

Strengthening Midwifery Toolkit

Module 1

Strengthening Midwifery: A background paper



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1. Introduction

The World Health Organization's (WHO) interest in strengthening midwifery services is driven by the recognition that effective and sustainable mortality reduction, for both mothers and newborn infants, requires the presence of health care personnel equipped with a full range of midwifery skills. International interest continues to be shown in the midwife's role in global strategies for women's health. Indeed strengthening the role and contribution of midwives¹ is a central component in WHO's special contribution to the global Safe Motherhood Initiative - *Making Pregnancy Safer*.

There have been serious efforts over the past several decades to review effective interventions for improved pregnancy and childbirth outcomes. A clear consensus has emerged from this analysis that providing skilled attendance for every birth is an essential component of programmes for reducing maternal morbidity and mortality, and promoting reproductive health. All efforts concluded that without availability of a health provider with specific midwifery skills and competencies, particularly life-saving skills, international goals for maternal and newborn health cannot be reached.

There are several types of practitioners who have a mix of skills and abilities that qualify them to serve as skilled birth attendants.² They include:

- midwives who have been educated and licensed to perform an agreed set of competencies;
- nurses, who have acquired selected midwifery skills either as part of a nursing curriculum or through special post-basic training in midwifery;
- medical doctors who have acquired these competencies at some point in their pre-service or post-basic education;
- obstetricians who have specialized in the medical management and care of pregnancy and childbirth and in pregnancy-related complications.

Thus, the WHO *Making Pregnancy Safer* department focuses on strengthening the health system, to ensure that all women and newborns have access to and care from a health practitioner with midwifery skills. The strategic approaches of the department aim to support countries in their efforts to accelerate progress towards the attainment of international development goals and targets related to reproductive health (WHO, 2004; WHO 2006 a).

2. Purpose of this toolkit

This toolkit focuses specifically on the role and function of the professional midwife, as central to the provision of quality reproductive and sexual health services. Guidelines have been prepared to assist member states as they consider

¹ It is acknowledged that in some countries a different name is ascribed to those who carry out the function and role of the midwife as identified in the international definition of midwife cited later in this module. Furthermore, in some countries the midwife (or country equivalent) may also have to carry out additional tasks to those included in the definition. For simplicity the term "midwife" will be used throughout this document to refer to any person, whatever their title and regardless of how they are formally prepared and licensed who fulfils the definition of the midwife.

² A skilled attendant is 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 (WHO, 2004).

strategies by which midwifery services can be strengthened. These guidelines have been developed by experts in the various areas, drawing on lessons learned from countries where there has been successful provision of quality midwifery services that are accessible to all women. The guidelines can be used for establishing or reviewing midwifery programmes according to a country's needs and priorities.

Critical components of a strategic approach to reducing maternal morbidity and mortality, as well as to promoting women's health throughout their reproductive life are addressed in these guidelines. These include:

- redefining the role of the midwife (Modules 2 and 4);
- establishing an enabling legislative and policy framework for practice (Module 2);
- defining essential competencies for clinical practitioners and educators, as well as for the health system, to support effective service delivery (Module 4);
- establishing standards that promote the quality of midwifery services (Module 3);
- updating educational programmes for both students and teachers, to respond to community needs (Modules 5 and 6);
- developing mechanisms for supportive supervision (Module 7) and the assessment of continued competency of midwives over their working lifetime (Module 8);
- proposing alternatives that countries might consider as they build capacity for quality midwifery services (Module 9).

This background paper underpins the *Toolkit*. It briefly considers the concepts of safe motherhood and reproductive health. It presents a brief historical background of the development of midwifery as a way of being “with women.” It also presents a conceptual framework that depicts the central position of midwives as key providers of safe motherhood services, within the context of the health systems policy and infrastructure that create the enabling environment for midwifery practice. The content of the specific modules is then described, and a rationale in support of the guideline is presented. An assessment tool offered in the annex is suggested as one approach that can be used to assess the status of the midwifery profession in a country, leading to identification of priorities for action.

3. The concepts of reproductive health and safe motherhood

3.1 Reproductive health

Women's reproductive health is a concept that embraces women's health from birth to menopause.

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed of and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. In line with the above definition of reproductive health, reproductive health care is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases.'

Source: (ICPD Programme of Action)

3.2 The status of women

The status of girls and women in society is an important determinant of their reproductive health. Girls and women in many resource-poor countries suffer great risks to their health from reproduction. From early childhood in most poor countries the girl is more likely to suffer from malnutrition. She is often breastfed for a shorter period of time. Subsequently girls and women may have to wait until the men and boys in the family have eaten before they are permitted to eat.

