

Regional Strategic Directions for
Strengthening Midwifery
in South East Asia Region
2020–2024



**World Health
Organization**

REGIONAL OFFICE FOR

South-East Asia

Regional Strategic
Directions for
strengthening midwifery
in the South-East Asia
Region 2020-2024

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Foreword

The WHO South-East Asia Region has made significant progress towards ending preventable maternal, newborn and child deaths. Between 2000 and 2019 the Region reduced the maternal mortality rate by more than 57%. Between 1990 and 2018 the Region reduced neonatal mortality by 60%. To meet the Sustainable Development Goal targets, sustained and accelerated progress is needed: By 2030, all countries must reduce maternal mortality by at least two thirds from the 2010 baseline. Neonatal mortality must be at least as low as 12 per 1000 live births. To achieve these targets, all countries must strengthen human resources for health, especially for sexual, reproductive, maternal and newborn health.



Across the Region, the services midwives provide, and the settings in which they work, vary. In many countries, at the primary health care level, midwives provide antenatal and postnatal care for the mother and newborn, as well as family planning. At secondary and tertiary levels, they provide intrapartum care, alongside medical doctors, nurses and, when complications occur, obstetricians/gynaecologists. In all settings, an adequate number of competent midwifery professionals and associate professionals must be trained and deployed to provide quality maternal and newborn care to all who need it.

Member States in the Region are making progress. Bangladesh, India and Nepal have in recent years introduced midwifery education. They joined DPR Korea, Myanmar, Sri Lanka and Timor-Leste in establishing midwives as an independent cadre of the health workforce. In Bhutan, Maldives and Thailand, nursing professionals continue to cover midwifery services. All countries must identify the policies and plans of action required to maximize the strength and quality of midwifery cadres.

This document – *Regional Strategic Directions on Strengthening Midwifery Education and Services in SEAR* – is designed to guide Member States and partners to assess, develop and strengthen midwifery education and services in a systematic and harmonized manner. It provides a set of key elements, strategic directions and key actions to support countries, and encourages them to learn from one another's experiences and adapt best practices. Member States are encouraged to use this document to understand and examine gaps and chart the way forward for improving midwifery education and services.

As we celebrate 2020 as the International Year of the Nurse and Midwife, I urge all Member States and partners to make full use of this resource to strengthen midwifery education and services across the South-East Asia Region. We must continue to reduce all preventable maternal, newborn and child deaths and accelerate towards the 2030 SDG targets.

A handwritten signature in black ink, reading 'P. Khetrpal Singh'.

Dr Poonam Khetrpal Singh

Regional Director
WHO South-East Asia Region

Acronyms

AAAQ	availability, acceptability, acceptability and quality of care
AMW	auxiliary midwife workers (Myanmar)
ANM	auxiliary nurse midwife
BMGF	Bill & Melinda Gates Foundation
BMP	Bachelor in Midwifery Programme
BMS	Bangladesh Midwifery Society
CHW	community health worker
CPD	continuing professional development
DPR Korea	Democratic People's Republic of Korea
EENC	essential early newborn care
EmOC	emergency obstetric care
FIGO	International Federation of Gynecology and Obstetrics
GCNMO	Government Chief Nursing and/or Midwifery Officer
GDP	gross domestic product
GMTP	Global Midwifery Twinning Project
GoI	Government of India
HRH	human resources for health
ICN	International Council of Nurses
ICM	International Confederation of Midwives
ILO	International Labour Organization
IPA	International Pediatric Association
IPC/INC	intrapartum care/intranatal care
IPE	inter-professional education
ISCO	International Standard Classification of Occupations
IT	information technology
KMC	kangaroo mother care
LHV	lady health visitor
MCH	maternal and child health
MDGs	Millennium Development Goals

MECC	Midwifery Educator Core Competencies
MIDSON	Midwifery Society of Nepal
MMR	maternal mortality ratio
MNH	maternal and newborn health
MoHFW	Ministry of Health and Family Welfare
MSF	Midwifery Service Framework
NGO	non-governmental organization
NHWA	National Health Workforce Accounts
NMR	neonatal mortality rate
NNC	Nepal Nursing Council
NPM	nurse practitioner in midwifery
PHM	public health midwife
PHN	post-natal care
PMAC	Prince Mahidol Award Conference
POCQI	point of care quality improvement initiative
QMNC	quality maternal newborn care
RCM	Royal College of Maldives
RMC	respectful maternity care
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SBA	skilled birth attendant
SDGs	Sustainable Development Goals
SEA	South-East Asia
SoWMy	The State of the World's Midwifery 2014
STI	sexually transmitted infection
SOP	standard operating procedure
TBA	traditional birth attendant
UHC	universal health coverage
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WRA	White Ribbon Alliance

The target audience of the *South-East Asia Regional Strategic Directions for Midwifery* comprise two professional groups as defined by the International Labour Organization (ILO)¹ in the International Standard Classification of Occupations 2008 (ISCO-08) providing Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) services. The professional term “midwife” is used in this strategy including the following two professionals defined by ILO.

◆ **Midwifery professionals (ISCO-08 code 2222)¹:**

“Midwifery professionals plan, manage, provide and evaluate midwifery care services before, during and after pregnancy and childbirth. They provide delivery care for reducing health risks to women and newborn children, working autonomously or in teams with other healthcare providers.”

Although this description varies from country to country, it includes general nurse-midwives, nurses and midwives.

◆ **Midwifery associate professionals (ISCO-08 code 3222)¹:**

“Midwifery associate professionals provide basic health care and advice before, during and after pregnancy and childbirth. They implement care, treatment and referral plans usually established by medical, midwifery and other health professionals.” These professionals include, for example, auxiliary nurse-midwives (ANMs) or lady health visitors (LHVs).

The target audience does not include non-professionals, i.e. community health workers (CHWs) or traditional birth attendants (TBAs), who are not trained, educated or regulated to the professional standards of that country.

The International Confederation of Midwives (ICM) defines the term “midwife” as follows:²

- ◆ An individual person who has successfully completed a midwifery education programme that is recognized in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery; and who demonstrates competency in the practice of midwifery.

In 2018, a joint statement by the World Health Organization (WHO), the United Nations Population Fund (UNFPA), the United Nations Children’s Fund (UNICEF), the ICM, the International Council of Nurses (ICN), the International Federation of Gynecology and Obstetrics (FIGO) and the International Pediatric Association (IPA) announced a new definition of “skilled health personnel providing care during childbirth”, also widely known as “skilled birth attendants (SBAs)”. The definition of skilled health personnel providing care during childbirth, which includes midwives, and a conceptual framework are given in Box 1 and Fig. 1, respectively.

Box 1**The 2018 definition of skilled health personnel (competent health-care professionals) providing care during childbirth³**

Skilled health personnel, as referenced by Sustainable Development Goal (SDG) indicator 3.1.2, are competent maternal and newborn health (MNH) professionals educated, trained and regulated to national and international standards.

They are competent to:

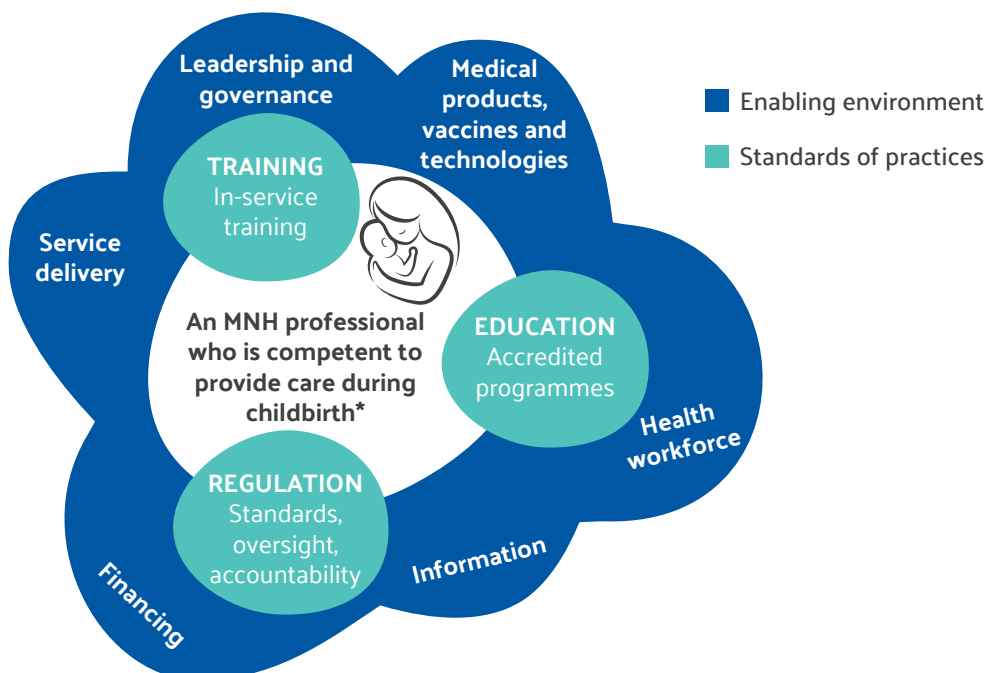
- ◆ provide and promote evidence-based, human-rights-based, quality, socioculturally sensitive and dignified care to women and newborns;
- ◆ facilitate physiological processes during labour and delivery to ensure a clean and positive childbirth experience; and
- ◆ identify and manage or refer women and/or newborns with complications.

In addition, as part of an integrated team of MNH professionals (including midwives, nurses, obstetricians, paediatricians and anaesthetists), they perform all signal functions of emergency maternal and newborn care to optimize the health and well-being of women and newborns.

Within an enabling environment, midwives trained to ICM standards can provide nearly all of the essential care needed for women and newborns.*

* The state of the world's midwifery 2014: a universal pathway: a woman's right to health. New York (NY): United Nations Population Fund; 2014 (www.unfpa.org/sowmy).

Figure 1: A conceptual framework for the definition of skilled health personnel providing care during childbirth



*The WHO-led Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030)*⁴ has been developed to support the implementation of Sustainable Development Goal (SDG) 3,⁴ which focuses on “good health and well-being” for all ages. This strategy aims to create “a world in which every woman, child and adolescent in every setting realizes their rights to physical and mental health and well-being, has social and economic opportunities, and is able to participate fully in shaping prosperous and sustainable societies by 2030” as a core vision aligned with the Every Woman Every Child movement since 2010.⁶ Importantly, the objectives of this strategy called “survive, thrive and transform”,⁵ move forward from the Millennium Development Goals (MDGs), which focused on survival of mothers and children, to a wider approach to ensure their health and well-being (thrive) and expand enabling environments such as eradicating poverty and ensuring gender equity (transform) as well as to end all preventable deaths during the perinatal period (survive). As shown in Box 2, reducing neonatal mortality including preterm birth and stillbirth is an unfinished agenda of the MDGs.^{4,5} This strategy provides a unique opportunity for embedding midwifery within the actions to scale up the achievement of SDG 3.

Box 2**Objectives and targets in the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030)⁵****SURVIVE – End preventable deaths**

- ◆ Reduce global maternal mortality to less than 70 per 100 000 live births
- ◆ Reduce newborn mortality to at least as low as 12 per 1000 live births in every country
- ◆ Reduce under-five mortality to at least as low as 25 per 1000 live birth in every country
- ◆ End epidemics of HIV, tuberculosis, malaria, neglected tropical diseases and other communicable diseases
- ◆ Reduce by one third premature mortality from non-communicable diseases and promote mental health and well-being

(Continued)

(Continued)

THRIVE – Ensure health and well-being

- ◆ End all forms of malnutrition and address the nutritional needs of children, adolescent girls, and pregnant and lactating women
- ◆ Ensure universal access to sexual and reproductive health-care services (including for family planning) and rights
- ◆ Ensure that all girls and boys have access to good-quality early childhood development
- ◆ Substantially reduce pollution-related deaths and illnesses
- ◆ Achieve universal health coverage (UHC), including financial risk protection and access to quality essential services, medicines and vaccines

TRANSFORM – Expand enabling environments

- ◆ Eradicate extreme poverty
- ◆ Ensure that all girls and boys complete free, equitable and good-quality primary and secondary education
- ◆ Eliminate all harmful practices and all discrimination and violence against women and girls
- ◆ Achieve universal and equitable access to safe and affordable drinking water and to adequate and equitable sanitation and hygiene
- ◆ Enhance scientific research, upgrade technological capabilities and encourage innovation
- ◆ Provide legal identity for all, including birth registration
- ◆ Enhance the global partnership for sustainable development

BOX 3

The definition of midwifery: the Lancet Series on Midwifery, 2014⁶

Skilled, knowledgeable and compassionate care for childbearing women, newborn infants and families across the continuum from pre-pregnancy, pregnancy, birth, postpartum and the early weeks of life

Core characteristics include the following:

- ◆ optimizing normal biological, psychological, social and cultural processes of reproduction and early life;
- ◆ timely prevention and management of complications;
- ◆ consultation with and referral to other services;
- ◆ respecting women's individual circumstances and views; and
- ◆ working in partnership with women to strengthen women's own capabilities to care for themselves and their families.

