

MIDWIFERY IN THE COMMUNITY: Lessons Learned

1st International Forum on Midwifery in the Community

11 - 15 December 2006, Hammamet, Tunisia



***"The world needs
Midwives now more
than ever - to save
the lives of mothers
and babies"***

**Organized by
UNFPA, ICM, WHO
in collaboration
with SIDA (Sweden),
IMPACT & FCI**

"MIDWIFERY IN THE COMMUNITY: LESSONS LEARNED"

International forum on training and scaling-up
midwives and others with midwifery skills

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A UNFPA-ICM Joint Initiative to support the call for a Decade of Action for Human Resources for Health made at World Health Assembly 2006

To see more information about what the organizers are doing to invest in skilled care for safe motherhood visit, United Nations Population Fund website www.UNFPA.org, International Confederation of Midwives (ICM) www.internationalmidwives.org, WHO Making Pregnancy Safer(WHO MPS) at www.who.int/making_pregnancy_safer

Acknowledgements

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Table of Contents

Acknowledgements	ii
Glossary of Terms	iv
Executive Summary	1
Background: Why focus on midwives in the community?	4
Overall Objective of the Forum	6
Inaugural session	8
Dedication and Opening Ceremony	8
Technical sessions	11
Summary of Presentations	11
Plenary session	12
Inter-professional collaboration	23
The RPMM Network: strengthening the enabling environment – lessons learned	24
M & E: Measuring what? Why Monitoring and Evaluation?	26
Advocacy	27
Case Study group work	29
Concluding session – day 5	31
Call to Action	34
The Way Forward	36
Key Messages	37
Annex 1: Final Agenda	38
Annex 2: List Of Participants	41
Annex 3: Case Studies	49
Annex 4: Call to Action	53
Annex 5: References and Bibliography	55
Annex 6: Definition of the Midwife	56

Glossary of terms adopted at the Forum

Midwifery (French <i>la pratique de sage-femme</i> ; Spanish <i>partería</i> ; Arabic <i>kebela</i>)	The scope of professional midwives' practice. The art and science of assisting a woman before during and after labour and birth
Midwife (<i>Sage-femme</i> ; <i>Matrona</i>)	An accredited (qualified) healthcare practitioner who assists women in pregnancy, throughout labour and childbirth and cares for women and babies in postnatal period. She has an important promotive and preventative function in broader reproductive health, health advocacy, empowerment of women and neonatal health. (See International Definition of a Midwife: http://www.internationalmidwives.org)
In the community (<i>Dans la communauté</i> ; <i>En la comunidad</i>)	Level of health system close to where families live, e.g. government, private or NGO health post or clinic, or the family home (sometimes referred to as primary health care level)
Midwifery workforce (<i>Les professionnels compétents dans la pratique de sage-femme</i> ; <i>Personal calificado de partería</i>)	Healthcare workers whose primary functions include health care to women in pregnancy and throughout labour and birth, and to mothers and babies in the postnatal period.
Maternity workforce (<i>Les professionnels compétents dans la pratique de sage-femme</i> ; <i>Personal calificado de partería</i>)	Total workforce needed for maternity care. The category includes midwives and others with midwifery skills; obstetric and surgical staff; paediatric (neonatal physicians and nurses); laboratory technicians, radiologists and other specialists.
Maternity support workers (<i>Les agents communautaires de santé maternelle</i> ; <i>Asistentes de maternidad</i>)	Healthcare workers, community workers and others, including traditional healers and others, who work and have links with the midwifery workforce. They play an important role in supporting women's and newborns' access to skilled care for safe pregnancy and childbirth, including postnatal and neonatal healthcare.
Emergency obstetric care (EmOC), basic and comprehensive (<i>Les soins obstétricaux d'urgence (SOU) de base et complets</i> ; <i>Cuidados Obstétricos de Emergencia (COEm) basicos y ampliados</i>)	<p>Consists of eight signal functions:</p> <p>Basic: Parenteral administration of antibiotics, oxytocics and anticonvulsants; manual removal of the placenta; manual vacuum aspiration; vacuum extraction; (plus stabilization of woman for referral), pre-referral care and referral.</p> <p>Comprehensive: all the above plus surgery (caesarean) and safe blood transfusion.</p>