Girls usually have fewer opportunities for education and far more household responsibilities than boys. They are frequently exposed to violence, sexual harassment and trafficking which may lead to pregnancy during adolescence and/or sexually transmitted infections (STIs). Early marriage and adolescent pregnancies are far too common in many countries. They often mark the end of the period of formal education for girls. They are associated with greater risks for ill health, long-term disability and even death of mother and child. Frequent pregnancies are also common, especially in circumstances where women's status is often linked to their ability to bear many children, especially boys. Complications during pregnancy and childbirth are relatively common, especially when women are in poor health and do not have adequate care during pregnancy, childbirth and the postnatal period. Women may also face risks in preventing unwanted pregnancies; they bear most of the burden of contraception and, often, have to endure complications affecting the reproductive tract, particularly STIs and cancers (Filippi et al., 2006; Keleher & Franklin, 2008; Sciarra, 2009; WHO, 2005).

Both young women and young men are particularly vulnerable to reproductive health problems because of lack of information and limited or no access to services such as family planning. The rapid spread of HIV/AIDS, particularly among young women, has demonstrated their vulnerability and the need for sensitive and responsive education messages, technologies and services that reach them wherever they may live. It also demonstrates yet again the need to address prevailing gender-based inequalities (UNICEF, 2006).

On a societal level, it would be possible to improve the standard of living for the whole of society if birth rates were reduced. Family planning services are therefore of the utmost importance for the whole population. In order to achieve acceptance, however, education is essential. Medical services and, in particular, maternal and child care have to improve so that families are assured that their existing children have a good chance of survival. On the family level, too many children impoverish the family and adversely affect the mother's health but, in some countries, a large number of children are considered to be important as a sort of social insurance for the old age of the parents. Also, the value of a woman is dependent on her capacity to bring living children into society and therefore her fertility is considered of great importance. Improved outcomes in pregnancy and childbirth together with adequate fertility regulation measures, health education and counselling could help to bridge these dichotomies and help couples to reduce the number of children in their family.

Gender equality is central to realizing current international goals related to the status of women. Safe motherhood goals and the practice of midwifery as a profession are both inextricably linked to the status of women. They are linked, not only because most midwives are women (which in many countries remains as true today as many years ago) but also because midwifery, as an art and a science, is concerned with working with women and caring for women during a life process that mainly affects the health of women, even though it will impact on men's lives and the wider society. Regrettably, in many countries, political, social, cultural and

religious factors, and gender stereotypes, prevent women from accessing health services freely and also limit the educational and economic opportunities that would improve their socio-economic status.

Eliminating gender discrimination and empowering women will require that women's influence be enhanced over key decisions made at the household level, in the workplace and in the political arena (UNICEF, 2007). Empowerment of women would foster their ability to act as self-advocates for changes at each of these levels of decision-making that would lead to betterment of women's opportunities for improvement of their personal health and well-being. These include:

- equal access to primary school education for themselves and for their children, and in particular for their girl children;
- access to health care services that promote sexual and reproductive health (e.g. family planning, legal abortion, treatment of sexually transmitted infections) (Grimes et al., 2006);
- reducing risks to personal health (e.g., HIV and AIDS from unprotected sexual intercourse);
- increasing understanding of complications in pregnancy, childbirth, the postnatal period and neonatal periods; in turn, increasing the demand for access to life-saving interventions, through referral and transport, when necessary;
- promoting delay in marriage and first birth;
- strengthening access to and control over income derived from their own employment, and enhancing their influence over expenditures made with household income (e.g. nutrition, preventative and curative health care services);
- influencing development of policies that promote their access to essential obstetric care and similar services that promote safe motherhood and that protect women from the risk of violence, rape, trafficking and abuse, and culturally-embedded practices that are harmful to health (e.g. female genital cutting) (Cook & Ngwena, 2006; Iyer, Sen & Östlin, 2008.; Mbizvo & Zaidi, 2010; Meleis, 2005; WHO, 2005; Glasier et al., 2006).

3.3 Safe motherhood and *The Safe Motherhood Initiative*

Safe motherhood is a central component of reproductive health. Many countries have initiated national or local efforts to improve and expand maternal and newborn health services. Some countries have even made encouraging progress in improving reproductive health and particularly maternal and newborn health outcomes. Almost all countries that have achieved such success have done so through strengthening the capacities of those who provide midwifery services and emergency obstetric care. Improvements in maternal and newborn health have come about usually when midwives have received a firm educational foundation for practice, receive ongoing support for their work (supportive supervision and continued education), and when there are effective systems in place that create a positive practice environment for midwifery services. These factors create the effective links and mechanism for referral of women and newborns with complications for comprehensive essential obstetric and neonatal care. These linkages are depicted in Figure 1, as the conceptual framework of quality, equitable and accessible health services.

Safe motherhood is a concept, a commitment, and a set of ideals; therefore the definition is continually evolving, shaped by those who are engaged in deliberation about the concept or taking action to move it forward. A holistic definition of safe motherhood was promulgated by the WHO in 1994.

Safe motherhood aims at attaining optimal maternal and newborn health. It implies reduction of maternal mortality and morbidity and enhancement of the health of newborn infants through equitable access to primary health care, including family planning, prenatal, delivery and post-natal care for the mother and infant, and access to essential obstetric and neonatal care.