The impact of midwifery

The Lancet Series on Midwifery (2014) sets out the evidence on the needs of women and their newborns. This evidence estimates that safe and effective midwifery care (which includes family planning) can avert 83% of all maternal deaths, stillbirths and newborn deaths.⁷ The potential impact of midwives who have been educated and trained and are regulated to provide the full scope of ICM competencies would be a rapid and sustained reduction in maternal and newborn mortality and morbidity. A recent Cochrane review, where a model of midwife-led continuity of care is in place in well-functioning midwifery systems, shows that 24% of preterm births can be prevented.⁸

Though there is an increase in overuse of interventions during pregnancy and birth globally in high- and middle-income countries, underuse of interventions exists in low-income countries.⁹ This is echoed in the 2018 Lancet Series on “Optimising caesarean section use”. Although WHO has recommended an optimal caesarean section rate of between 10 and 15%,¹⁰ several high- and middle-income countries exceed the recommended range. Relevant Cochrane reviews indicate that midwife-led care approaches have no identified adverse effects compared with medical care and have decreased the likelihood of medical interventions such as caesarean section and augmentation of oxytocin. Recommendations include midwife-led care approaches in certain contexts to prevent unnecessary interventions and increased access to quality care, as well as investing in the training of all relevant health professionals.

Another recent global concern is mistreatment and violence against pregnant and intrapartum women in reproductive health services, which occurs in the context of structural inequality, discrimination and insufficient education of health professionals.¹¹ Promoting “a woman-centred approach” among the midwifery workforce is very important not only to protect women’s human rights, but also to promote an enabling society ensuring equal status, autonomy and freedom from discrimination for women.

Together with the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030),⁵ the WHO Global Strategy on Human Resources for Health: Workforce 2030¹² and the WHO Strategic Directions for Nursing and Midwifery 2016–2020,¹³ provide further guidance to strengthen midwifery to accelerate the achievements made in the MDG era and to improve universal access to RMNCAH services. Availability, accessibility, acceptability and quality of care (AAAQ) is a key concept to enhance the nursing and midwifery workforce. Worldwide, there is a constant shortage of health service professionals. The midwifery workforce is neither sufficient nor equitably distributed geographically. According to the WHO Global Strategy on Human Resources for Health: Workforce 2030,¹² an indicative minimum density of 44.5 doctors, nurses and midwives per 10 000 population was identified as representing the need for health workers. In addition, quality midwifery services should provide care to span the entire reproductive continuum including family planning and screening for sexually transmitted infections (STIs), as well as breast and cervical cancer.

A regional workshop on strengthening midwifery was convened in 2015 in the South-East Asia (SEA) Region and a draft was evolved on the “Roadmap for strengthening midwifery to improve maternal and newborn health in South-East Asia Region 2015–2020”. This draft identified

strategic areas and key actions for country consideration on midwifery to improve maternal and newborn health. This was followed by the “Decade of strengthening human resources for health (HRH) in South-East Asia Region 2015–2024”, which focuses on four priority areas: transformative education, rural retention, HRH governance, and HRH data and information; as a result, the situation of overall health workforce has improved.^{14,15} In 2017, the WHO Regional Office for South-East Asia carried out a regional survey on the nursing and midwifery workforce. The survey aimed to identify key issues in each country, highlight areas for action and propose recommendations. However, challenges to improving the midwifery workforce remain in terms of governance and regulation, access to quality education and training, workforce management (including deployment) as well as having better quality research and evidence to inform progress.

This first Regional Strategic Directions for strengthening Midwifery in the South-East Asia Region 2020–2024 is being developed on the basis of the existing draft regional roadmap (2015), the regional workforce survey and is aligned with the above-mentioned global strategies and guidelines. It aims to provide a set of key elements, strategic directions and key actions to support countries for improving RMNCAH services for UHC. Internal and external reviews were done and discussion for inputs by the 11 countries in the Region took place at the “Regional meeting to strengthening nursing and midwifery education and services to improve RMNCAH in the South-East Asia Region”, convened by the WHO Regional Office for South-East Asia during 5–7 February 2019. In addition, final review was conducted through the expert group consultation meeting during 16–17 December 2019.

1. Health trends and challenges in maternal and newborn health in the SEA Region

Across 11 countries in the SEA Region, there is great diversity in terms of geography, population, gross domestic product (GDP) and health indicators. Basic data relevant to RMNCAH for the 11 countries in the SEA region are shown in Table 1.

Many countries in the SEA Region still have a long way to go to meet the regional targets of maternal mortality ratio (MMR) and neonatal mortality rate (NMR) reduction (MMR: reduce MMR by at least two thirds from the 2010 baseline by 2030; NMR: reduce NMR to at least as low as 12 deaths per 1000 live births)¹⁶ despite significant progress made since the MDG era. Given that most maternal and newborn mortality takes place in the early postnatal period, institutional delivery assisted by a skilled birth attendant (SBA) has been promoted over the years. As a result, there was a 78% increase in institutional delivery in the Region over the past decade and access to an SBA increased. However, the expected rate of decline in maternal and newborn mortality has not taken place in all countries. This can partly be attributed to the huge disparities in the health workforce and geographical access to an SBA. In addition, it should be noted that women from lower economical background are more likely to face difficulty in access to qualified health care, leading to a higher risk of complications during the perinatal period. Therefore, it is necessary to improve UHC in countries of the SEA Region, including establishing or strengthening the systems for regulation, education and continuous training of midwifery care providers. The evidence is clear that improving the quality of reproductive,

Table 1: Sexual, reproductive, maternal and newborn health in the SEA Region

Country	Population (million) ¹⁷	MMR: 100 000 LB ¹⁸	NMR: 1000 LB ¹⁹	% Births attended by SBA ^{20,21}				% Institutional deliveries ^{20,21}	% C-section ^{20,21}	Adolescent birth rate ²² : 1000 LB	
				Total	Urban	Rural	Wealth index Lowest 20 percentile				Wealth index Highest 40 percentile
Bangladesh	164.7	173	20	42 (2014)	61 (2014)	36 (2014)	17 (2014)	52 (2014)	37 (2014)	23 (2014)	33 (2016)
Bhutan	0.808	183	18	64 (2010)	90 (2010)	54 (2010)	34 (2010)	81 (2010)	63 (2010)	12 (2010)	28 (2012)
DPR Korea	25.5	89	9	100 (2017)	100 (2017)	99 (2017)	99 (2017)	100 (2017)	92 (2017)	13 (2017)	0.0 (2017)
India	1339.2	145	25	81 (2015-16)	90 (2015-16)	78 (2015-16)	64 (2015-16)	92 (2015-16)	79 (2015-16)	17 (2015-16)	28 (2015-16)
Indonesia	264.0	177	14	91 (2017)	96 (2017)	86 (2017)	75 (2017)	97 (2017)	74 (2012)	17 (2012)	40 (2014)
Maldives	436	53	5	95 (2016-17)	NA	NA	99 (2016-17)	99 (2016-17)	95 (2009)	32 (2016-17)	13 (2014)
Myanmar	53.4	250	25	60 (2016)	88 (2016)	52 (2016)	36 (2016)	80 (2016)	37 (2016)	17 (2016)	36 (2014)
Nepal	29.3	186	21	58 (2016)	68 (2016)	47 (2016)	34 (2016)	70 (2016)	57 (2016)	9 (2016)	88 (2015)
Sri Lanka	20.9	36	5	99 (2016)	99 (2016)	99 (2016)	98 (2016)	99 (2016)	99 (2016)	56 (2016)	20 (2015)
Thailand	69.0	37	7	99 (2016)	99 (2016)	99 (2016)	98 (2016)	99 (2016)	99 (2016)	33 (2016)	51 (2015)
Timor-Leste	1.3	142	22	57 (2016)	86 (2016)	45 (2016)	26 (2016)	90 (2016)	49 (2016)	4 (2016)	70 (2016)

Sources: World Population Prospects 2017; UN-MMEIG 2017; UN IGME 2017; National survey including DHS and/or MICS in countries; WHO GHO (2018)

Box 4**Filling maternal and child health (MCH) service gaps through auxiliary midwife workers (AMWs) in Myanmar²³**

Myanmar faces severe shortage of qualified health-care providers, especially for maternal and child health (MCH) in far-flung rural areas. Auxiliary midwife workers (AMWs) work in rural areas in the place of absent midwives and provide essential maternal and child health (MCH) services. AMWs were given training for six months in essential maternal and newborn care.

AMWs lived in the village of their posting and earned their living through other means, mainly farming. They carried out MCH and other health-related activities as volunteers. They provided antenatal and postnatal services and supported women during childbirth.

More than 1000 AMWs in 19 townships were studied to assess their knowledge and practices related to MCH. Their contribution to maternal, newborn and infant care was clearly visible. However, there were huge gaps in knowledge and skills. They expressed need for technical supervision and further refresher training. Since they were from the same community, they were committed to continuing their work as a long-term activity. Their availability and retention, though a positive point, needs to be weighed with the need for providing quality services with technical competence.

Source: Wangmo S, Suphanchaimat R, Htun WM, Tun Aung T, Khitdee C, Patcharanarumol W et al. Auxiliary midwives in hard to reach rural areas of Myanmar: filling MCH gaps. *BMC Public Health*. 2016;16:914.

maternal and newborn health is essential to expedite progress and for better outcomes.

2. Midwifery situation in the SEA Region

To strengthen midwifery and achieve universal access to RMNCAH to all women, it is important for countries in the SEA Region to continue to improve the AAAQ of the midwifery workforce.²⁴

1) Governance and regulation of the midwifery workforce

Good governance is critical to strengthening midwifery care. Regulation of the workforce is essential for protecting women and newborns, as well as for legal protection of educators and practitioners. Assessment and review of existing regulatory mechanisms is an important step in strengthening midwifery. In countries such as India engaging with women and families on the care that women want midwives to provide to them has been shown to be highly beneficial; it helps to improve the public understanding of midwifery and perception of midwives.

Midwifery leadership and governance

The evidence shows that midwifery leadership can be weak as a result of complex, gendered hierarchies of power in medical institutions combined with limited opportunities for the

development of leadership among both nurses and midwives.²⁵ In countries where midwifery is incorporated within nursing, there are fewer opportunities for the development of good governance and leadership for midwifery. The WHO-ICM-WRA (White Ribbon Alliance) global report on “Midwives Voices, Midwives Realities”²⁶ documents the real constraints they face in areas such as career progression and opportunities to influence policy, planning and budgeting. Thus, ensuring that midwifery leadership is strengthened and that midwifery leaders have a voice in formulating policy and decision-making will be critical to improving outcomes for women and their newborns.

Table 2: Government chief nursing and/or midwifery officer (GCNMO) in countries of the SEA Region²⁷

Country	GCNMO* appointment	Affiliation of GCNMO
Bangladesh	Yes	Directorate General of Nursing and Midwifery, Ministry of Health and Family Welfare
Bhutan	Yes	National Hospital of Bhutan
DPR Korea	Yes	Department of Medical Education, Ministry of Public Health
India	Yes	Nursing Division, Ministry of Health and Family Welfare
Indonesia	Yes	Indonesian Health Workforce Council, Ministry of Health
Maldives	Yes	Nursing and Midwifery Council, Ministry of Health
Myanmar	Yes	Department of Medical Services Department of Human Resource for Health, Ministry of Health and Sports
Nepal	Yes	Nursing and Social Security Division, Department of Health Services, Ministry of Health and Population
Sri Lanka	Yes	National Hospital of Sri Lanka
Thailand	Yes	Ministry of Public Health
Timor-Leste	Yes	Department of Human Resource, Ministry of Health

Source: Country data presented during the Regional Meeting to strengthen nursing and midwifery in the SEA Region, February 2019.