Emergency obstetric and neonatal care (EmONC) (*Les soins obstétricaux et néonataux d'urgence [SONU]; Cuidados obstétricos y neonatológicos de emergencia [CONEm]*)

Consists of ten signal functions:

Basic: Parenteral administration of antibiotics, oxytocics and anticonvulsants; manual removal of the placenta; manual vacuum aspiration; vacuum extraction; basic newborn care; (plus stabilization of woman and newborn for referral), pre-referral care and referral. **Comprehensive:** all the above plus caesarean surgery and safe blood transfusion, neonatal resuscitation.

Skilled care for pregnancy and birth (*Soins obstétricaux qualifiés; Atención calificada durante el embarazo y el parto*)

“Skilled care” denotes a skilled attendant assisting pregnancy and birth in an enabling environment, supported by a functional referral system.

Competency

The knowledge, skills, attitudes and experience required for individuals to perform their jobs.

Skills

Abilities learned through training or acquired by experience to perform specific actions or tasks. Usually associated with individual tasks or techniques, particularly requiring the use of the hands or body.

Core competencies

A combination of complementary skills and knowledge bases (i.e. more than one knowledge base) in an area of specialized expertise such as midwifery, embedded in the group, team or professional cadre.

MDG-5

The fifth of the Millennium Development Goals adopted by world leaders at the Millennium Summit at the United Nations in the year 2000, with the aim of halving extreme poverty by 2015. The goal is to reduce the maternal mortality ratio by three-quarters between 1990 and 2015.

Executive Summary

The 1st International Forum on Midwifery in the Community was held 11-15th December 2006 in Hammamet, Tunisia, organized by the International Confederation of Midwives (ICM), the United Nations Population Fund (UNFPA) and the World Health Organization (WHO), with the support of the Swedish International Development Agency (SIDA), the Government of Luxembourg, the global research initiative IMMPACT, Family Care International (FCI), Averting Maternal Death and Disability (AMDD) and the Partnership for Maternal Newborn and Child Health (PMNCH).

The Forum brought together multi-disciplinary experts from 22 low and middle-income countries in four regions of the world (Africa, Asia, Middle East and Latin America and the Caribbean) to consider how midwifery care in the community could be scaled-up. The Forum organizers recognized that activities under the Safe Motherhood Initiative have always prioritised the need for skilled care at birth. However, strengthening quality midwifery care in the community has not received due attention, as compared to scaling-up emergency obstetric and neonatal care; yet without skilled midwifery providers, working closely with women and their families, the knowledge of when and how to access such care—even the willingness to do so—is limited.

The international community's involvement in scaling-up midwives and others with midwifery skills took on urgency with the publication of the World Health Report 2006 Working Together for Health. The recognition of the magnitude of human resource shortages, coupled with the Lancet's series on maternal survival published later in 2006, triggered debate about the most effective strategies for reaching the fifth Millennium Development Goal (see glossary) particularly how best to increase and improve human resources. There is an urgent need to review current programmes for scaling-up human resources for safe motherhood and assess their potential effectiveness, before other countries embark on costly initiatives.

The Forum's general objective was to collate knowledge and experience in developing policy and programme guidance for low-income countries wishing to strengthen their community midwifery workforce to save the lives of mothers and newborns. Specific objectives were:

- 1) to share lessons learned in countries about strengthening community midwifery as a part of MMR reduction;
- 2) to develop a framework for assessing midwifery capacity;

- 3) to highlight issues requiring policy and programmatic action;
- 4) to develop a consensus on best-practice options for rapid scale-up on educating midwives and others with midwifery skills; and
- 5) to share experience in developing a plan of action at country and regional levels to strengthen midwifery professional associations.