Source: WHO, 1994

The global Safe Motherhood Initiative was launched at an international conference in Nairobi, Kenya in 1987 and was sponsored by the WHO, the World Bank and the United Nations Fund for Population Activities (UNFPA). Since that time midwives have worked in collaboration with other professionals, agencies, governments and communities in pursuit of the goals of safe motherhood, including the Millennium Development Goals (MDGs) adopted by 189 countries in the year 2000 (UN, 2000; UN, 2005). Three of the MDGs are directly related to reproductive and sexual health.

- improve maternal health
- reduce child mortality
- combat HIV/AIDS, malaria and other diseases.

Four additional goals have a close relationship with health, including reproductive health:

- eradicate extreme poverty and hunger in communities
- achieve universal primary education
- promote gender equality and empower women
- ensure environmental sustainability.

Much has been learned about the complexity of these problems, and about the difficulties associated with implementing many of the strategies aimed at improving reproductive health. Some progress has been made, but much remains to be accomplished, particularly in lower-resource countries (UN, 2000; Stanton et al, 2007). A strategy to accelerate progress toward achieving the MDGs was formulated by the WHO in 2005. The WHO strategy is formulated on the guiding principle of human rights, specifically including rights to self-determination with respect to reproductive and sexual health. These human rights are also the essence of the safe motherhood initiative. The strategies were revisited and reaffirmed during a meeting of delegates to the UN Summit on Millennium Development Goals in 2010.

A summary of the fundamentals of safe motherhood is offered as follows.

Safe motherhood is the collective actions of childbearing families, women, men, health professionals working with women, health systems, government agencies, donors, and policymakers to take action that promotes the health and well being of women and their newborns during the childbearing period, including evidence-based interventions and policies needed to prevent unnecessary deaths and disabilities.

Source: Thompson, 2005

4. A brief history of midwifery, and the contemporary role of the midwife in maternal, newborn and reproductive health

The occupational role of the midwife is timeless in history. It emerged from the experience of being “with women” for childbirth, as a simple act of caring and compassion, that characterized the way of women regardless of culture or time. A more structured role emerged in many countries during our middle history, reflecting the development of the guild concept, with its apprentice approach to occupational status and function. The midwifery role and function has now evolved to the internationally recognized and respected status of a profession. The midwife’s traditional responsibilities have been extended into the broader context of reproductive health, counselling and education. The midwife has also become, in different times and places according to need, a manager, researcher, educator and advocate. The midwife’s field of action now extends beyond pregnancy and birth, to encompass issues such as the reproductive health of the adolescent, family planning, and the care of menopausal women. Midwives provide essential care for the newborn. They also care for the health of the communities in which they live and that they serve.

The following sections briefly trace the development of the midwifery profession. They provide brief comment on certain factors that continue to present challenges to the full realisation of the potential of the midwife as a key contributor to safe motherhood.

4.1 The early tradition of midwifery: Issues of social class and gender

Midwives are named in early Jewish and Christian writings which call them *wise women*. Prehistoric sculptures and ancient Egyptian drawings depict the work of midwives. The midwives’ work was central to the survival of the women and children of her time. Women were caretakers and healers. They mixed, brewed, and administered herbs and portions (early pharmaceuticals) for healing. The knowledge and skills of midwives were passed from generation to generation through apprenticeship.

The Greeks and Romans were the first to apply qualifications to midwifery practice, requiring that all midwives had to have had a child of their own. The writings of Hippocrates in the 5th century B.C. include a description of normal birth. Hippocrates is thought to be the first to organize and formally educate midwives (Wright, 1999).

The historical literature on midwifery suggests that midwives took care of normal births but that in an emergency a male physician (or priest) had to be summoned. Soranus of Ephesus, a 2nd century A.D. physician, wrote an obstetrical treatise giving instructions for midwives, including techniques for management of malpresentation by internal version and breech extraction. Women did not write books in that era; historians suggest that the obstetrical knowledge attributed to physician-authors were likely drawn from stories told by the midwives who learned their midwifery art and their intervention skills from their practical experiences (Soranus, in Cutter & Viets, 1964).

However important this work might have been to the community, it was, nevertheless, not necessarily considered respectable work, and was undertaken almost exclusively by women, and rarely by women of higher class status in their society. This social stigma prevailed well into the middle ages, with particularly strong endorsement by the Church, which forbade males to attend at births. Midwifery was seen as an unclean profession at best; and an unholy one – the

practice of witchcraft – at worst. Female healers became the target of witch-hunting, a program of ruthless persecution that was promoted by the church and supported by both clerical and secular authorities (Minkowski, 1992).

In ancient times and in primitive societies, the work of the midwife had both a technical or manual aspect and a magical or mystical aspect. Hence, the midwife was sometimes revered, sometimes feared, sometimes acknowledged as a leader of the society, sometimes tortured and killed. The midwife had knowledge and skill in an area of life that was a mystery to most people. Since women had no access to formal education, it was widely assumed that the midwife's power must come from supernatural sources, such as an alliance with the devil. During the Middle Ages, a frenzy of witch-burning, promoted by both church and civil authorities, was responsible for the killing of up to several million women, many of whom were midwives and healers.