Establishing a National Midwifery Task Force with multiple stakeholders is recommended by WHO.²⁸ The leadership and visibility of this process is enhanced where the task force is led by the government chief nursing and/or midwifery officer (GCNMO). Table 2 shows the appointment of GCNMO in the SEA region. All countries in the SEA Region appoint GCNMO. Their affiliation depends on the individual countries, most of them belong to the Ministry of Health; however, the division varies such as health/medical services or HRH. The roles and responsibilities of GCNMO include mainly (i) development of policy/strategy/guideline/action plan related to nursing and midwifery services; (ii) coordination and collaboration with relevant programme under government, professional societies and academic institutions.²⁹

Midwifery regulation and recognition

Gathering the baseline data on regulation and the recognition of midwives is an important starting point in strengthening midwifery. Table 3 highlights key issues that can facilitate, or create a barrier to, quality midwifery care. Most of the countries except India and Myanmar have their policy or guidelines on midwifery regulation based on ICM guidelines. Seven of the 11 countries of the SEA Region have recognized a clear definition of a midwifery professional and eight countries have a clear licensure process required for midwifery practice. Currently, Nepal is establishing a licensure process for midwifery practice as well as considering the definition of midwife.

Table 3: Midwifery regulation and recognition in countries of the SEA Region^{24,27,30}

	BAN	BHU	DPRK	IND	INO	MAV	MMR	NEP	SRL	THA	TLS
Existence of national policy/guidelines on regulation based on ICM standards	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes
Recognized definition of a midwifery professional exists	Yes	Yes	Yes	No	Yes	Yes	Yes	Under development	Yes	Yes	Yes
A licensure process required for midwifery practice	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Under establishment	Yes	Yes	Yes
Type of regulator	Council	Council	MoH	Council	MoH	Council	Council	Council	Council	Council	MoH

MoH: Ministry of Health

Source: SOWMY 2014; RMNCAH policy survey 2018; Country data presented during the Regional Meeting to strengthen nursing and midwifery in South-East Asia Region, February 2019

Box 5

Indonesian Parliament passes the Midwifery Act²⁷

Midwifery education and practice are governed and regulated through specific laws and decrees in Indonesia. The country has a separate cadre of midwives, which is different from nurses, who work in rural and urban areas. The country also has vibrant professional associations and groups interested in contributing to maternal and child health (MCH).

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The Midwifery Act was submitted before Parliament in 2005 and revised in 2014. For the past four years the Act has been under consultation between the government and Parliament. The Midwifery Law was passed by Parliament on 4 February 2019.

Several other laws facilitate the regulation of midwifery practice in Indonesia. Under Regulation No. 32/1996, midwives and nurses were grouped together under a common head – nursing. The Health Professional Law No. 36/2014 mentions midwives as a separate cadre among 12 other groups of health-care providers. Career pathways are designed for different levels of the midwifery workforce.

Governance and regulation for midwifery practice are clearly defined in the country. Registration letters issued by the council are mandatory for practising midwifery. Registration is for five years and renewal is required for further practice. Besides this, practising midwives require a licence from the district government to practise within the district. A midwife is allowed to practise in any setting – public or private, within a facility or as a private practitioner.

The scope of midwifery practice is regulated by the Ministry of Health (MoH) Decree No. 2/2017, which mentions antenatal health care, neonatal, infant and child care (<5 years), reproductive health and family planning. A series of decrees by the MoH further facilitates and regulates the practice of midwives. For example, Decree No. 71/2013 states that fee for midwifery services will be covered by the National Health Insurance.

Current challenges for the midwifery workforce in Indonesia include difficulties in maintaining the quality of training, trained faculty, and standardization of midwifery practice across all facilities and private practice. The uneven distribution of the midwifery workforce is also a challenge.

Source: Country data presented during the Regional Meeting to strengthen nursing and midwifery in South-East Asia Region, February 2019.

National Midwives Association

The State of the World's Midwifery (SoWMy) 2014 report identified three strategic priorities in "Midwifery 2030: Education, Regulation and Association (ERA)".²⁴ National associations, supported and guided by the ICM, provide independent support to their actively practising members. It is the members of the National Midwives Association who are closest to the reality on the ground and who are well placed to influence policy. Members of the association also play a significant role in applying evidence to practice. An association ensures accountability by holding midwives and the government responsible. Self-motivated members of the association ensure that the National Midwives Association (to which they pay membership fees) provides what they need to give women and their newborns the best care possible. Historically, countries with strong and independent midwifery associations have strong midwifery leadership, education and practice.

Nine of the 11 countries in the SEA Region (except Bhutan and DPR Korea) have a national professional association which covers midwifery. Some countries have a midwifery association separate from the nursing association while others have a combined nursing association.

Box 6

Professional twinning: building an association of midwives in Nepal³¹

The presence of a strong professional association of midwives in a country yields double benefits. On one side, the association provides inputs into framing policies and developing standards of care, and on the other, it ensures quality services by continuously updating its members with information and evidence for practice.

The Midwifery Society of Nepal (MIDSON) was launched in 2010 with the objectives of introducing a separate education programme and official recognition for midwives. The founders believed that a strong association was required to spearhead the introduction of a separate midwifery workforce in the country. However, they did not have funds or organizational experience to launch activities for raising awareness, creating visibility and influencing policy.

The Royal College of Midwives (RCM) in the UK entered into a twinning relationship with MIDSON through its Global Midwifery Twinning Project (GMTP). Both organizations gained as a result of the twinning relationship as it created interest in volunteerism among UK midwives and enhanced awareness about midwifery in Nepal. After the initial floundering steps the RCM members worked with the MIDSON executives to conduct workshops on the role that midwives play in maternal and infant health and the strengths of introducing a midwife model of care in the country (Ireland et al., 2015).

There are several challenges. There are many problems in introducing midwifery as a profession distinct from nursing. Mothers and communities in Nepal do not distinguish between a nurse and a midwife. This requires setting up models of midwife-led care across the country. MIDSON continuously advocates for introducing midwife-led care and birthing centres run by midwives in hospitals and as independent units.

Source: Ireland J, van Teijlingen E, Kemp J. Twinning in Nepal: the Royal College of Midwives UK and the Midwifery Society of Nepal working in partnership. *Journal of Asian Midwives (JAM)*. 2015;2(1):26–33.

2) Midwifery education system

The midwifery education system varies across the Region. In some countries in this region, midwifery education is integrated into nursing education as is the cadre. The length of midwifery education courses varies between 6 and 48 months depending on the country and the existence of accreditation mechanism for midwifery education programme or institutions. Most of the countries have national systems for continuing professional development (CPD) in midwifery. Strengthening the function of nursing and midwifery councils as well as collaboration between

the MoH and nursing and midwifery councils would be important to develop a rigorous and robust system for midwifery education and training.

Educational standards for midwifery education

The ICM Essential Competencies for Midwifery Practice³² outline the minimum set of knowledge, skills and professional behaviours required by an individual to use the designation of midwife as defined by the ICM when entering midwifery practice. These globally accepted competencies underpin the ICM definition and scope of practice of a midwife. As the global norms and standards setting agency, WHO provides the guidelines and evidence for practice. For example, the WHO conceptual framework for quality of care in maternal, newborn and child-health services provides evidence-informed guidance to implementing the ICM competencies through addressing, monitoring and evaluating both the provision of care and the experience of the woman receiving that care.³³ The WHO recommendations on antenatal care for a positive pregnancy experience³⁴ and the WHO recommendations on intrapartum care for a positive childbirth experience³⁵ provide the evidence and recommendations on midwife-led continuity of care. Countries can use the ICM competencies and WHO guidelines to adapt and set standards appropriate to country needs.

In the SEA Region, almost all countries have educational standards for midwifery education as well as accreditation system for midwifery educational institutions and their programmes.

Table 4: Existence of educational standards and accreditation system for midwifery education in countries of the SEA Region^{30,36}

	BAN	BHU	DPRK	IND	INO	MAV	MMR	NEP	SRL	THA	TLS
Existence of educational standards based on ICM standards ³⁷	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Existence of mechanisms for accreditation of midwifery educational institutions and their programmes	Yes	Yes	Yes	Yes	Yes	Yes	Partly	Yes	No	NA	Yes
Existence of a national system for CPD for midwifery	Yes	Yes	Yes	No response	Yes	Yes	Partly	Partly	No	Yes	No

Source: RMNCAH policy survey 2018; Decade for health workforce strengthening in the South-East Asia Region 2015-2024; Second review of progress, 2018.

Types of midwifery education

There are multiple pathways to midwifery education, and globally there is a lack of consistency in content and duration of education and training. Many countries in the SEA Region have a mixture of types of midwifery education (refer country profile). Bridging courses can function to enable career progression for health workers in remote area who require additional education to reach the level of competency required by a midwife. This can be helpful in improving retention of midwives in rural areas.

Table 5: Types of education in countries of the SEA Region²⁷

	Certificate level	Diploma level	Bachelor's degree level
Direct entry to midwifery course	DPRK (3 years), SRL	BAN, INO MMR (2 years), TLS	INO, TLS
Direct entry to nurse-midwifery course	IND, NEP	BHU, IND, NEP	BHU, IND, THA
Entry from nursing to midwifery			NEP (at least 3 years of bachelor's degree after 3 years of diploma in nursing)
Bridge course	BAN (stopped)	MAV (advanced diploma)	
	MAV (stopped)	IND (post-diploma/BSc will start)	

Note: Graduates in orange work as dedicated midwifery cadre, Graduates in black work as integrated nurse-midwifery cadre

Source: Country data presented during the Regional Meeting to strengthen nursing and midwifery in South-East Asia Region, February 2019

Box 7

Bachelor-level professional midwifery education in Nepal²⁷

Midwifery has been an integral part of nursing in Nepal. The SBA policy of 2006 initiated the setting up of a professional cadre of midwives as a long-term goal for the country. The Bachelor-level professional midwifery education was started in 2016. ICM global standards were incorporated and the three pillars of Education, Association and Regulation were in place. The Nepal Health Sector Strategy (2015–2020) made a commitment to “initiate midwifery education to create professional midwives cadres in the country”. This was reiterated in the National Health Policy 2017.

The Nepal Nursing Council (NNC) developed minimum requirements for the Bachelor's in Midwifery Programme (BMP). The BMP education was started in Kathmandu University, the National Academy of Medical Sciences, and Karnali Academy of Health Sciences in 2016, 2017 and 2018, respectively. The first batch will graduate in 2020. A Certificate-level midwifery course is also being prepared. The vision of the government is to gradually replace ANMs by Certificate-level midwives.

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Challenges still exist. The scope of practice of midwives is to be defined. The NNC drafted regulations for midwives. Lack of midwife-led birthing centres has affected the learning of students. Midwifery educators have to be trained on the unique method of teaching midwifery. For this birthing centres have to be established as models.

Source: Country data presented during the Regional Meeting to strengthen nursing and midwifery in South-East Asia Region, February 2019

3) Workforce planning and management

Effective planning and management enables sufficient numbers and better distribution of the health workforce. Strategizing production and allocation including retention of the midwifery workforce in rural areas depending on the types and levels of services as part of the RMNCAH workforce are essential to fulfil the needs of women. Providing options for career progression motivates the midwifery workforce to retain and improve their expertise, which in turn leads to strengthening the midwifery workforce as a whole.

Almost all countries in the Region have an HRH policy/strategy/plan, which includes a midwifery workforce though the modes of entry, preparation and duration of training vary widely.