The Forum was inaugurated by Prof. Mohamed Bechir Helayem, Director of the Tunisian National Centre for Training of Health Personnel, on behalf of the Tunisian Minister of Public Health. Technical sessions and country presentations fell under six main themes seen as crucial, consistent with current evidence, for scaling-up human resources for safe maternal and newborn care:

- 1) Getting on to the political radar screen;
- 2) Ensuring that the poor and hard to reach have midwifery care;
- 3) Education;
- 4) Supervision;
- 5) Enabling factors, and
- 6) Monitoring and evaluation.

Following the country presentations participants worked for two days in multi-country groups to consider recommendations for scaling-up midwifery in the community in three typical, but different, case scenarios.

Participants determined that issues to be addressed in any country scenario for scaling-up midwifery in the community fell under six major headings:

- 1) Policy, legal framework and national standards and guidelines on midwifery;
- 2) Ensuring equitable access to midwifery care;
- 3) Competency based education and training, including competency-based curricula, competent midwife teachers, capacity building of training institutions and parallel action for short and long-term human resources strategies;
- 4) Supportive and capacity building supervision;
- 5) Providing an enabling environment for midwives working in the community, including professional collaboration, equipment and supplies, housing and personal security;
- 6) Better evidence gathering, mainly through strong monitoring and evaluation.

Participants felt that there was an urgent need to bring to the attention of the wider community, globally and their own countries, the issue of lack of access to midwifery care, particularly at the community level. With this in mind they made a “Call to Action” to all stakeholders, for urgent and intensified attention to scaling-up midwifery in the community, addressing a number of priority areas: policies to ensure equitable access to midwifery care; strengthening regulatory systems for deployment and retention; investing in competency-based education and training; peer support and supportive supervision; and provision of an enabling environment that included ensuring basic safety of staff and their families. Findings from regular monitoring and evaluation should be drive all efforts.

SUMMARY

Participants concluded:

- It is the right of all pregnant women to have access to skilled care before, during and after childbirth, as close as possible to where they live.
- Countries with high maternal mortality should scale up skilled attendance with providers possessing the full range of midwifery core competencies (as defined by ICM: see glossary). Skills alone are not sufficient. Evidence from regular monitoring and evaluation should drive all efforts.
- Birth attendants without full midwifery competencies must be supervised and trained by a competent midwife.
- Midwifery is different from obstetric or maternity nursing and should be respected for its discrete and unique body of knowledge.
- All midwives, including those working in the community, must function in an enabling environment, including a supportive legal and policy framework, with back-up from a supportive fully-functioning EmONC facility; adequate housing; provision for children’s education, and personal security. Midwives should be part of the overall maternity care team.
- Teachers and supervisors of midwifery must be competent and experienced in midwifery, as well as educational and training technologies.
- Men should be actively encouraged to engage more in culturally appropriate solutions to ensure access to skilled midwifery care in the community.

Background: Why focus on midwives in the community?

An estimated 530,000 women die each year from complications of pregnancy and childbirth, with over 90 per cent of deaths occurring in South Asia and sub-Saharan Africa, and less than one per cent in more developed regions. Another 10 to 20 million women annually are estimated to suffer severe health problems, such as obstetric fistula, as the result of pregnancy and childbirth. An estimated 7 million newborns die each year. Seventy per cent of maternal deaths are attributable to five major complications, most of which occur during labour, delivery and the postpartum period. Most of these cannot be predicted, but almost all can be managed. Approximately 15 per cent of women will experience a complication during pregnancy or childbirth. Most maternal deaths and disabilities and at least half of the 7 million neonatal deaths every year could be averted if skilled healthcare professionals who have access to quality referral facilities attended all births. This is most likely to happen where skilled attendants work as close to the population as possible – at the community level.

The organizers of the 1st International Forum on Midwifery in the Community held 11-15th December 2006 in Hammamet Tunisia—the International Confederation of Midwives (ICM), United National Population Fund (UNFPA) and World Health Organization (WHO)—recognize that activities under the Safe Motherhood Initiative have always prioritised the need for skilled care at birth. However, strengthening quality midwifery care in the community has not received due attention, as compared to scaling-up emergency obstetric and neonatal care; yet without skilled midwifery providers, working closely with women and their families, the knowledge of when and how to access such care—even the willingness to do so—is limited.