Source: Sullivan, 2002

4.2 The middle tradition of midwifery: Issues of technological developments, and the dominance of male physicians in the practice of obstetrics

As late as the 15th century, only women birth attendants are depicted in paintings and engravings. The man-midwife appears around the 17th century, at a time when the male medical profession begins to control the practice of the healing arts. Barbara Ehrenreich and Deirde English, in their classic treatise *Witches, Midwives and Nurses: A History of Midwifery* (1973) document the emergence of the male medical profession, under the protection and patronage of the ruling classes.

Medical training was introduced into the arts and sciences taught in medieval universities, from which women were excluded. The general status and reputation of midwifery was even further negatively affected, suffering from a continued lack of organization and regulation, with little or no support for training and development.

There were certainly exceptions, worldwide. For example, German midwifery has a strong tradition that has developed since the 12th century. The first known professional contract between a midwife and a municipal authority dates to 1381, when the city of Nünberg established a salary, accommodations and tax benefits for the midwife who agreed to serve the city's poor. The first professional midwifery code was written in 1452, and was written specifically to protect midwifery against attempts by other groups to influence or control the profession (Scheuermann, 1995).

Louise Bourgeois is one of the more well known midwives of the middle ages, because of her service as midwife to the French royal court. She may have been a graduate of the school for midwives that had been established at the Hotel-Dieu in Paris in 1531. It is known that in 1598 she passed an official examination giving her a license to practice midwifery. She authored a textbook on midwifery that was widely translated into other languages (Perkins, 1996, Dunn 2004).

Madam du Coudray, who lived and worked in the mid-1700s travelled throughout the nation of France, bringing education to midwives on behalf of the King (Gelbart, 1998). She wrote her own text (*Abrégé de l'art des accouchements*, 1750) and crafted a life-size obstetrical teaching mannequin. Madam du Coudray taught over 10,000 students over a thirty-year period.

However, these women serve as exceptions to the generally negative perception that prevailed at the time of the competence of women healers in general and female midwives in particular. In fact, the history of midwifery in each of these countries parallels the experience of the middle centuries when church and male dominance and control caused many reversals and downturns in midwifery's attempt to reach an honourable occupational and professional status.

The development of obstetrical forceps, used only by man-midwife obstetricians

had a further negative influence on the status of midwifery. The Chamberlain family are credited with invention of the forceps in the mid-1600s, but it remained a closely guarded family secret for many years. William Smellie recorded his use of forceps in France nearly a century later. After the forceps became available to all male – and to almost no female – childbirth practitioners, an exclusive class of birth provider was created; and they began to more systematically dispute and devalue midwives' knowledge (Cahill, 2001).

Developments of the 19th century included pioneering efforts in obstetric anaesthesia, specifically, the use of chloroform (Simpson, 1990), advances in understanding of the function of the placenta, and, importantly, the conquest of childbed fever (Drife, 2002). Still, without wide access to education, the midwife was largely left without opportunity to benefit from new knowledge, creating an even wider social and economic gap between male-physician midwives and women practitioners of the midwifery art (Loudon, 2008).

4.3 The present tradition of midwifery: Issues of professional practice

Midwifery as a profession has its origins in the 17th century when European countries such as Sweden, France, Belgium and the Netherlands began to acknowledge that traditional attendants at birth required specialist education, assistance in skills development and appropriate supervision. Other European countries such as the United Kingdom, eventually followed suit later in the 19th and early 20th century. Educational opportunities opened for women. Midwifery institutes opened throughout Europe, and, by extension, to developing nations (Summers, 2000) (e.g. the Nightingale Ward, King's College Hospital London, 1862). Midwifery regulation was developed and widely implemented, in the interest of raising the standards of midwifery education and practice (Stevens, 2002).

The stories told about the emergence of midwifery in many (mainly Western) nations invariably include commentary about the evolution from the apprenticeship model of occupational preparation to the contemporary acknowledgement of the need for a more formal educational foundation for practice. However, these same stories reflect the importance of retaining aspects of the social and cultural context of midwifery practice, resisting full transformation of midwifery practice in the biomedical model of obstetrical health care services (Cosminsky, 2001; Jenkins, 2001; Armstrong, 2005; Temmar et al., 2006; Woods, 2007; Shields 2009).

The profession of midwifery at the turn of the century and in the new millennium has emerged in many nations as an autonomous profession, separate from other professions, even though, in many countries, it is linked conceptually and practically to both nursing and medicine (Dawley, 2002; ICM, 2005). Midwifery in many other nations (those lesser developed, and several Asian nations) continues to struggle with the challenges inherent in changing understandings, expectations and values, that are necessary to changing a traditional cultural paradigm. Midwifery remains an occupation or craft, and has yet to achieve a professional identity.

The International Confederation of Midwives (ICM), founded in 1919, currently represents a federation of midwifery associations from 75 nations of the world. The ICM and its members associations represent the organized efforts of midwives in countries, to speak for themselves on matters that affect the occupation and the profession, and to speak out with a unified voice about matters that affect the health of women, families and communities. This includes advocacy for development of national health strategies in all countries that would give midwives and doctors complementary roles in maternity care, as well as equal involvement in setting public health policy (Högberg, 2004).