Table 6: National health workforce strategies in the WHO SEA Region³⁶

Country	Name of the document	Period
Bangladesh	Bangladesh health workforce strategy 2015	2016–2021
Bhutan	Health human resource master plan	2011–2023
DPR Korea	Strategic plan for development of human resource for health	2011–2015
India	No separate HRH strategy. Contained in the National Health Policy 2017	2017–2025
Indonesia	Action plan for the development of HRH	2015–2019
Maldives	National health workforce strategic plan	2014–2018
Myanmar	Myanmar human resources for health strategy	2018–2021
Nepal	Human resources for health: strategic roadmap 2030	2018–2030 (draft)
Sri Lanka	Human resources for health strategic plan	2009–2018
Thailand	Health workforce plan	2016–2026
Timor-Leste	National strategic plan for Human Resources for Health	2020–2024

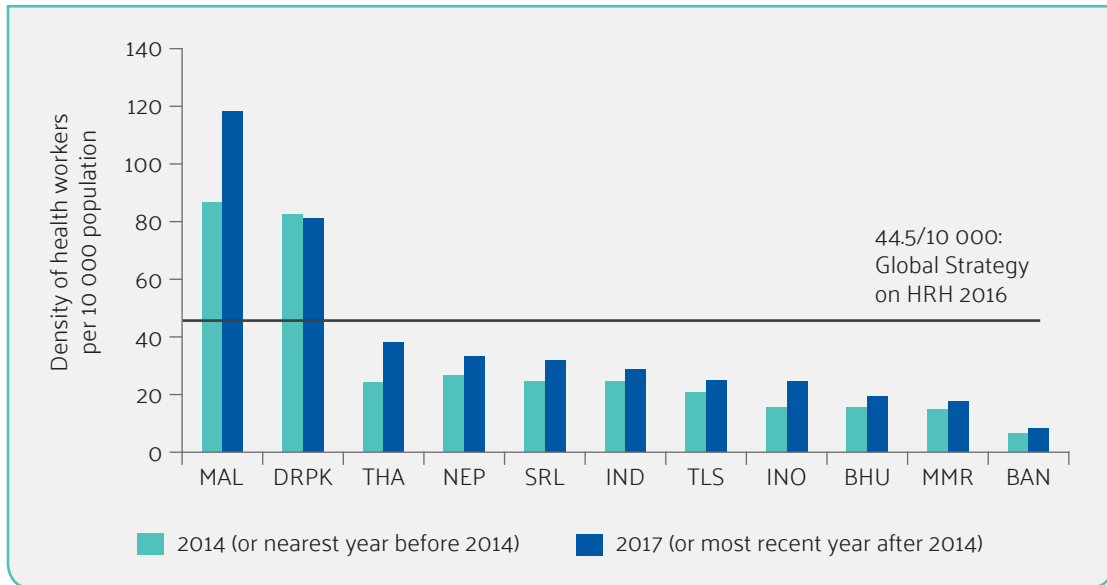
Source: Decade for health workforce strengthening in the South-East Asia Region 2015–2024; Second review of progress, 2018

Availability of the midwifery workforce

According to the Global Strategy on Human Resources for Health 2016,¹² an indicative minimum density of 44.5 doctors, nurses and midwives per 10 000 population was identified as representing the need for health workers. Figure 2 shows the density of the health workforce

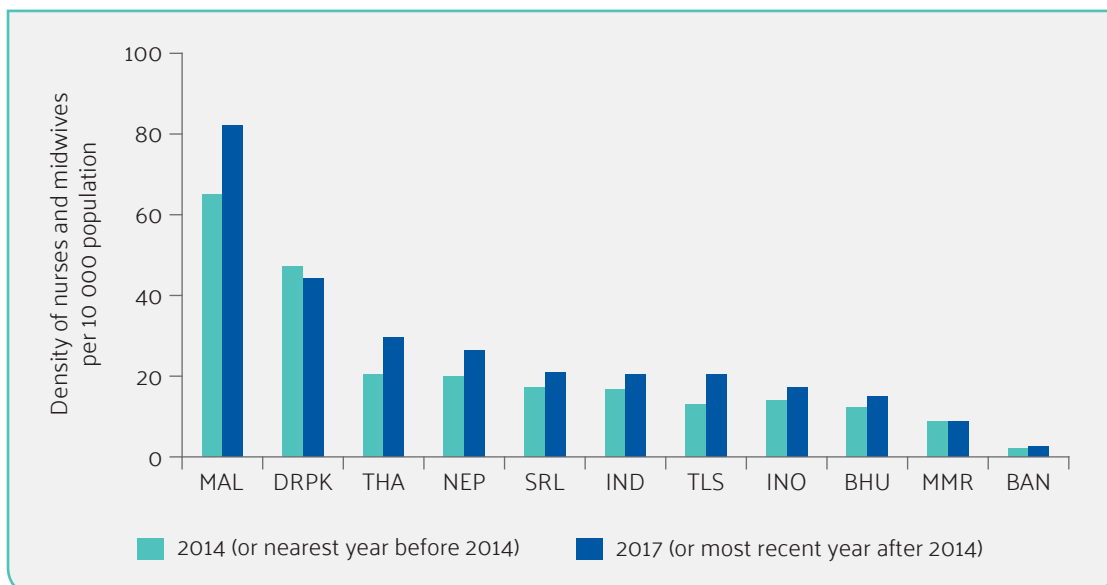
including medical doctors, nurses and midwives per 10 000 population in the SEA Region. While the density of the health workforce in almost all countries increased in the past three years, only two countries meet the global target of 44.5 health workers per 10 000 population. Figure 3 shows the same results with only two countries of the Region (Maldives and DPR Korea) having more than 40 nurses or midwives per 10 000 population. The proportion of nurse midwife to population appears to have reduced in one country and stayed the same in another country.

Figure 2: Density of the health workforce (medical doctors, nurses and midwives) per 10 000 population in the SEA Region¹⁵



Source: The Decade for Health Workforce Strengthening in the SEA Region 2015-2024: Second review of progress, challenges, capacities and opportunities, 2018

Figure 3: Density of nurses and midwives per 10 000 population in the SEA Region¹⁵



Source: The Decade for Health Workforce Strengthening in the SEA Region 2015-2024: Second review of progress, challenges, capacities and opportunities, 2018

Establishment of the midwifery workforce in Bangladesh: political commitment, multistakeholder involvement and the professional association pave the way^{27,38}

The past decade saw large-scale initiatives for introducing midwifery services and a midwife cadre in Bangladesh in successful collaboration with multiple stakeholders. UN agencies, professional organizations, non-governmental organizations (NGOs) and international universities pooled their resources for evidence.

The Strategic Directions (2008–2014) indicated a clear commitment of the government for maternal and newborn health through the strengthening of midwifery services. Most importantly, the Prime Minister’s announcement for training and deploying 3000 midwives fast tracked the development of a midwifery workforce in Bangladesh. In 2010, a high-level decision was taken to start a three-year diploma course in midwifery. The first batch of 525 students was admitted in 20 nursing institutions in 2013. By 2016, the number of admissions rose to 975 students in 38 institutions.

Parallel to these developments at the government level, there was a growing realization among nurses for the need to have a midwifery association. The Bangladesh Midwifery Society (BMS) was established and was given recognition by the Ministry of Women’s Affairs. The BMS has taken up advocacy for introducing a cadre of midwives with well-defined training, new positions, rules for deployment and career progression, technically supported by UN agencies – WHO and UNFPA.

Moreover, a three-year midwifery programme was introduced in 20 institutions in Bangladesh. The question was how to prepare a large number of midwifery teachers within a short time to work in the institutions where midwifery had been introduced. The Mentorship Programme was introduced in 2017 for 19 faculty members teaching in 10 institutions where the midwifery course had been introduced. It was a one-year blended web-based Master’s degree in Sexual, Reproductive and Perinatal Health Care provided over a two-year period and specifically designed for Bangladesh by a university in Sweden.

Mentorship was “conceptualized as a process that equips midwifery faculty members to become confident and competent in their roles as midwifery teachers in a midwifery diploma level programme”. Swedish midwifery teachers mentored their Bangladeshi colleagues. They used field notes from site visits to strengthen teaching. Online teaching and mentoring were the main focus. Process evaluation of the 19 faculty members indicated that close and trustful communication between the faculty and students in clinical sites was the most facilitating factor in student learning. The faculty also mentioned that communication between educational institutions and clinical sites was an important factor in practical learning of students.

Source: Country data presented during the Regional Meeting to strengthen nursing and midwifery in South-East Asia Region, February 2018; Erlandsson K, Doraiswamy S, Wallin L, Bogren M. Capacity building of midwifery faculty to implement a 3-years midwifery diploma curriculum in Bangladesh: a process evaluation of a mentorship programme. *Nurse Educ Pract.* 2018;29:212–18

In some countries of the SEA Region, midwifery is not recognized as a profession distinct from nursing, with no independent professional association or regulatory body to support the professional development or career progression of midwives. However, some progress has been made in Bangladesh and Nepal, creating dedicated midwifery cadres in those countries; this would be a game changer in improving RMNCAH services. Important in this process is the deployment of a dedicated midwife who is not rotated to nursing duties, thus enabling midwifery competencies to be sustained.

On the positive side, almost all countries in the Region have provision of policies/guidelines for midwifery service delivery (Table 3). They set forth a competency framework for maternal and newborn health care. Almost all the countries have a national policy/guideline on education of midwifery care providers based on ICM competencies.

Box 9

Improving universal access to quality reproductive health services in DPR Korea³⁹

The lack of essential supplies, equipment and skills are among the barriers to achieve full universal access to quality reproductive health services in DPR Korea. Support from UNFPA, which began in 1985, has made essential contributions by supporting training and family planning and providing life-saving medicines and equipment.

Key achievements are as follows:

1. Minimum initial package 160 health service providers and managers were trained on the minimum initial service package.
2. Midwives in public health facilities Newly graduated midwives were deployed in public health facilities with support from UNFPA.
3. Sexual and reproductive health coordination body during crisis During a humanitarian crisis, a functioning inter-agency sexual and reproductive health coordination body was in place.
4. Midwifery curriculum The first midwifery school nationally accredited according to ICM standards.

According to the State of the World's Midwifery (SoWMy) report, availability of the midwifery workforce has been improved. However, by 2030, the population is projected to increase by 8% to 26.7 million. It is important to continue to enhance the availability of workforce and quality of care.

Source: UNFPA Democratic People's Republic of Korea, 2018

Career development of midwifery

The WHO-ICM-WRA global report on “Midwives Voices, Midwives Realities”²⁶ suggested that “career development” is an important part of workforce planning and management for enhancing midwives’ leadership and ensure the quality of professional competencies. Career

progression is a significant motivation for midwives as a means of promoting and incentives for retention. Also, demonstrating clear career paths attracts the future generation to become a midwife. In the SEA Region, career progression of a midwife seems to be limited compared to the one for nurses in some countries. Within their profession, midwives are able to become senior-level midwives or clinical instructors, while nurses have various pathways including education and service (management) sectors. Educational qualifications such as Master's and PhD courses provide opportunities for midwives to expand their career in educational sectors.

4) The scope of midwives' practice, and models of service delivery

To ensure quality midwifery practice, countries must clearly define and support the scope of practice of midwives through a national policy. The WHO recommendation on midwife-led continuity of care^{34,35} is effective only in “well-functioning midwifery systems”, but where this model of care is implemented there are significant benefits to women and newborns. This includes a 24% reduction in preterm birth, fewer interventions, increased spontaneous vaginal births and better satisfaction experienced by women. National standards for care and a code of ethics are important to guide and monitor respectful, quality care.

RMNCAH services provided by the midwifery workforce

Table 7 maps out what RMNCAH services are provided by which cadres, and at which level of the health system, in countries of the SEA Region.

Table 7: Types of nursing and midwifery professionals and coverage of RMNCAH services²⁷

Professional	Care level	Services covered				
		ANC	IPC	PNC	FP	EmOC
Bangladesh						
Registered nurse	Secondary, Tertiary	Yes	Yes	Yes	Yes	No
Registered midwife	Primary, Secondary	Yes	Yes	Yes	Yes	Partly
Certified midwife		Yes	Yes	Yes	Yes	No
Bhutan						
Clinical nurse	Secondary, Tertiary	Partly	Yes	Yes	Yes	Yes
GNM		Partly	Yes	Yes	Yes	Yes
ANM		Partly	Yes	Yes	Yes	Yes
Health assistant	Primary, Secondary, Tertiary	Yes	Yes	Yes	Yes	No
DPR Korea						
Nursing professional	Tertiary	No	No	No	Partly	Yes
Nursing general practitioner	Primary, Secondary	No	No	No	No	No

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Professional	Care level	Services covered				
		ANC	IPC	PNC	FP	EmOC
Midwifery professional	Primary, Secondary, Tertiary	Yes	Yes	No	No	Partly
Nursing/midwifery general practitioner	Secondary, Tertiary	No	Yes	Yes	No	Partly
India						
ANM	Primary, Secondary	Yes	Yes	Yes	Yes	Partly
GNM	Primary, Secondary	Yes	Yes	Yes	Yes	Partly
BSc Nurse	Secondary, Tertiary	Partly	Partly	Partly	No	Partly
Master of Nursing	Tertiary	Partly	Partly	Partly	No	Partly
Indonesia						
Professional midwife	Primary, Secondary, Tertiary	Yes	Yes	Yes	Yes	Yes
Vocational midwife	Primary, Secondary, Tertiary	Yes	Yes	Yes	Yes	Yes
Maldives						
Registered nurse	Primary, Secondary, Tertiary	Yes	Yes	Yes	Yes	NA
Registered nurse-midwife		Yes	Yes	Yes	Yes	NA
Myanmar						
Diploma Midwife	Primary, Tertiary	Yes	Yes	Yes	Yes	Yes
Nepal						
ANM (preferably SBA trained)	Primary, Secondary	Yes	Yes	Yes	Yes	Partly
Nurses (preferably SBA trained)	Secondary, Tertiary	Yes	Yes	Yes	Yes	Yes
Sri Lanka						
Nursing officer	Primary, Secondary, Tertiary	Yes	Yes	Yes	Yes	Partly
Public health midwife	Primary, Secondary, Tertiary	Yes	Yes	Yes	Yes	Partly
Supervisory public health midwife		Yes	Yes	Yes	Yes	Partly
Thailand						
Professional nurse						
Timor-Leste						
Midwife	Primary, Secondary, Tertiary	Yes	Yes	Yes	Yes	Partly

Note: ANC Antenatal care; IPC Intrapartum care; PNC Postnatal care; FP Family planning; EmOC Emergency obstetric care

Source: Country data reported to WHO 2019;

Where quality is a culture, not just a goal: case study of Bhutan^{27,40}

Highest priority is given to quality at all levels in Bhutan. There is a Quality Assurance and Standard Division in the Ministry of Health (MoH) to make sure that continuous capacity building of health workers takes place for updating of standards. The Bhutan health system provides an example of how quality can become a part of everyday work culture of health-care providers. Bhutan implements two major interventions for quality maternal and newborn care.

