1: Tuesday 21 March

8:30-9:00	**Hospitality: coffee and breakfast**
9:00- 9:30	Session 1: **Opening address and welcome remarks** • **Kunio Waki, Deputy Executive Director (programmes), UNFPA** • **Rogelio Fernandez-Castilla, Director, Technical Support Division, UNFPA** • **Jean Yan, Chief Scientist Nursing and Midwifery WHO/ Chair Steering Group Community of Practice on Nursing and Midwifery (CoP)** • **Kathy Herschderfer, Secretary General CEO, ICM**
9 :00-10 :30	**Objectives of meeting – Arletty Pinel, Chief, Reproductive Health Branch,** **Technical Support Division, UNFPA** **Interactive participant activity: what each partner is bringing to the table and expects to takeaway. Della Sherratt, Midwife, Consultant, UNFPA**
10:30-10:45	**Visual Representations of Pregnancy and Childbirth (7 min slide show) followed by Break**
10 :45-11:00	Session 2: • **Presentation of maternal health framework: Vincent Fauveau, Senior Maternal Health Advisor, Reproductive Health Branch** • **Presentation on the scaling up of MH into national plans: Arletty Pinel**
11:00-12 :30	• **Presentation of background paper: Della Sherratt** • **Followed by comments from 2 discussants:** • **Q&A on all 3 presentations**
12 :30- 2 :00	Lunch
2 :00-2:15	Session 3: **Break into regional groups (3 or 4) (Africa 1, (Africa 2), Asia and ME, LAC):** Topic: **Quick situational analysis/ regional perspective on the role of professional midwives and associations, lessons learnt –what has worked and not worked and identification of remaining gaps.**
2:15-3 :30	**Kick off in group with short 5 min presentation from 1 key stakeholder to set scene and start discussion.** **Africa 1: West Africa, Dr Diallo and Dr Lazaro** **Africa 2: Zimbabwe, Dr Campbell** **Asia : Sochea Sam, Cambodia** **LAC : Dr Dominguez**
3 :30-45	Break

3 :45-5 :30	Session 4: Plenary for session 3. **Presentations and discussion Rapporteurs from each group – 5 minute presentation to give snapshot of Regional Situation followed by plenary discussion to identify common themes and major differences.** Facilitator : **Vincent Fauveau** Wrap-up of day, **Arletty Pinel**
5:30	**Reception by kind invitation of Rogelio Fernandez-Castilla, Director, Technical Support Division, UNFPA, joined by Executive Director UNFPA Thoraya Obaid**

Day 2: Wednesday 22 March

8:30-9:00	**Hospitality: coffee and breakfast**
9:00-10 :30	Session 5: Lead Presentations • **Saramma Mathai, CST SAWA –Islamabad Meeting Skilled Attendants 2004 and Joint WHO/UNFPA Meeting on Accreditation, Rajasthan,India 2005;** • **Atf Gherrisi Midwife Tunisia – Addressing inequalities in access to skilled care in middle income country –Tunisia** • **Margareta Larsson – Midwife MPS, WHO -Report on South Sudan and Afghanistan** Group work: Topic: **What are the prospects - taking into consideration the current situations in low-income countries, inequity in middle-income countries, and countries in post conflict - for applying, replicating and scaling up successful lessons to develop sufficient numbers of professional skilled midwives** **Break into 3 groups:** **1) low-income countries,** **2) inequities in middle income countries, and** **3) countries in conflict and post-conflict**
10:30-10:45	Break
10 :45-11:00	Session 6: Presentations: **Swedish midwives seconded to UNFPA –country initiatives** **Anneka Knutsson – Bangladesh; Ulrika Rehnstrom – Bolivia; Barbro Fritzon - Mozambique**
11:00-12 :30	**Plenary for session 5, presentations and discussion** **Facilitator: Bruce Campbell**
12 :30- 2 :00	Lunch
2 :00-2:15	Session 7: Lead presentation: **Presentation of Community of Practice** Group work: **Regional groups** Topic: **What are the prospects - taking into consideration the current situations of low-income countries or inequity in middle-income countries and in complex situations - for applying, replicating and scaling up successful lessons to ensure quality of midwifery skills, to enable adequate provision of skilled attendance at birth**

2:15-3 :30	Facilitator : **Jean Yan**
3 :30-45	Break
3 :45-4:00	Session 8: Presentation: **Making Pregnancy Safer - WHO's flagship for maternal and newborn health – Margareta Larsson**
4:00-5 :30	**Plenary for session 7, presentations and discussion** Facilitator: **(CoP)**
5:30	**Wrap-up of day**

Day 3: Thursday 23 March

8:30-9:00	**Hospitality: coffee and breakfast**
9:00 - 09:15	Session 9: **What should UNFPA do?** Lead Presentation: **Donor perspective - Gunilla Essner, Senior Health Advisor, SIDA, Stockholm**
09-15 -10:30	Group work: **Regional groups** Topic: **What should UNFPA's role be in supporting the scaling up of midwifery training?** **Discuss - Examples from participants of past and planned activities related to the supporting scaling up of midwifery training – Presentations from Nepal,** Facilitator: **Vincent Fauveau**
10:30-10:45	Break
10:45-12 :30	Session 10: **Plenary for session 9 and discussion** **Facilitator: Arletty Pinel**
12 :30- 2 :00	Lunch
2 :00-3 :30	Session 11: Topic: **Opportunity for addressing specific issues and developing some concrete plans around these issues** **Break into issues groups as follows :** **1. CoP (By invitation - CoP steering committee meeting).** **2. Strengthening Professional Associations - (lead facilitator ICM)** **3. Regulation and delegation of authority - (lead facilitators Barbara Kwast and Helen DePinho)** **4. Relationship between professional midwives and the communities (lead facilitators WRA and FCI)**
3 :30-45	Break
3 :45 - 4 :30	Session 12: **Final Plenary & Recommendations: Presentations of issues groups and discussion**
4:30-5:00	**Closing comments and preparation of next steps – Arletty Pinel**
Meeting closed	

Appendix 2: List of Participants

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Appendix 3: In-house meeting of UNFPA

UNFPA staff and selected invitees – to consider UNFPA strategies for increasing capacities of midwives to contribute to reducing maternal mortality.