5. The international definition of the midwife.

The definition of a midwife that follows was adopted by the International Confederation of Midwives (ICM) and the International Confederation of Gynaecologists and Obstetricians (FIGO) in 1972 and 1973 respectively, and later adopted by the World Health Organization (WHO). It was amended by the ICM in 1990; the amendment was ratified by FIGO in 1991 and by the WHO in 1992. A further amendment to the definition was developed by the ICM in 2005. The definition defines the broad scope of practice, and the settings in which the midwife provides maternity care services.

International Definition of the Midwife

A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.

The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.

The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care.

A midwife may practice in any setting including the home, community, hospitals, clinics or health units.

Source: ICM, 2005

6. The Strengthening Midwifery Toolkit

6.1 Module 1: Strengthening midwifery services: background paper

This introductory module is intended to highlight the place of midwives and the midwifery profession into the context of global strategies for improving safe motherhood, and the status of women. Current global maternal mortality data indicate that the risk of a woman dying as a result of pregnancy or childbirth during her lifetime is about one in six in the poorest parts of the world compared with about one in 30,000 in Northern Europe. Inequalities in the risk of maternal death occur not only by geographic region, but also by cause of death (Kahn et al., 2006; Ronsmans & Graham, 2006). The timing of maternal deaths clusters around labour, childbirth, and the immediate postpartum period. Recent attention has also been paid to the status of the newborn, and the impact that neonatal mortality has on the rate of mortality of children under the age of five (Lawn, 2005; Lawn et al., 2009).

The role of skilled attendants in reducing these very undesirable statistics has been clearly demonstrated in several developing countries that have managed to reduce their rates over the past several decades (Hogan et al., 2010). These achievements have been attributed, in substantial part, to

- scaling up of midwifery education,
- promotion of facility-based births, and support for systems that promote

- referral and transfer to these facilities;
- development of a supportive system for maternity care, that addresses regulation, control and supervision of the medical and midwifery professions.

The major direct causes of maternal death (haemorrhage, hypertensive diseases, sepsis and infection, obstructed labour and unsafe abortion) continue to be those for which effective life-saving interventions are available (Ronsmans & Graham, 2006). Midwives and other skilled attendants therefore have a major role to play in any effort further to reduce these undesirable rates of maternal and newborn morbidity and mortality. Guidance for countries about ways to promote and enhance the role of midwives as essential providers of skilled care within an enabling environment of care, are offered in the separate modules.

Each module deals with a different element that must be strengthened in order to have a competent, fully qualified, midwifery cadre. Each module has a number of checklists or a simple quick assessment guide, which are aimed at assisting those responsible for strengthening midwifery, or those who are just looking for ideas of where to start. The annex to the background paper (Module 1) provides a checklist for conducting a rapid situational assessment or ‘*health-check*’ for midwifery. This rapid assessment can be carried out by midwifery leaders in a small group; or they can complete it individually, then together share ideas and come to a consensus. The assessment aims to start the discussion around developing an agenda for creation of a ‘strengthening midwifery’ action plan. The “*health-check*” will help identify quickly the areas where there is a need to work. The criteria used for this rapid assessment have been developed with input from a wide variety of professional leaders at policy, education and managerial levels, in both developing and developed countries.

6.2 Module 2: Legislation and regulation of midwifery: Making safe motherhood possible

Effective legislation and regulation of midwives is essential for quality practice and improved standards of care. This module considers the purpose of legislation for the midwife, outlines the requirements for establishing a regulatory body for midwives and describes its main functions. It also incorporates an examination of general legislation affecting midwifery care and reproductive health, including laws concerning gender discrimination. Finally it provides information to assist those involved in the formulation or reform of legislation governing midwifery education and practice. The checklist presented in the annex to this module outlines the essential elements of a supportive legislative and regulatory environment that would enable midwives and other skilled providers to practice to the full extent of their competency, within the context of country-specific needs for safe motherhood.

6.3 Module 3: Developing standards to improve midwifery practice

This module links a discussion of the purpose of standards in advancing quality of high quality health care service delivery. A step-by-step process for assessing the need for a standard to guide the development of midwifery education programs and the process of health service delivery, and for then moving forward to accomplish the development, implementation and monitoring of the standard, is presented. The conceptual purpose and the process of standard-setting are linked to the *Making Pregnancy Safer* clinical care standards that have been developed. The checklist offered in the annex to Module 3 is an audit tool that can serve the purpose of assessing clinical care performance against the established *MPS* standard.

6.4 Module 4: Competencies for midwifery practice

The essential competencies for midwifery practice that are presented in the annex to this module were developed by the International Confederation of Midwives in 1999, approved by the ICM Council in 2002, and updated in 2010. The competencies emerged from an extensive process of global consultation, a detailed scientific Delphi study that drew consensus for the specific task statements, a field test conducted in 17 countries (2002), and a survey of ICM member associations in 88 countries (2010) that affirmed their global feasibility and importance in practice. The competencies provide an answer to the question “What is a midwife able to do?” The competencies address the needs of women and newborns throughout the pregnancy, childbirth and postnatal periods and include crucial life-saving skills. They also address the role of the midwife in contributing to the health and welfare of the community that she serves. The competencies:

- provide the basis for developing a programme for midwifery education ;
- give clear direction to midwives about the competencies they require in order to fulfil their role and responsibilities, at the time of entry into practice of the profession;
- give clear direction to teachers about essential midwifery knowledge and skills;
- provide information for governments and other decision makers, who often need a better understanding of exactly what midwives do and how they can be prepared for practice.