- a. Point of care quality improvement initiative (POCQI) is done through webinar presentations on neonatal discharge before 11 a.m. Besides these, hand hygiene, handing-taking over during change of shift, and partograph implementation are strictly implemented and monitored. Coaching is provided at the facility level to all health-care providers. Required infrastructure modifications are made. Monitoring and evaluation are carried out regularly.
- b. Essential early newborn care (EENC) and kangaroo mother care (KMC) are implemented in the country to improve quality of newborn care. Over 500 health professionals were trained in newborn assessment, resuscitation and KMC.

Providing quality care became an internalized virtue for health professionals. However, several challenges remain of continued training and evaluation, need for further development of ownership about the programme at all levels, and sustainability over long periods with changing staff. Further hand-holding and continued support are required if quality maternal and newborn care is to be embedded as a culture.

In terms of respectful care, the woman in labour provides the nurse-midwife with an opportunity to use her skills in supporting and comforting. The vulnerability of the woman makes it crucial not only to provide technical services and monitoring, but also to safeguard her dignity. Though patient ethics are part of nursing training, adequate attention is not paid to respectful maternity care (RMC) in nursing and midwifery education programme.

A study in Bhutan in three hospitals with 83 nurse-midwives working in birthing and maternity units showed that though a quarter of the providers allowed the woman to adopt the position she preferred while birthing, there were many restrictions on her movement and intake of food and fluid. There was adequate knowledge and practice related to giving information and taking consent. Promoting skin-to-skin contact and breastfeeding were practised by all providers. This indicates that aspects of care that are prioritized in programmes and are regularly monitored tend to be implemented more fully and by most health-care providers.

RMC does not have a separate content in the curriculum and tends to be forgotten. The health-care providers in this study reported that they often came across disrespect and abuse – verbal as well as physical – meted out to women in childbirth by staff. Almost all providers said they required training in implementing RMC. This indicates a strong need for teaching nurses and midwives using the midwife model.

Sources: Country data presented during the Regional Meeting to strengthen nursing and midwifery in South-East Asia Region, February 2019; Deki S, Choden J. Assess knowledge, attitude and practices of respectful maternity care among nurse midwives in referral hospitals of Bhutan. *Bhutan Health Journal (BHJ)*. 2018;4(1):1-7.

5) Evidence and research

The information on the qualifications and experience of midwifery educators is scarce in the Region. Health information systems and data collection in some countries is not complete, which makes it problematic for countries to allocate resources appropriately. Research related to midwives, their practices and their impact on outcomes of pregnancy has also been scarce in the countries of the Region due to administrative and regulatory issues such as nursing and midwifery being combined as a single professional group or the ambiguity in their roles. There is a need to initiate research both on practices, effectiveness of models and services, and also to generate evidence on care within the specific sociocultural context.

Box 11

Research assessing midwifery competency among tutors, students and nurse-midwives in India²⁷

The Government of India (GoI), Ministry of Health and Family Welfare (MoHFW) has taken up a systematic study of the competencies of midwives and midwifery educators to investigate the effect of midwifery-led model of care in collaboration with the initiative led by WHO and Bill & Melinda Gates Foundation (BMGF), the Foundation for Research in Health Systems (FRHS, Bangalore), Indian Institute of Public Health (IIPH, Gandhinagar) and MAMTA (New Delhi). In this study, midwifery tutors, students and nurse-midwives in selected states of the country were assessed on the core competencies in terms of self-practice.

Findings of the study are helpful to understand opportunities and barriers and also to establish benchmarks for nurse-midwife curricula based on the ICM Essential Competencies for Basic Midwifery Practice. Further, mixed method approaches including vignette-based interviews and in-depth interviews and a quantitative survey distributing self-administered questionnaires in multi-settings, have been conducted.

The study is being taken up in the context of the policy decision of the GoI to roll out professional midwifery in the country. The competency assessment of midwifery educators and nurse-midwives is critical for rolling out this programme in India as midwifery education is currently integrated within the nursing education at the degree and diploma level.

Source: Country data presented during the Regional Meeting to strengthen nursing and midwifery in South-East Asia Region, February 2019

Rationale and framework

The Regional Strategic Directions for strengthening Midwifery in the WHO South-East Asia Region provide a framework consisting of a goal, six guiding principles and strategic directions (under five key elements) that support countries, WHO and other stakeholders to improve RMNCAH services towards achieving UHC and SDGs.

1. Goal of the Regional Strategic Directions

All women of reproductive age, including adolescents, newborns and children, have universal access to quality care provided by midwives, when needed, by scaling up the AAAQ of the midwifery workforce.

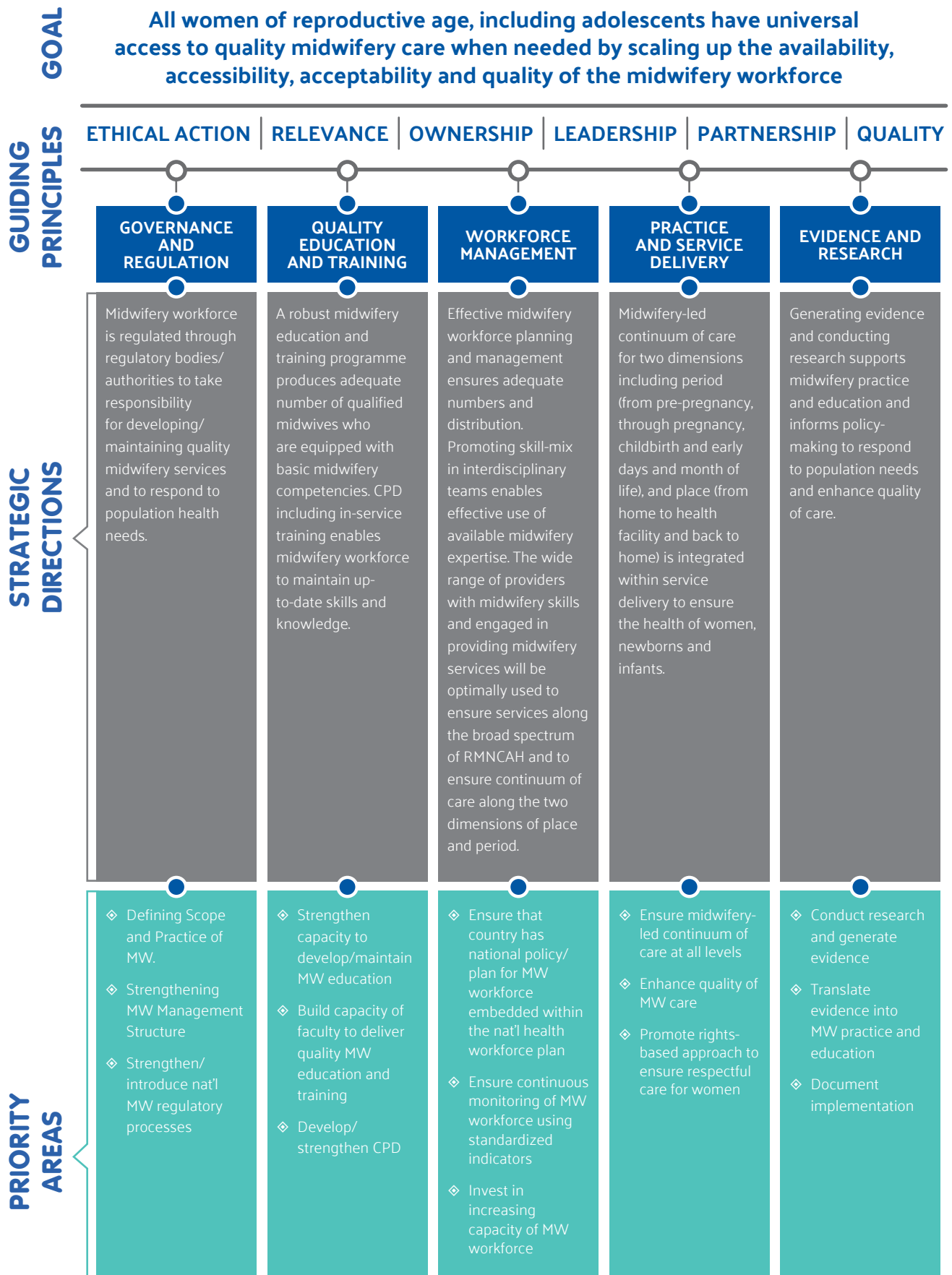
2. Guiding principles

- I. Ethical action:** High quality health services based on equity, integrity, fairness and respectful practice, in the light of gender and human rights, are planned and provided, and safe and accountable services are advocated for. A rights-based approach based on the international Code of Ethics for Midwives by the ICM ensures that women have access to quality RMNCAH services. The code of conduct for midwifery services with women's choices and needs is clearly stated and implemented in clinical sites and community areas. Childbearing and childbirth are treated as natural physiological processes that require the midwifery model of care that respects women and upholds their dignity.
- II. Relevance:** Midwifery educational programmes, research, services and management systems are developed on the basis of health needs, research-based evidence and strategic national priorities. Services planned and implemented are socioculturally sensitive and relevant to different groups of women and communities. The scope and span of midwifery services are relevant to the situation of health and health needs in the society.
- III. Ownership:** A flexible approach is adopted to ensure effective leadership, management and capacity building with active participation of midwifery professionals at every level within professional associations, government, private sectors and other stakeholders. Professional associations of midwives participate actively in designing and implementing

educational programmes and practice protocols. All stakeholders are involved in the accountability mechanisms and engaged in all aspects of designing and implementing interventions.

- IV. Leadership:** Midwives demonstrate leadership for providing high quality services to all women of reproductive age, their newborns and infants. They are willing to meet changing challenges through regular updating, continuing education design and implementation based on research evidence. Within the government, midwives take leadership roles and actively participate in policy development, decision-making and programme management at every level of care of mothers and babies. Midwives play a key role in interdisciplinary teams for improving RMNCAH. Midwife-led centres become models for high quality normal birthing services.
- V. Partnership:** Midwives work in partnership with women, families and other professionals for providing high quality care and referral. All relevant professionals, managers and stakeholders work respectfully together on common objectives, act collaboratively and support each other's efforts to obtain best results for women and babies.
- VI. Quality:** Mechanisms and standards based on evidence for best practice are adopted in education and practice; and continuous quality improvement mechanisms are built into programmes and services at all levels. Regular research for improving quality becomes a part of midwifery teaching, practice and governance. A corpus of midwifery knowledge and evidence becomes available for use at all levels. A people-centred and humanistic approach including RMC is practised.

Figure 4: Framework for implementation of the Strategic Directions for strengthening midwifery in the WHO South-East Asia Region 2020-2024



Regional Strategic Directions for strengthening Midwifery

The Regional Strategic Directions for strengthening Midwifery 2020-2024 present a vision, guiding principles and strategic directions to guide in preparing and strengthening a midwifery workforce in each country of the Region. This part contains a brief listing of the five key elements of the strategic directions and an implementation framework. The six guiding principles are interwoven within each of the five elements of the Regional Strategic Directions.