The one-day working session followed immediately after the workshop. UNFPA is convinced of the need to strengthen the capacity of midwives to provide quality midwifery care, and thus contribute to reducing maternal mortality; but currently this is lacking in their MMM strategy.

Dr Arletty Pinel opened the session by reminding everyone that: Women are and must always be at the centre of care and the first of the care provider's concerns.

Plenary discussion

All agreed that:

- Midwifery is fundamentally about women working with, for and by women.
- Women are not and should not be perceived as victims, nor passive recipients of care, nor powerless care providers. Women as both users of healthcare and as providers of midwifery care are strong, powerful, women. As such their greatest need is to change the paradigm of midwifery and of midwives as a professional group.
- The UNFPA staff meeting should synthesise recommendations from the workshop and decide what can UNFPA can best do to make maximum impact with available resources.

(Remaining session, chaired by Vincent Fauveau)

Participants were encouraged to say what for them had been the highlight of the previous three days. Also what they intended to take action on as soon as they returned to their country offices. Individual action plans from staff members were discussed in detail.

All agreed that it would not be easy, as UNFPA own systems did not easily permit changes to the country plans. In addition, that strengthening midwifery was not in the MISP and, until it was, it would difficult to take the agenda forward. HQ staff agreed to take this up at the forthcoming staff meeting.

All agreed that country offices could benefit from having a midwife in

their country office team, as in Zimbabwe. Gift Mwanyisa-Malunga, midwife from the Zimbabwe CO, also thought that there were benefits from the midwife being a national, rather than recruiting an international midwife, because it would raise the profile of local midwives. She also suggested however, that the TOR should include linkages with the national professional midwifery associations and national midwifery leaders. Hers did not and she found the experience of working in the CO professionally isolating – although she enjoyed working there and was well supported by her colleagues in the CO, especially Dr, Bruce Campbell.

Country offices all promised to send information and stories to Vincent Fauveau that could be used for both the background paper and the forthcoming Maternal Mortality Update 2006.

Next steps

1. The report of the workshop will be communicated to all participants, and widely disseminated to all partners and others.
2. The background document will be finalised and disseminated, as above. Further work is needed to identify who can be useful and where the paper would be best placed to get maximum attention and impact.
3. UNFPA needs to consider how best they can "make a noise" on 7th April, World Health Day, and May 5, the International Day of the Midwife. The latter will be discussed with ICM – possibly issue a joint press release.
4. UNFPA has requested a proposal for support for ICM to support professional associations in-country to raise the profile of the midwife and increase midwifery leadership and training capacities at country level. This proposal should include support for midwives in UNFPA country offices so they can be linked into the global community of midwife practitioners. The proposal should be sent by ICM to New York office as soon as possible, ideally within two to three weeks.
5. UNFPA HQ are developing a number of proposals for additional funding, including to SIDA.
6. Strategic partnerships are required for scaling up capacity development of midwifery at country, regional and global levels. On regional basis work has already commenced by WHO; UNFPA are involved in some of this but needs to advocate with WHO for more collaboration.
7. Consider lessons learned from HIV, but remember that maternal health has things to teach and add to HIV strategies. UNFPA should articulate this much better and make it known to the wider community.

8. This work on capacity-building for midwives can be a model for scaling up capacity in other areas.

9. Midwives globally are ready to work with all stakeholders including UNFPA on efforts for maternal mortality reduction and beyond maternal health. ICM and the community of midwives present applauded this work and the aspirations outlined by UNFPA during the whole four days. This is something they have been trying to do for a long time. They are ready and willing to work with UNFPA.

However, to succeed in this global action it will be necessary to change the paradigm of midwifery and of midwives and to elaborate these in UNFPA's plans of action for MMM. UNFPA at all levels of the organization, stands ready to work with others on this important agenda

Appendix 4:

Resources And Reference Materials For Strengthening Capacities Of Midwives To Contribute To Maternal Mortality Reductions

Chamberlain, J. McDonagh, A. Lalonde, S. Arulkumaran *Averting maternal death and disability. The role of professional associations in reducing maternal mortality worldwide, J.*, available at *http://www.figo.org/content*

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International Midwives Association (ICM) web-site *www.internationalmidwives.org*, conations all position statements of ICM, philosophy of midwifery care, midwifery model of care, Core competencies of a midwife and the *International Definition of a Midwife*

ICM/WHO/UNICEF *Pre-Congress Workshop, The Hague, 21-22 August 1987 Women's Health and the Midwife - A Global Perspective*, WHO/MCH/87.5.

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World Health Report 2005: Making every mother and child count, WHO, Geneva 2005 available at *http://www.who.int/whr/2005/whr2005_en.pdf*
World Health Assembly Resolution 42.27, 1989 and 45.5, 1992 on Strengthening Nursing and Midwifery in Support of Strategies for Health for All

Yemeni women prefer friendship and support of home delivery, *Safe Mother*. 1996;(20):9