6.5 Module 5: Developing a midwifery curriculum for safe motherhood: Guidelines for midwifery education programmes

This module offers a framework for midwifery education and training that can be adapted to meet the needs of each country. The framework proposes an education programme that is community-based, because evidence has shown that when midwives are based in the community they can make a real difference to reproductive health, particularly in countries and communities where health care infrastructure is less developed, and where there are differences in access to care because of differentials in personal wealth (Page, 2001; McCaw-Binns, 2005; Borghi et al., 2006; Koblinsky et al., 2006). Some clinical experience in referral hospitals is included, however, because student midwives must learn to recognise and manage complications effectively and be competent in life-saving skills. The curriculum is problem-based, involving students in their own learning throughout the education and training programme. The model curriculum, presented in modular form, is included as an Annex to *The Strengthening Midwifery Toolkit*, rather than of this specific module.

6.6 Module 6: Developing effective programmes for preparing midwife teachers

A sufficient number of well-prepared midwife teachers, who are also competent in midwifery practice, are essential for the effective education and training of midwives. Regrettably, there is a serious shortage of well-prepared midwife teachers in many developing countries. This means that the trainers of midwives are often other professionals, who do not fully understand midwifery, midwifery philosophy or the culture, role and responsibilities of a midwife, and are not skilled practitioners of midwifery. As a consequence midwifery has not always been well understood; in some countries midwife graduates do not possess the full complement of midwifery competencies and or may not be grounded in the professional ethic of midwifery. This module builds on the basic elements of sound educational theory and practice that apply equally to the preparation of students for entry into practice (Module 5) to the preparation of practising midwives to become effective teachers in the classroom and in the clinical practice setting. The recommendations made for content of a teacher-education programme include the pedagogy of curriculum development, effective teaching strategies, and methods of evaluation. A number of options for the provision of programmes for the education of midwife teachers are included that build on shared resources within and among countries. A self-assessment checklist of midwife teacher competence is included in the annex.

6.7 Module 7: Supervision of midwives

Midwives predominantly work independently and often in challenging situations. There is great advantage to midwives, as well as to mothers and babies, when midwives are supported in practice by supervisors. There is evidence that midwives value this support. Midwives are enabled to provide a higher level of care when they are nurtured, developed and empowered. The role of the supervisor includes monitoring the practice of midwives to see that safe standards are maintained and encouraging continuous personal educational development. Supervisors are available to provide advice and guidance to midwives on practice issues. Supervisors contribute to the protection of mothers and babies through this service.

This module looks at the wider benefits of supervision. It offers a step by step guide for introducing supervision to maternity services. An example of introducing supervision for other cadres of skilled birth attendants is also included. A supervision check list is provided in the annex.

6.8 Module 8: Monitoring and assessment of continued competency for midwifery practice

The evidence that forms the basic of high quality clinical care is continually emerging and evolving. Continued competency for practice requires that each individual practitioner engage in an on-going process of inquiry and life-long learning. This commitment is consistent with the ethics that underpin professional midwifery practice. Nevertheless, access to current information is often restricted in lower-resource countries, where midwives may practice in communities that are geographically distant from educational centres, and that have limited access to resources that are available electronically (Internet). These community-based practitioners may also often practice with limited peer and supervisor review and support, as a strategy for reflecting on one's own performance in relation to established standards of practice. This module offers guidelines for individuals and for health systems managers who wish to establish mechanisms for promoting continued professional development, and a continuous quality improvement process. Two tools have been developed for individual and for peer or supervisor assessment of continued competency for midwifery practice. The tools are based on the ICM *Essential Competencies for Midwifery Practice* (see Module 4), and can be adapted to reflect the particular competencies that reflect the specific situation of the various countries.

6.9 Module 9: Developing midwifery capacity for the promotion of maternal and newborn health

The final module in this *Toolkit* offers alternatives that countries can consider as interim strategies, while building capacity for midwifery personnel. The strategies have in common the recruitment and posting of health workers in the community, after giving them basic additional training in midwifery, and particularly, in life-saving skills (Fauveau, 2006; Koblinsky et al., 2006; WHO, 2006 b). This module also proposes strategies to address the recruitment of new aspirants to the profession and the retention of midwives, countering the adverse impact of international migration of members of the healthcare workforce. A capacity assessment tool that addresses the status of development of country midwifery association(s) is provided in the annex.