A. The five elements of the Regional Strategic Directions

The five elements of the Regional Strategic Directions include large areas that cover the broad spectrum of midwifery.

1. Governance and regulation

The midwifery workforce is regulated through regulatory bodies/authorities that take responsibility for developing/maintaining quality midwifery services to respond to the needs of population health.

2. Education and training

A robust midwifery education and training programme produces adequate number of qualified midwives who are equipped with ICM essential competencies for midwifery practice. CPD enables the midwifery educators and service providers to maintain up-to-date skills and knowledge.

3. Workforce planning and management

Effective planning and management of the midwifery workforce ensures adequate numbers and acceptable distribution. Promoting skill-mix in interdisciplinary teams enables effective use of available midwifery expertise. The wide range of providers with midwifery skills and engaged in providing midwifery services will be optimally used to ensure services along the broad spectrum of RMNCAH and to ensure continuum of care.

4. Practice and service delivery

Midwifery-led continuum of care for two dimensions including period (from pre-pregnancy, through pregnancy, childbirth and early days and month of life), and place (from home to health facility and back to home) is integrated within service delivery to ensure the health of women, newborns and infants.

5. Research and evidence

Research with focus on midwifery and women's health is conducted and the generated evidence is utilized in midwifery practice through continuous monitoring and documentation. Research and evidence need to be translated into policy to respond effectively to the needs of the population.

B. Implementation and monitoring framework of the Regional Strategic Directions

This section provides the detailed action plan, and indicators for monitoring progress for each country to consider. Each element is further divided into two to four priority areas. Actions to be taken by each country and indicators for monitoring under each priority area are provided.

1. Governance and regulation

The midwifery workforce is regulated through regulatory bodies/authorities that take responsibility for developing/maintaining quality midwifery services to respond to the needs of population health.

Priority Area 1.1: Define scope and practice of midwifery

Actions

- a. Define “Midwife”, “Midwifery Services” “Midwifery Workforce”, “Midwifery Model of Care” and “Midwife-led Continuum of Care” (WHO recommendations on antenatal care for a positive pregnancy experience and Intrapartum care for a positive childbirth experience) in clear terms (refer ICM, Annex 1 for definition of “Midwife”).
- b. Ensure that the word “Midwife” is applicable only to recognized and licensed practitioners with the full scope of ICM competencies based on the country context.
- c. Establish/create a cadre of midwives with legal support to provide the full scope of ICM competencies.
- d. Prepare a framework for responsibilities and accountability of midwives and protocols for admission of women into midwife-led facilities, and guidelines for documenting care provided by midwives at all levels of care.
- e. Prepare standards of practice, standing instructions for treatment/algorithms, and protocols for referral and follow up at each level in the facility and community.

- f. Design and conduct orientation and/or reorientation training/workshops across all relevant professional groups including nurses, midwives, nurse-midwives, health workers and medical professionals, especially obstetricians and paediatricians, on the roles and responsibilities of a midwife.
- g. Professional associations take active part in designing practice guidelines and disseminating them among members.
- h. Integrate the ICM Midwifery Service Framework (MSF) to strengthen quality of RMNCAH services across all health systems.

Indicators for monitoring

- ◆ Statements and definitions are formulated and disseminated in the public domain
- ◆ Standards of practice, standing instructions for treatment/algorithms, protocols and guidelines for practice and referral are available for use and review at all levels of midwifery practice
- ◆ A cadre of midwives is established, regulated and deployed only for midwifery care
- ◆ Practice guidelines are designed and disseminated by professional associations in collaboration with the government
- ◆ Countries have integrated the ICM MSF to strengthen the quality of RMNCAH services across all health systems

Priority Area 1.2: Strengthen the midwifery management structure at all levels

Actions

- a. Assess/strengthen the current governance structure of midwifery services and professionals at the national, subnational, institutional and community levels.
- b. Strengthen/establish a national responsible department/directorate in the MoH and other sectors at the national and subnational levels with adequate numbers and support systems to administer the midwifery workforce and service delivery efficiently, and regulate progression and movement of midwives.
- c. Allocate a budget specified clearly for a midwifery division/department for ensuring optimum growth and functioning of the division/department.
- d. Review the role of the chief nursing and/or midwifery officer and make changes to introduce the position of a chief midwifery officer, if necessary.
- e. Ensure that the chief nursing and/or midwifery officer is involved in policy discussions and decision-making related to midwifery practice and education, and policies related to RMNCAH at all levels of administration.
- f. Introduce/strengthen management skills for upgrading capacity of the chief nursing and/or midwifery officer and other midwifery management staff to enable them to participate actively in policy discussions and provide meaningful inputs into policies.

- g. Establish a career progression path for midwives, including management, teaching and research positions, within midwifery and RMNCAH and other sectors of public health.
- h. Ensure that midwifery-based services and units are managed by midwifery qualified professionals at the facility and community levels.
- i. Promote collaboration between departments of HRH and RMNCAH and midwifery within the MoH and other health sectors.
- j. Establish/strengthen a multistakeholder National Midwifery Task Force and have regular reviews.

Indicators for monitoring

- ◆ Countries have a specific department/directorate responsible for planning and management of the midwifery workforce
- ◆ The midwifery workforce is clearly defined, mapped and enumerated
- ◆ Chief nursing and/or midwifery officers are introduced/strengthened where necessary
- ◆ Chief nursing and/or midwifery officers are members of national committees for discussing health priorities
- ◆ Clear cadre and career pathways exist for midwives in the country
- ◆ Midwives are placed in management positions at every level where the midwifery workforce is deployed
- ◆ A national midwifery task force is established and led by a midwife

Priority Area 1.3: Strengthen/introduce national midwifery regulatory processes for governing midwifery education and practice

Actions

- a. Assess and review the regulatory body to ensure that evidence-based and ethics-based regulation is in place in midwifery education and practice.
- b. Review/introduce a distinct licensing system for midwives, separate from nursing, and formulate requirements and processes for renewal.
- c. Review the current situation of regulation/standards for midwifery practice, education and licensure and develop/strengthen the existing ones.
- d. Review/develop legislation to recognize midwifery as an autonomous profession with clearly defined roles and collaborative partnerships with other professionals.
- e. Introduce/update/support the Midwifery Act.
- f. Establish/strengthen a national professional association of midwives.

Indicators for monitoring

- ◆ Countries have regulation/standards for midwifery practice, education and licensure including an Act to regulate midwifery practice

- ◆ Midwifery practice is sanctioned through separate licensing from nursing
- ◆ Standards and protocols are available for practice at all levels

2. Education and training

A robust midwifery education and training programme produces adequate number of qualified midwives who are equipped with ICM essential competencies for midwifery practice. CPD enables midwifery educators and service providers to maintain up-to-date skills and knowledge.

Priority Area 2.1: Strengthen capacity to develop/maintain midwifery education

Actions

- a. Review and update the curriculum based on national standards and ICM competency-based education for the midwifery workforce by each institution.
- b. Establish/strengthen a national accreditation mechanism of educational programmes and institutions for continuous quality improvement.
- c. Update a list of essential equipment based on national standards for skill laboratory and information technology facilities for each institution.
- d. Establish guidelines for practicum – practical hours, case-loads, student–teacher ratio, methods of clinical teaching and supervision.
- e. Review midwifery education and training across different levels and programmes to match required competencies.
- f. Review and update processes and methods for midwifery education distinct from other educational programmes, and include respect, choice and dignity of women within the basic midwifery educational programmes.
- g. Establish criteria for clinical training sites that clearly follow the midwife-led model of care to mothers and babies.
- h. Establish a mechanism for monitoring, evaluation and documentation of the educational programme.

Indicators for monitoring

- ◆ An updated and relevant curriculum based on elements of ICM competencies is available and implemented
- ◆ Countries have clearly stated standards for midwifery education
- ◆ Accreditation mechanisms for educational programmes and institutions providing midwifery training are available and widely disseminated

Priority Area 2.2: Build capacity of educators to deliver quality midwifery education and training

Actions

- a. Assess educator competencies as per WHO Midwifery Educator Core Competencies (MECC).⁴¹

- b. Design and implement a competency-based midwifery educator programme as per the standards of WHO MECC with regards to duration, case-load, teaching, use of research-based evidence and principles of ethical practice.
- c. Introduce/update competency assessment tools for midwifery educators to monitor and evaluate the quality of education.
- d. Evolve national criteria for selection of a midwifery educator, including qualifications as well as experience in practice and teaching.
- e. Expose educators to the midwifery model of care, where available, to encourage them to incorporate this within their teaching.
- f. Introduce/enhance inter-professional education (IPE) by encouraging midwifery educators to study and collaborate with other professionals working for RMNCAH.
- g. Introduce information technology (IT)-based educational methods and facilities.
- h. Streamline practical teaching methods specific to midwifery education in skill laboratories and clinical training sites.
- i. Ensure processes and standards for clinical skill updates for all midwifery educators.
- j. Promote research and evidence generation among midwifery educators at all levels of education.
- k. Prepare/establish/strengthen training facilities for midwifery educators.
- l. Ensure that midwifery educators associate with and provide services at midwifery practice sites.
- m. Establish a system to ensure that all midwifery educators also practice in clinical settings and keep records of their practice in order to provide practice-based midwifery teaching.

Indicators for monitoring

- ◆ Countries have a system of monitoring educators' expertise based on WHO MECC
- ◆ Midwifery educators are assessed for their competencies using standardized assessment tools and processes adapted from WHO MECC
- ◆ Midwifery educators should engage in research and publish at least one academic/research paper every year
- ◆ Countries have a system to ensure updated knowledge and clinical skills of midwifery educators, which is available and used by them

Priority Area 2.3: Develop/strengthen continuing professional development (CPD)

Actions

- a. Establish/strengthen a national mechanism for CPD for the midwifery workforce at all levels.

- b. Review/promote in-service training for the midwifery workforce in collaboration with government, professional associations and stakeholders with a clear plan for career progression and professional growth.
- c. Promote/encourage setting up of innovative CPD programmes including short-term courses by professional associations and institutions.
- d. Promote self-directed and e-learning by practising midwives to enhance their skills and practice.
- e. Encourage peer-review/evaluation and mentoring at workplace to enhance skill improvement.
- f. Equip midwifery educators with IT skills to regularly take up CPD.

Box 12

Inter-professional education in Thailand²⁷

Inter-professional education (IPE) was started as a project under Mahidol University Strategic Plan as “Transformative Education” between 2013 and 2015. The WHO Framework for Action on IPE and collaborative practice for improved health outcomes, and the Prince Mahidol Award Conference (PMAC) in 2014 were used as the background for introducing Transformative Health Professional Education for the 21st Century (2014–2019). Strategies were approved by the National Health Commission chaired by the Prime Minister. Reform of health professional education was part of the country’s plans for human resources development for achieving UHC within the context of primary health care.

IPE is an approach where learning takes place with and from professionals and other educators for improving quality of care. It was meant as a step for collaborative practice. Competencies of IPE were visualized as (i) roles and responsibilities and respect; (ii) team work; (iii) learning and reflection; and (iv) leadership. Team work included all faculties of the university – medical, nursing, health-related and even social sciences, engineering, pharmacy, veterinary science, etc.

IPE is recognized as a way to equip and strengthen health-care professionals with non-technical skills and improve team work and patient safety. An elective course for health workers was developed for “Enhancing patient safety through inter-professional collaborative practice”.

Challenges for IPE and collaborative practice are low availability of faculty, complexity of scheduling to suit all participants, and the need to change mindset from vertical courses to collaboration. Commitment to collaboration and exchange are the core values for IPE. Thailand’s experiences and the observed benefits are an encouragement to introduce IPE as a strategy for collaborative practice, especially in the area of midwifery.

Source: Country data presented during the Regional Meeting to strengthen nursing and midwifery in South-East Asia Region, February 2019

Indicators for monitoring

- ◆ Countries have a CPD mechanism for licensure/registration renewal for all levels
- ◆ Self-directed learning and skill upgradation are documented
- ◆ Professional associations are supported to provide in-service training

Box 13

Implementing emergency obstetric care (EmOC) in Timor-Leste²⁷

With its high fertility rate, low use of modern contraceptives, low proportion of institutional deliveries and low antenatal coverage, Timor-Leste faces critical problems for providing emergency obstetric services. Assessment showed that less than half of the health facilities were performing the seven signal functions for saving lives of women and newborns.