The Forum brought experts together to consider how midwifery care in the community could be scaled up. It followed on a meeting held by UNFPA in New York in March 2006, and held with the support of the Swedish International Development Agency (SIDA), the Government of Luxembourg, the global research initiative IMMPACT, Family Care International (FCI), Averting Maternal Death and Disability (AMDD) and the Partnership for Maternal Newborn and Child Health (PMNCH). The results of the meeting in New York, plus the outcome of this larger meeting, in which 22 nations from three different continents participated, will form the basis for a smaller technical meeting to be hosted by WHO in Geneva in 2007.

Historical as well as contemporary evidence from many countries show midwifery's impact on maternal and neonatal mortality: Sweden, Malaysia and

Sri Lanka, with skilled midwives functioning in or very close to the community (Högberg, 1985, Padmanathan, Liljestrand, et al 2003); Kerala, a province in southern India, which has promoted midwifery; and Chile, which has a five-year university programme for midwives (Segovia, 1998).

The core skills required to provide care that will save women's and newborns' lives are those of a midwife (WHO, 2004). The MDGs include an indicator on the proportion of births attended by skilled personnel, emphasizing the crucial role of the midwife in improving maternal health. The World Health Report 2005 recognizes the midwife as the prototype skilled birth attendant (WHO, 2005). According to current estimates a skilled attendant assists no more than 40 per cent of births in low-income countries (Stanton et al, 2006), and this may be an overestimate, because not all countries comply with the international definition of a skilled attendant. This only highlights the immense efforts needed to reach the target for 2015 of 90 per cent coverage of all births by a skilled attendant. WHO estimates that an additional 334,000 midwives are required to fill the existing gap; almost double this number are required to implement universal access to a full package of care services (WHO, 2005).

Scaling-up of midwifery in the community is a complex issue with great challenges. It is not self-evident that young professional midwives are willing to live in rural areas, which offer limited opportunities for their own and particularly their children's education and future careers. Midwives feel insecure in communities where they are strangers, a serious constraint raising issues such as insecure living conditions, sexual harassment and cultural unfamiliarity. Political instability or civil war, for example, can bar deployment of qualified midwives outside their own ethnic groups (Pettersson et al, 2004).

Yet, in most cases midwives are the primary contact for women and their families. Equitably deployed, midwives can reach all women, even the poorest, especially those who would otherwise not seek care. Properly trained, midwives working in the community can not only intervene to save lives, but can stabilize women and their babies if complications develop, while arranging for their transfer to the next level of care (deBernis, Sherratt et al, 2003).

Working in and with communities, midwives can be effective partners for wider public health initiatives. In countries with strong midwifery services, midwives also offer immunizations, health education and promotion on many aspects of healthy lifestyles, and often take part in school health and environmental health initiatives.

The international community's involvement in scaling-up midwives and others with midwifery skills took on urgency with the publication of the World Health Report 2006 Working Together for Health. The recognition of the magnitude of human resource shortages coupled with the Lancet's series on

maternal survival, published later in the year, triggered debate about the most effective strategies for reaching MDG-5 (see glossary).

The current focus of attention is on how best to invest in human resources to reach MDG-5, especially in low-income countries, particularly in sub-Saharan Africa and some parts of South Asia. There is an urgent need to review current programmes for scaling-up human resources for safe motherhood and assess their potential effectiveness, before other countries embark on costly initiatives.

OVERALL OBJECTIVE OF THE FORUM

The overall objective of the Forum was to collate knowledge and experiences to develop policy and programme guidance which would help low-income countries strengthen their community midwifery workforce to save the lives of mothers and newborns. Specifically, the Forum gave a platform for sharing countries' positive and negative experiences and lessons learned while strengthening the community midwifery workforce. It also provided an opportunity to exchange knowledge and experiences in developing a plan of action at country and regional levels to strengthen midwives' professional associations.