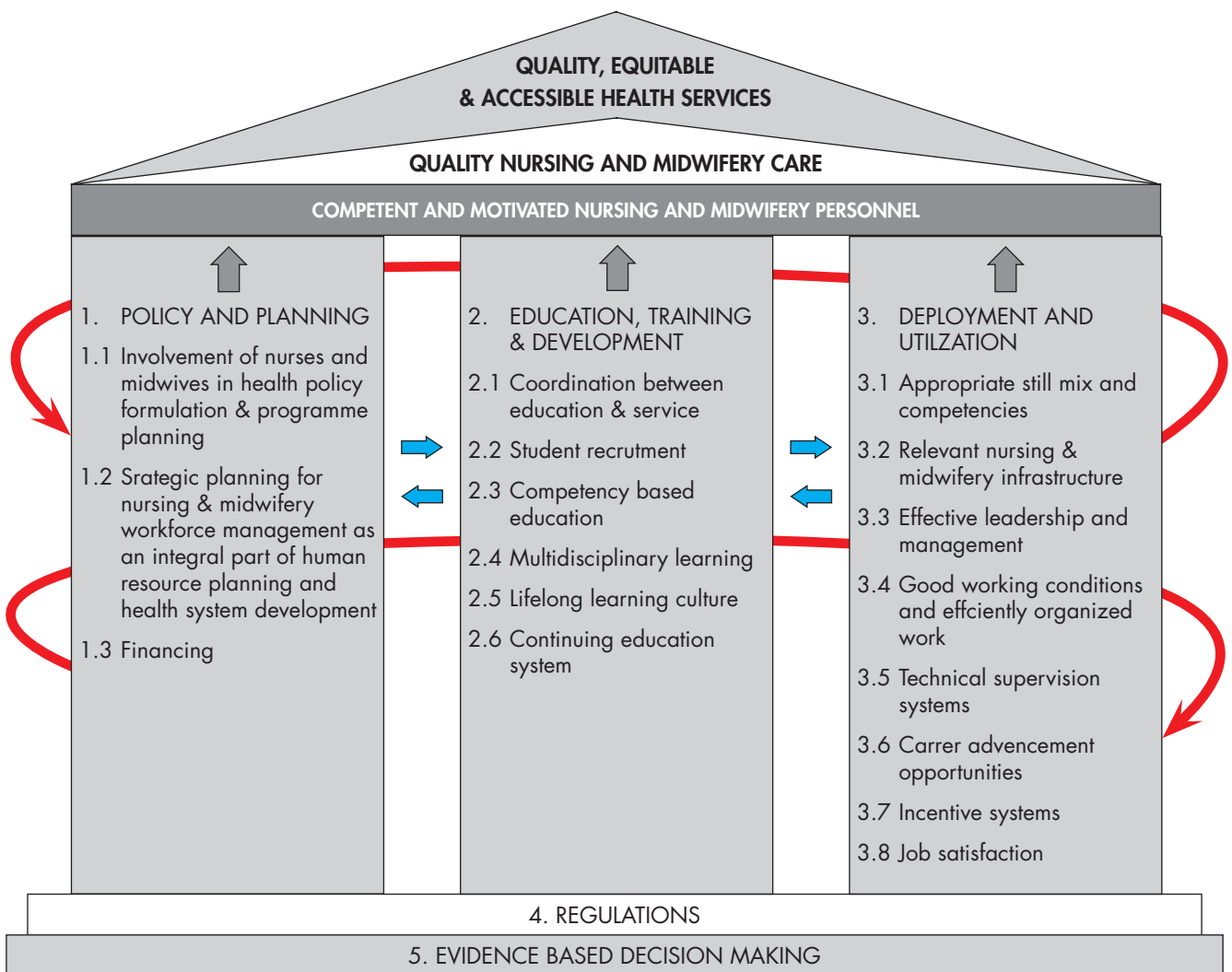
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Figure 1: A conceptual framework of quality, equitable and accessible health services.



ANNEX: A rapid assessment approach to identifying the need to strengthen midwifery in-country

Current Status	0	1	2	3
1. Rules/legislation are in place that frame/define the authority to practice midwifery.	No legislation covering authority to practice midwifery exists.	Rules are in place but not functioning.	Rules governing authority to practice are functioning but are assessed as being in-effective.	Authority for practice as defined in the ICM 'Definition of the Midwife' are in place and assessed as operating well.
2. A re-licensing procedure is in place that promotes the maintenance of continued competence.	No re-licensing procedure is in place.	A re-licensing procedure is in place, but is not linked to demonstrating competency to practice.	Plans are being developed / implemented to ensure re-licensing procedures that are linked to competent practice.	A re-licensing procedure is in place and linked to continued competency to practice. The procedure is operating and assessed as being effective.
3. A midwifery education curriculum has been developed and is based on particular country needs ("fitness-for-purpose").	No central standards have been established for a midwifery curriculum.	Central curriculum standards have been established, but no evidence exists that they meet current needs of the country.	Curriculum standards have been revised to be in line with fitness-for-purpose; however, they are awaiting approval or implementation.	Central curriculum standards based on fitness-for-purpose have been established, updated, and implemented. They are regularly reviewed.
4. Evidence-based (EB) standards have been established for midwifery practice (competency based).	EB standards of midwifery care have not been established.	EB standards are not developed, or no system is in place for regular updating or auditing.	EB standards are currently being developed/ implemented.	EB standards are in place and are regularly audited; action is taken based on audit findings.
5. Areas for midwifery and student clinical practice are assessed for the provision of quality service provision (care based on evidence-based standards) and for their fitness to provide appropriate clinical experience for students to gain competency in midwifery.	No assessment has been made of clinical areas.	Clinical areas do not provide quality care, or the experiences required for developing competent midwifery practice.	Clinical areas have been assessed; quality midwifery care is provided. However, the areas do not provide the full experiences required for developing competency.	Clinical areas provide quality midwifery care and all experiences required for students of midwifery, including supportive supervision of students.