An EmOC improvement plan was implemented with enhancement of facilities, introduction of protocols and records, implementation of competency-based training, supportive supervision and mentoring, and communication among health professionals.

Implementation of the EmOC training helped to improve quality of services. Results showed that institutional deliveries doubled and antenatal coverage improved. Maternal mortality was also reduced to half.

Though coverage did improve between 2010 and 2016, intranatal services needed further improvement. Timor-Leste continues to strengthen the provision of EmOC to avert maternal and newborn deaths.

Source: Country data presented during the Regional Meeting to strengthen nursing and midwifery in South-East Asia Region, February 2019

3. Workforce planning and management

Effective planning and management of the midwifery workforce ensures adequate numbers and acceptable distribution. Promoting task-shifting in interdisciplinary teams enables effective use of available midwifery expertise. The wide range of providers with midwifery skills and engaged in providing midwifery services will be optimally used to ensure services along the broad spectrum of RMNCAH and to ensure continuum of care.

Priority Area 3.1: Ensure that each country has a national HRH policy/plan including the midwifery workforce based on clearly identified needs, place of work and sociocultural aspects of the country

Actions

- a. Review the current national policy/plan for the midwifery workforce as part of HRH and RMNCAH strategies.

- b. Decide on indicators for calculating the midwifery workforce based on the range of services and needs – for all levels of health facilities including community-based follow up and education, number of women and babies cared for by each midwife in a facility during intrapartum care, the units in a hospital that require midwives such as postnatal units, antenatal clinics and triage rooms, labour room, birthing centre, family planning and MCH clinic, etc., based on the sociodemographic and health situation in a country.
- c. Map departments/divisions/facilities where midwives work within each country and compile the range of services provided by them.
- d. Work out the equivalence of education, tasks and career pathways for all categories of midwives to streamline the midwifery workforce.
- e. Review the management structure of the midwifery workforce within the MoH and other ministries, and formulate practical administrative guidelines to enhance quality care and practical monitoring and supervision at each level and across each country.
- f. Ensure collaborative mechanisms among persons/departments responsible for HRH and RMNCAH for ensuring skill upgradation of midwives.
- g. List tasks/skills of midwives specific to the country, such as core functions and expanded role functions.
- h. Develop and implement welfare programmes for the workforce to reduce burn out and to improve quality and job satisfaction.
- i. Review/develop strategies for deployment and retention of the midwifery workforce including developing positive practice environment and upward career movement.
- j. Design and disseminate an organogram for indicating the channels of communication, supervision and management of the midwifery workforce including promotions and requirement for promotion.
- k. Introduce/strengthen a mechanism of recognition/awards/commendation based on performance appraisal for midwives based on clearly defined criteria.
- l. Develop an inter-professional team approach to provide comprehensive RMNCAH services.
- m. Analyse the health labour market for a deployment plan for the midwifery workforce in both public and private sectors.
- n. Distribute the above action points to the authorities at the central, provincial/regional and community/local, facility level.

Indicators for monitoring

- ◆ Countries have a national HRH policy
- ◆ Countries have a strategic plan on HRH including deployment of the midwifery workforce, projection maintenance for career development and upward mobility
- ◆ The scope of practice, standard/protocol of midwifery practice, tools/quality of supervision and monitoring, CPD with credit hours, are clearly written and maintained

- ◇ A performance appraisal system is in place to recognize and award for exemplary practice, incentives or career pathways.

Priority Area 3.2: Ensure continuous monitoring of the midwifery workforce using standardized indicators

Actions

- Review the current availability of a minimum of 10 pieces of information recommended in SoWMy* and the National Health Workforce Accounts (NHWA) to monitor the midwifery workforce.
- Agree on indicators that align with a minimum of 10 pieces of information recommended in SoWMy* and NHWA.
- Identify a mechanism/platform to collect/collate data integrating into the existing information system in the country.
- Continue the use of indicators of NHWA.

*A minimum of 10 pieces of information for the midwifery workforce: headcount, percentage time spent on RMNCAH, roles, age distribution, retirement age, length of education, enrolments into, attrition and graduation from education, and voluntary attrition from the workforce.

Indicators for monitoring

- ◇ Countries agree on a set of standardized indicators to monitor the midwifery workforce
- ◇ Countries have an integrated information system to collect/collate data on the midwifery workforce
- ◇ Countries have a defined set of tasks that midwives are expected to perform
- ◇ Measurable, standardized indicators are in place

Priority Area 3.3: Invest in increasing the numbers, resources and capacities of the midwifery workforce

Actions

- Allocate a budget for strengthening the midwifery workforce over a period for training, additional positions, research and evidence, and faculty development.
- Assess/identify the gap between demand and supply of the midwifery workforce.
- Formulate a policy for regulating admission and maintaining standards of both public and private institutes.
- Develop guidelines for building capacities of a large number of community-based workers with innovative programmes so that they support midwives.
- Introduce/set up models of practice for maternal health that have different levels of midwifery workforce to assess cost-efficiency, quality and effectiveness.

Indicators for monitoring

- ◆ Countries have estimates and a plan for production, deployment and retention of the midwifery workforce
- ◆ Countries are reviewing the turn-over rate, attrition and job satisfaction levels regularly
- ◆ A budget is allocated specifically for midwifery education, workforce development and monitoring

Box 14

India gears up for introducing a midwifery workforce²⁷

Pilot projects for introducing midwifery training and launching a cadre of midwives were taken up in India in different states with international collaboration. West Bengal had tried a midwifery practitioner programme two decades ago. During the past decade, Gujarat and West Bengal implemented the 10- month Nurse Practitioner in Midwifery Programme which was formulated by the Indian Nursing Council. The trained nurse practitioners in midwifery (NPMs) were posted to work in labour rooms of subdistrict hospitals. The latest initiative is from Telangana State for the training of nurses with a diploma in general nursing and midwifery (GNM) for 18 months exclusively in midwifery.

Though training programmes for NPMs were implemented in many states, the lack of a structured system of deployment and career progression was a barrier to their success. There were hurdles in terms of placement, role charts, integration within the current health workforce structure and ambiguities of the legal and regulatory framework. There were also perceived gaps in the course content in terms of ICM competencies.

Evidence from the Lancet series on midwifery (2014) indicated that an effective midwifery cadre can avert 83% of maternal deaths, stillbirths and newborn deaths. This sparked interest in midwifery in India. Concerns over the rising numbers of caesarean sections in the country also supported the introduction of a midwife model of maternal care. A Technical Advisory Group was constituted. The GoI examined the initiatives in different parts of the country and reviewed midwifery models of care in different countries. The decision to launch a programme for introducing a cadre of midwives was taken.

The “Guidelines on Midwifery Services in India” were released in December 2018 with a high level of political approval. The GoI is now working with the regulatory body – Indian Nursing Council – for formulating guidelines, reviewing curriculum, identifying and training faculty. The country is now preparing to identify educational institutions for faculty development, set up and strengthen midwifery training institutions, etc. The government proposes to start the training of educators from June 2019 onwards.

As a starting point, the government proposes to introduce the midwife-led model of care in all the 2100 LaQshya facilities. The biggest challenge is the shortage of certified midwifery educators. The government is identifying all trained faculty to teach midwifery under different projects so that they are available to launch this initiative.

Source: Country data presented during the Regional Meeting to strengthen nursing and midwifery in South-East Asia Region, February 2019

Resolving the problem of retention of nurses and midwives in rural areas: unique experience from the Maldives²⁷

Reaching the remote islands and atolls of Maldives with quality MCH services is a major challenge. There are 200 islands scattered over a large area of 90 000 sq. km. The population in most of the islands is too sparse and because they have problem of access to the city, nurses and midwives have to stay on the islands to provide timely service in case of an emergency. The remoteness and isolation are the major hurdles in retaining the staff.

Approximately 1600 nurses and midwives from a total of 2500 are posted to work in these remote islands. Retaining trained nurses and midwives in the remote areas is the key to serving the population. Problems of security, less opportunities for social interaction, lack of immediate professional support, age and gender of the health-care providers further impair the retention of midwives in remote islands. The Government of Maldives aimed to enhance retention in a systematic manner.

The National Health Workforce Strategic Plan 2014–2018 developed measures for improving attraction and retention of the workforce in atolls and islands. The new workforce strategy introduced rural recruitment, local training and placement of island-specific candidates. Double benefit interventions were introduced. On one side incentives were provided for working on the islands, and on the other side, the bond system after training was strictly implemented. Both these measures helped to improve retention to a great extent.

At the same time, attention was paid to improving working environment in collaboration with local councils to provide security and social recognition of the health staff. Health workers demonstrating exemplary work were recognized and awarded. The health sector is being marketed as an attractive opportunity to work with many benefits for those working in remote areas.

Challenges include limited opportunities for nurses and midwives to practice as the number of patients are few and women prefer specialists for childbirth. This means gradual loss of skills and growing disinterest, which need further attention.

Source: Country data presented during the Regional Meeting to strengthen nursing and midwifery in South-East Asia Region, February 2019

4. Practice and service delivery

Midwifery-led continuum of care for two dimensions including period (from pre-pregnancy, through pregnancy, childbirth and early days and month of life), and place (from home to health facility and back to home) is integrated within service delivery to ensure the health of women, newborns and infants.

Priority Area 4.1.1: Ensure the continuum of midwifery care throughout the life-cycle of women and families at different levels of health facility and community

Actions

- a. Review the policy for midwives/midwifery-led centres/midwifery care and advocate to initiate midwives/midwifery-led care models for service delivery.
- b. Map and review midwifery services available in the country.
- c. Review/develop the scope of practice for midwifery service providers.
- d. Create visibility for midwife-led units among the public and professionals.
- e. Review/develop the role of midwives in adolescent health, child health, family planning and reproductive health.
- f. Promote inter-professional team work through a team of midwives, obstetricians, paediatricians and other health professionals to work collaboratively for RMNCAH.
- g. Document and share best midwifery care practices within and between countries.

Indicators for monitoring

- ◇ Countries have clearly defined and written scope of practice for midwives, which leads to midwifery-led continuum of care
- ◇ Countries have a policy and/or strategy and guidelines for all aspects of midwife practice
- ◇ Countries have models of practice, and these are documented and shared
- ◇ Programmes are implemented for highlighting the role of a midwife as a primary care provider for women's and adolescent reproductive health needs as well as for their newborns and infants

Priority Area 4.1.2: Ensure an enabling environment for midwifery care providers

- a. Establish a cross-referral system as appropriate.
- b. Develop standard operating procedures (SOPs) for midwifery services.
- c. Ensure adequate financing for developing cost-effective models of midwifery practice.
- d. Establish an appraisal system and recognize midwifery care providers.

Indicators for monitoring

- ◇ Countries have clearly defined risk categorization and have established an appropriate cross-referral system
- ◇ Countries have clearly defined SOPs for midwifery services in all facilities
- ◇ Countries have a clearly defined deployment policy and/or strategy and guidelines for a midwifery model of practice
- ◇ Countries have the provision for an appraisal system for midwifery care providers

Priority Area 4.2: Ensure quality of midwifery care by continuous strengthening of knowledge, skills and attitudes

Actions

- a. Review and update national standards for quality of care in the context of midwifery education and practice.
- b. Establish a mechanism for renewal of licensure.
- c. Introduce competency assessment tools for midwifery service providers and educators.
- d. Identify the modes of integration/coordination between midwifery practice, midwifery training institutions and national programmes.

Indicators for monitoring

- ◇ Countries have national standards for midwifery embedded in quality of care
- ◇ Countries have an established mechanism for renewal of licensure
- ◇ Countries use assessment tools for midwifery service providers and educators based on ICM competencies
- ◇ Countries demonstrate the integration of midwifery education and practice

Priority Area 4.3: Promote the rights-based approach to ensure respectful care for women and newborns

Actions

- a. Review the current national code of ethics for midwifery practice in line with the international code of ethics for midwives (ICM, 2019).
- b. Review and ensure that the principles of respectful care for women and newborns are embedded in policy, education and service.
- c. Include gender equity, respect and dignity of woman within pre- and in-service training programmes.
- d. Ensure that education and practice are in line with the current policies on the human rights-based approach.
- e. Incorporate the needs of women, families and the community while developing midwifery education and practice.