Tangible outputs included: guidance on specific policy and programme action to strengthen the community midwifery workforce; a consensus on best practice for rapid scale-up of midwifery, especially at the community level, and key messages for advocacy.

PARTICIPANTS

Twenty-two countries were represented in the Forum, from four regions of the world, Africa, Asia, the Middle East and Latin America and the Caribbean: Bangladesh, Bolivia, Burkina Faso, Cambodia, Guatemala, Haiti, India, Indonesia, Jordan, Kenya, Malawi, Mexico, Morocco, Mozambique, Nepal, Niger, Pakistan, Sudan, Tanzania, Tunisia, Yemen and Zimbabwe. In addition midwives from Canada, Chile, Netherlands, Sweden and United Kingdom shared experiences from middle and high-income countries. The Ministry of Health of Tunisia kindly hosted the Forum and delegations from the Ministry of Health officiated at the opening and closing sessions.

Most country delegations included midwives, obstetricians, officials of Ministries of Health and programme officers from either UNFPA or WHO. Organizations attending included the Swedish International Development Agency (SIDA), Africa Development bank, the Initiative for Maternal Mortality Programme Assessment (IMMPACT) based at Aberdeen University, Family Care International (FCI), Averting Maternal Death and Disability (AMDD) programme, Columbia University and the Regional Prevention of Maternal Mortality (RPMM) Network. For full list of participants see Annex 2.

PRE-FORUM EXERCISE

Country teams were asked to prepare:

- a national matrix on midwifery;
- a presentation under a designated theme.

POST-FORUM ACTIVITIES

- Wide dissemination and advocacy for the Call to Action
- Preparation, translation, printing and dissemination of the final report and guidance document
- Follow up Technical meetings in regions and countries
- Follow up Technical meeting to be arranged by WHO, to review evidence and make recommendations to Member States
- Joint Plan of Action by partners to help countries implement recommendations.

AGENDA – SEE ANNEX 1

Inaugural session

DEDICATION AND OPENING CEREMONY

The Forum began with a moment of silence remembering mothers who died during pregnancy and childbirth: Each woman who dies is not just a mother, but is also a wife, a daughter, a daughter-in-law, a granddaughter, a sister and a friend to many in her community. Each newborn is an individual and divine being; each child a grandchild, maybe a brother or sister, representing the future and hopes not realised; a life tragically ended at its very beginning.

The Mexican team presented a traditional ceremony in which they gave homage to all who have gone before and to the four directions of the world, beginning with the east from where the sun rises. They recognised and greeted the four elements, air, water, fire and earth.

Forum participants having pondered the matters at the heart of the Forum, a team representing South Asia ended the dedication ceremony by lighting three candles symbolising partnership to ensure the safety of mothers and babies, and light representing wisdom and guidance.

OPENING

Professor Mohamed Bechir Helayem, director of Tunisia's national centre for training health personnel opened the Forum on behalf of the Minister of Public Health. Dr Helayem shared his own feelings about the symbolic dedication ceremony, stressing the sacred relationship between women and midwives. He then read the official speech of the Minister of Public Health. The Minister sent his wishes for a successful meeting and emphasised the privilege felt by the Tunisian authorities as the host country for such an important event. The speech stressed the need for political will to strengthen the health sector, particularly for maternal health care. Investment in strategic actions, especially in midwives as key players in maternal health care, had led to a reduction of maternal mortality in Tunisia. Professor Helayem then declared the Forum open and expressed his own best wishes for a successful meeting.

Dr. Rym Ben Aissa, of the national board of family planning and director for the centre of research on reproductive health, gave an overview of the major determinants of maternal mortality reduction in Tunisia. Reiterating the Minister's words she emphasised the importance of political will that had made possible women's emancipation, abortion regulation and compulsory education for females, in addition to promoting midwifery for family planning and safe motherhood.