Current Status	0	1	2	3
6. Realistic norms have been established for the number of midwives needed in each district.	No staffing norms have been established for districts, or norms for midwives are not generally known at district level.	Staffing norms are being established but current numbers of staff in the establishment are below that required to meet the needs of women and newborn in the district/country.	A national plan is being developed or revised to establish norms required to meet current needs.	Norms have been established and are being met in all districts, with only minimal shortfalls of midwifery staffing in some areas.
7. The number of midwives in clinical post (both government and private) are known and mapped according to actual place of work.	No mapping of midwives in clinical practice has been undertaken recently. There is no real knowledge of the total number of midwives currently working (including in private practice).	The numbers of midwives in clinical practice are known, but many vacant posts exist and there is no realistic plan in place to address the shortfall.	Mapping of midwives in clinical practice is taking place as part of national plan to address needs and shortfalls.	A realistic map of all midwives is currently in place, is known at national and district level. Special efforts are in place to meet the needs of hard-to-fill/long-term vacant posts.
8. Sufficient midwife teachers are in place - based on norms set for student:teacher ratio (S:TR).	No S:TR norms have been agreed, or the S:TR is unrealistic.	A realistic S:TR has been established, but is not in place in most areas.	A plan is currently being developed to address the shortfall of midwife teachers; the plan is based on a realistic S:TR.	A realistic S:TR has been established and is being met in most places.
9. A programme for preparation of midwife teachers is in place to ensure that midwife teachers are competent in all aspects of midwifery practice and education, including teaching and learning strategies, and have been adequately prepared for their post.	The numbers of midwife teacher posts required has not been determined and/or posting as a midwife teacher is not determined by successfully completing a specialist teacher preparation programme/ educational course.	Very few teachers of midwifery have received training and been assessed as competent in all aspects of midwifery, as well as competency to teach.	A plan is currently being developed/ implemented to ensure all teachers of midwifery are competent to be teachers of midwifery.	All teachers of midwifery have successfully completed specialist preparation as a midwife teacher.
10. Quality teaching and learning (T&L) resources are available.	No or very few T&L resources are available in all midwifery schools/ educational institutions.	Limited T&L resources are available in most centres, but many out of date.	Plans are currently in place to develop in-country appropriate quality T&L material to be available in all centres.	Sufficient and varied T&L materials of good quality are available and being used in all centres.

Current Status	0	1	2	3
11. Job descriptions for midwife at all levels of service (including the community) have been developed, are regularly updated/ revised, and include statements about the minimum standard of midwifery practice required by the post holder.	No specific job description is available for the person who provides midwifery care, or job descriptions are not prepared for posts at all levels of the service.	Job descriptions of clinical midwife posts are too vague, do not specify the particular needs of midwifery, or are out of date.	Job descriptions are currently being reviewed/ updated, to ensure that specifics of midwifery practice are covered, including EB standards of care and practice.	Job descriptions specific to midwifery practice are in place; they are based on provision of EB standards of care in all areas, including the community.
12. An in-service/ updating programme (prescribed by the midwifery association and/ or developed in liaison with the midwifery regulatory body) is in place.	There is no provision for updating or in-service and on-the-job training.	Limited updating is available to some midwifery practitioners in some areas.	A plan is being developed to implement a regular updating programme for all midwifery practitioners in all areas, including rural, hard-to-reach areas.	All midwifery practitioners participate in a regular updating programme. All have received some updating in last three years.
13. Provision has been made for continuing education programmes (CEP) for strengthening the capacity of midwives in country to provide leadership, and for career enhancement; the strategy is operating well.	No or limited provision has been made for midwifery practitioners to participate in CEP/ advanced education programmes, and/ or research development, management, policy, or leadership programmes.	Provision of CEP/ advanced education programmes for midwifery practitioners to increase capacity of midwives to plan and deliver quality midwifery, including research and management services, is under consideration.	Plans are currently being developed or implemented that will increase access to CEP/ advanced education programmes, including midwifery management and research.	Midwifery practitioners at all levels of the service have the opportunity to participate fully in CEP or advanced education programmes, including specialist midwifery studies at both Master's and PhD level and specialist programmes for midwifery leadership, management, research and policy development.

Table legend/scoring rule: 0= low 3= highest. (Ideal is to score 3 for each criterion.)

TOTAL SCORE

Date assessment undertaken:



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