Indicators for monitoring

- ◇ Countries have a national code of ethics for midwifery practice
- ◇ Education, policy and service provision have a component of respectful care for women and newborns
- ◇ The content of gender equity, respect and dignity of women is reflected in the curriculum of both within pre- and in-service midwifery training programmes
- ◇ The human rights-based approach and the needs of women, families and community are reflected in the midwifery education and practice

Time for task-shifting? Public health midwives of Sri Lanka^{27,42}

The public health midwife (PHM) and the supervising PHM are key members of the health team in the antenatal clinics of Sri Lanka. Their regular interactions with women have ensured that 92.5% of mothers visit antenatal clinics. Regulated and supported PHMs have contributed to bringing down the levels of MMR, NMR and stillbirths in Sri Lanka. PHMs also play a major role in family planning. There are 6690 PHMs in the country.

PHMs are usually selected from local areas and trained for 18 months. They are trained to carry out multiple functions in MCH, health education, sanitation, family health, and health information and management. In the area of MCH, PHMs are responsible for antenatal risk screening, assessment of body mass index (BMI), immunization to mothers and babies, health education, etc. In the area of Intrapartum care, the midwife is responsible for monitoring labour, normal delivery, newborn resuscitation and initiation and continuation of breastfeeding.

With the lower demand for their skills during childbirth (because of the high demand for specialist services), PHMs have to broaden the scope of their work to women's health, adolescent health and other areas of public health. With their broad and multipurpose training, PHMs are appropriate for task-shifting. Identifying and counselling for vaginal discharge, cervical cancer screening and their referral and follow-up are being explored as areas for task-shifting to PHMs.

The challenges are a large number of vacancies, shifts in health-seeking behaviour towards specialized services and resistance to task-shifting.

Sources: Country data presented during the Regional Meeting to strengthen nursing and midwifery in South-East Asia Region, February 2019; Ilankoon P, Cse G, Fernandupulle RC, Perera PPR. Public health midwives' role in health education regarding vaginal discharge: a cross sectional descriptive study. *International Journal of Scientific Research and Management (IJSRM)*. 2016;4(6):4303-10 (<https://www.ijerm.in/index.php/ijerm/article/view/361>, accessed 27 February 2020).

5. Research and evidence

Research with focus on midwifery and women's health is conducted and the generated evidence is utilized in midwifery practice through continuous monitoring and documentation. Research and evidence need to be translated into policy to respond effectively to the needs of the population.

Priority Area 5.1: Identify the existing evidence and gaps, set priorities, and conduct research based on priorities (conduct research and generate evidence)

Actions

- a. Classify research and structure into different types: academic research, operational research (monitoring and evaluation, M&E), and student-based research.

- b. Ensure that the midwifery curriculum includes the content of research process and evidence-based midwifery practice.
- c. Assess and build capacity for midwife-led research and collaborative inter-professional research.
- d. Identify the research agenda and encourage midwives to conduct research for midwifery practice and education.
- e. Ensure that evidence-based knowledge is used to inform practice at all levels.
- f. Monitor and evaluate policy and practice and feedback in the project cycle.
- g. Enhance collaboration with WHO collaborating centres to take lead on evidence generation and dissemination in the Region.

Indicators for monitoring

- ◆ The core curriculum of midwifery pre-service education includes the content to acquire research competencies
- ◆ Academic institutions are engaged in conducting research on key aspects of midwifery practice including collaborative research

Priority Area 5.2: Translate evidence into midwifery policy, education and practice

Actions

- a. Develop/strengthen a national government-led strategy and department to facilitate, disseminate, adopt and monitor the use of evidence in policy and practice.
- b. Develop capacity of midwives to continuously review the literature related to maternal and newborn care and other areas of RMNCAH.
- c. Review/ensure that the midwifery curriculum is based on evidence from research for all procedures and practices.
- d. Encourage strengthening/introduction of newsletters, professional journals and house journals among midwifery institutions.
- e. Strengthen academic institutions and professional organizations to organize workshops, seminars and conferences to share and learn about the latest evidence.
- f. Develop/strengthen knowledge-sharing forums for exchanging and learning lessons from innovations and implementation.
- g. Professional associations are encouraged to facilitate research and disseminate research findings.

Indicators for monitoring

- ◆ Number of research articles published in peer-review journals by the faculty and midwife practitioners
- ◆ Number of regional and national knowledge-sharing forums for midwifery research facilitated by professional associations

Priority Area 5.3: Monitor and evaluate progress, identify challenges, and continuously update policy-making and practice

Actions

- a. Ensure that the voices of midwives are heard for research from the start.
- b. Enhance collaboration with academic institutions for documentation and analysis of midwifery services and midwife-led models.
- c. Develop strategies to prioritize research areas of RMNCAH.
- d. Ensure that the implementation of research evidence is translated into national or subnational policy, planning and practice.

Indicators for monitoring

- ◆ Number of documents released that report on implementation
- ◆ Documentation processes clearly outlined

Annexes

I. Definition of a midwife (International Confederation of Midwives)²

The International Confederation of Midwives (ICM) defines a midwife as one who has successfully completed a midwifery education programme that is recognized in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title “midwife”; and who demonstrates competency in the practice of midwifery.

Source: International confederation of midwives (<http://www.internationalmidwives.org/who-we-are/policy-and-practice/icm-international-definition>)

II. Evidence-based Essential Competencies for Basic Midwifery Practice – 2018 update³²

Category 1: General competencies

The midwife’s accountabilities as a health professional, the relationships with women and other care providers, and care activities that apply to all aspects of midwifery practice	<ol style="list-style-type: none">Assume responsibility for own decisions and actions as an autonomous practitionerAssume responsibility for self-care and self-development as a midwifeAppropriately delegate aspects of care and provide supervisionUse research to inform practiceUphold fundamental human rights of individuals when providing midwifery careAdhere to jurisdictional laws, regulatory requirements and codes of conduct for midwifery practice
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	<ul style="list-style-type: none">g. Facilitate women to make individual choices about careh. Demonstrate effective interpersonal communication with women, families, health-care teams and community groupsi. Facilitate normal birth processes in institutional and community settings, including women's homesj. Assess the health status, screen for health risks, and promote general health and well-being of women and infantsk. Prevent and treat common health problems related to reproduction and early lifel. Recognize conditions outside midwifery scope of practice and refer appropriatelym. Care for women who experience physical and sexual violence and abuse
Category 2: Pre-pregnancy and antenatal	
Health assessment of the woman and fetus, promotion of health and well-being, detection of complications during pregnancy, and care of women with an unexpected pregnancy	<ul style="list-style-type: none">a. Provide pre-pregnancy careb. Determine the health status of womenc. Assess fetal well-beingd. Monitor the progression of pregnancye. Promote and support health behaviours that improve well-beingf. Provide anticipatory guidance related to pregnancy, birth, breastfeeding, parenthood and change in the familyg. Detect, manage and refer women with complicated pregnanciesh. Assist the woman and her family to plan for an appropriate place of birthi. Provide care to women with unintended or mistimed pregnancies
Category 3: Care during labour and birth	
Assessment and care of women during labour that facilitates physiological processes and a safe birth, the immediate care of the newborn infant, and detection of complications in mother or infant	<ul style="list-style-type: none">a. Promote physiological labour and birthb. Manage a safe spontaneous vaginal birth and prevent complicationsc. Provide care of the newborn immediately after birth
Category 4: Ongoing care of women and newborns	
The continuing health assessment of mother and infant, health education, support for breastfeeding, detection of complications and provision of family planning services	<ul style="list-style-type: none">a. Provide postnatal care for the healthy womanb. Provide care to healthy newborn infantc. Promote and support breastfeedingd. Detect and treat or refer postnatal complications in womane. Detect and manage health problems in newborn infantf. Provide family planning services

Source: International confederation of midwives (<https://internationalmidwives.org/what-we-do/education-core-documents/>)

III. Evidence to support strengthening midwifery

Author/year/publication	Actions/targets	Target year
World Health Organization (WHO) and partners		
WHO, 2015. The global strategy on human resources for health: workforce 2030	To ensure availability, accessibility, acceptability and quality of the health workforce through adequate investments and the implementation of effective policies at the national, regional and global levels, for ensuring healthy lives for all at all ages, and promoting equitable socioeconomic development through decent employment opportunities	2030
WHO, 2015. Strategic directions for nursing and midwifery 2016–2020	To guide growth of capabilities and maximize the contributions of the nursing and midwifery workforce to improve global health	2020
WHO, 2015. Ending preventable maternal mortality	To reduce maternal mortality ratios (MMRs) to fewer than 70 per 100 000 live births globally	2030
WHO, UNFPA, ICM, 2014. The state of the world's midwifery 2014. A universal pathway. A woman's right to health	To provide an evidence-base on the state of the world's midwifery in 2014 that will: support policy dialogue between government and their partners; accelerate progress on the health MDGs; identify developments and inform negotiations for and preparation of the post-2015 development agenda	-
WHO, 2014. Every newborn: an action plan to end preventable deaths	To reduce neonatal deaths to fewer than 12 per 1000 live births by 2030 and fewer than 10 per 1000 live births by 2035	2030 and 2035
WHO, 2013. Maternal death surveillance and response: technical guidance. Information for action to prevent maternal death	To eliminate preventable maternal mortality by obtaining and strategically using information to guide public health actions and monitoring their impact; to count every maternal death, permitting an assessment of the true magnitude of maternal mortality and the impact of actions to reduce it	-
WHO and UNICEF, 2013. Countdown to 2015: Maternal, newborn and child survival	Uses available data to hold stakeholders to account for global and national action. Focuses on the 75 countries where more than 95% of all maternal and child deaths occur (in the SEA Region, includes Bangladesh, DPR Korea, India, Indonesia, Myanmar and Nepal; excludes Bhutan, Maldives, Sri Lanka, Thailand and Timor-Leste)	2015
WHO, 2012. Nutrition: global targets 2025	50% reduction of anaemia in women of reproductive age; 30% reduction in low birth weight babies; increase the rate of exclusive breastfeeding in the first 6 months to at least 50%	2025
WHO, 2011. Preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries	To improve sexual and reproductive health outcomes among adolescents by reducing the chances of early unwanted pregnancy, which can result in poor health outcomes	-

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Author/year/publication	Actions/targets	Target year
WHO, 2010. Global strategy for women's and children's health Every Woman Every Child (EWEC) is the movement that puts the global strategy into action	The global strategy sets out the key areas where action is urgently required to enhance financing, strengthen policy and improve service delivery. These include: <ul style="list-style-type: none"> ◆ country-led health plans ◆ integrated delivery of health services and life-saving interventions ◆ stronger health systems ◆ innovative approaches to financing ◆ improved monitoring and evaluation 	2015
Framework for action: strengthening quality midwifery education for universal health coverage 2030	Provide the seven-step action plan to strengthen quality	2030
UN Agencies		
Every Woman Every Child, 2015. Global strategy for women's, children's and Adolescents' Health (2016–2030) Survive, Thrive and Transform	To take a life-course approach that aims for the highest attainable standards of health and well-being – physical, mental and social – at every age To adopt an integrated and multisector approach, recognizing that health-enhancing factors including nutrition, education, water, clean air, sanitation, hygiene and infrastructure are essential to achieving the SDGs	
UNFPA, ICM 2014 Comprehensive midwifery programme guidance	To assist Ministries of health, partner agencies in developing, scaling up and/or strengthening midwifery programmes at the national level in areas of education, regulation and association, stakeholder engagement, effective policy advocacy and fund raising.	-
UNFPA, Bill and Melinda Gates Foundation, 2014. Family Planning 2020	To make available affordable, life-saving contraceptive information, services and supplies to an additional 120 million women and girls with unmet need for contraceptives in the world's poorest countries	2020
UNAIDS, 2011. Countdown to zero: global plan towards the elimination of new HIV infections among children by 2015 and keeping their mothers alive	The estimated number of new HIV infections in children is reduced by at least 85% in each of the 22 priority countries. The estimated number of HIV-associated pregnancy-related deaths is reduced by 50% (in the SEA Region, includes India)	2015
International Confederation of Midwives (ICM)		
ICM, 2015. Midwifery services framework	To aid in the development of RMNCAH services by midwives, to help governments and development partners develop or strengthen midwifery services from within their national contexts and situations	-
Other stakeholders		
The Lancet Series on Midwifery, 2014. Papers 1–4	Provides scientific evidence and a framework for quality maternal and newborn care (QMNC) that firmly places the needs of women and their newborn infants at its centre	-

Source: compiled by the authors

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