Ms. Gunilla Essner from SIDA, a major sponsor of the Forum, then gave her opening statement on SIDA's support for midwifery. She mentioned that SIDA had recently launched their international document to guide Sweden's strategies for sexual and reproductive health. She told participants "An improved situation for women is emphasized in the policy, where the trained midwife has a key role to play in the maternal and newborn survival and is of a crucial importance in reaching the MDGs for 2015". An important aspect of the strategy was to empower women and girls in their natural context. Empowering women lies at the heart of a midwifery model of care.

Referring to the history of Sweden's success in reducing maternal mortality, Mrs. Essner identified the keys to success as good basic education, and making sure that the community used the professional midwives allocated to every parish. She recognized that different countries would require different support and assistance and outlined the many ways SIDA was currently supporting strengthening of midwifery in a number of countries in Africa, Asia and Latin America and the Caribbean.

She concluded by saying SIDA was happy to support the Forum, to emphasize the importance of a comprehensive view of midwives and an enabling environment in which to work. She hoped that the Forum would provide guidance on many issues, including helping midwives to gain respect and better salaries, as well as upgrading and improving training curricula and institutions, and the skills of midwife teachers. Equally, there was need for guidance and support to countries in addressing policy issues surrounding midwives' scope of practice.

Dr. Arletty Pinel, director of reproductive health, welcomed participants on behalf of UNFPA. She referred to the meeting UNFPA and its partners hosted in March 2006 on the general subject of midwives' contribution to MDG-5. As a direct result of this meeting, UNFPA developed their strategy for supporting midwifery scale-up in countries with high maternal mortality and morbidity.

She reiterated that the movement for skilled birth attendance relates not only to acquiring technical skills, but also to the importance of motivation, guided by passion. She challenged participants to find the "fire in the belly" to protest against the fact that, 20 years after the launch of the global Safe Moth-

erhood Initiative so many women still gave birth alone or without a skilled attendant. Such a situation could not continue, she said. She conveyed her regrets that the organizers had not been able to provide support to all those countries that had expressed a desire to participate in the Forum. She said that the number of requests was a positive sign, showing that many countries are committed to increasing access to midwifery care.

In conclusion, Dr Pinel reminded participants that the Forum's considerations and recommendations must be practical, but also comprehensive. Countries needed guidance on urgent action, but also long-term solutions to ensure sustainability. "There must be no more poor solutions for countries tackling poverty alleviation. Skilled care at birth should not be regarded as a luxury that low-income countries cannot afford, but a basic human right of all women in the world, wherever they live".

Kathy Herschderfer, secretary-general of ICM, then added her welcome on behalf of ICM. "Saving the lives of mothers and babies has always been at the heart of ICMs' mission and mandate" she said. In particular, ensuring access to skilled midwifery care for women who could not afford to pay was one of the founding tenets of the confederation. She went on to outline the purpose and specific objectives set for the meeting.

Dr. Jelka Zupan, coordinator for norms, tools and technical cooperation with countries in the making pregnancy safer unit of WHO, Geneva, welcomed participants on behalf of WHO. She then gave the floor to Dr. Margareta Larsson, midwife in the department of making pregnancy safer, who presented statistics and trends on maternal and neonatal health. Dr. Larsson said that the health of mother and newborn was inseparable because of commonalities which led to health or ill-health. When maternal mortality increases, so does neonatal and perinatal mortality.

Dr. Larsson discussed trends in the use of skilled attendants and referred to the modified definition of a skilled birth attendant from 2004, which added the concept "accredited" (WHO, 2004). The current definition of skilled attendant developed by WHO, ICM and FIGO was endorsed by UNFPA, the World Bank, the International Council of Nurses and many others, and could be found on the WHO web site. Adding the term "accredited" acknowledged the critical need for a specific set of midwifery skills and for validation of healthcare workers' skills before they could be approved as skilled birth attendants.

Technical Sessions

SUMMARY OF PRESENTATIONS

The background – maternal and newborn health on the eve of the 20th anniversary of the Safe Motherhood Initiative

Ms. Ann Starrs, executive vice president, Family Care International (FCI) and co-chair of the Partnership for Maternal, Newborn and Child Health (PMNCH) opened the technical sessions. Her presentation on “Shaping the Global Agenda for Maternal Health” described the contribution PMNCH fore-saw for itself.

The partnership, established in 2005, involves the major UN organisations, governments, NGOs and academic institutions. Its focus is on a continuum of care from adolescence and pre-pregnancy through pregnancy, birth, post-partum and maternal health, involving skilled care in the home and the community, health centres and referral hospitals. The PMNCH has four working groups: on advocacy; country-level support; monitoring and evaluation; and effective interventions.

Ms. Starrs gave a brief overview of coming events, including the first general meeting of the PMNCH’s members (the “Forum”) in April 2007 in Tanzania, and a political conference in London in October 2007 under the title “Women Deliver”. The conference will aim to raise awareness and prompt stakeholders into action to improve care during pregnancy and childbirth. Information on the London conference can be found on www.womendeliver.org

The Africa Road Map and Framework set the agenda for the Partnership’s country-level action:

- birth in facilities;
- care and facilities to be as close to the community as possible;
- midwifery team approach;
- community mobilization.

Ms. Starrs concluded by arguing for political advocacy to promote each country’s needs.

Bridget Lynch, deputy director ICM, outlined the Confederation’s core values. ICM, founded in 1948, is the only professional association represent-

ing the voices of midwives on the international stage. ICM's mission, goals and aspirations are built on the belief that all women in the world should have access to a professionally trained midwife. Working in partnership with women, ICM believes that midwives make a major contribution to protecting and promoting the health of woman and babies. ICM are pleased that many countries, even some high-income western countries, share this belief and are returning to and investing in midwifery as a cost-effective measure for keeping mothers and babies safe. As an example, Ms. Lynch presented the Canadian case, where midwifery was not an established profession until the early 1990s. In Canada midwives graduate from a three-year direct-entry midwifery programme and work as autonomous practitioners in the community, caring for women during pregnancy, childbirth and the postpartum period. They also refer and assist women who give birth in hospitals.

According to Ms. Lynch, the late development of midwifery made it possible from the outset to develop a women-centred model of midwifery. Moreover, the complaints of Canadian indigenous women who were subjected to relocation from their local areas to the southern part of the country as early as six months into their pregnancy, gave rise to a three-stage tailored training of indigenous midwives, in which students can leave with a diploma at the end of each year. The diploma at the end of year one permits them to function as a doula; at the end of year two as an assistant to a midwife or as an antenatal and postnatal healthcare worker. It is important that education programmes become more flexible and seek to build entrants' capacity to their full potential. ICM has a large network of members in all regions of the world, some of whom were present at the Forum. As such ICM stands ready to work with partners in countries by sharing their wealth of experience in helping countries design and strengthen midwifery services.

The morning session concluded with Ms. Della Sherratt, consultant to ICM, and senior scientific advisor and leader of the Forum secretariat, giving an overview of the background paper, which is available on ICM and UNFPA websites. The emphasis of her presentation was on the interpretation of the terminology in the workshop's background paper, including the difficulty of finding appropriate translations in French and Spanish for terms such as "midwife", "midwifery", "community", and "skilled birth attendant". She introduced the glossary of terms to be used during the Forum (see p. xx).

PLENARY SESSION

During the plenary session the following issues were raised:

- Directives from international partners do not always correspond to country-level reality. Partners should come to countries to learn and understand the impact of directives in different contexts, before passing them as international guidance.
- National governments should respond to problems in their own health systems, deciding whether or not they need midwives.
- Obstetricians, who usually have a stronger political presence, can at times oppose the presence of midwives.
- Many countries need to clarify midwives' role, with clear demarcations between midwives and obstetricians.
- In many countries home birth is not a matter of choice but the only reality, given local geography.
- Health workers' negative attitudes must be addressed.
- In some countries, 90 per cent of mothers attend ante-natal care but only 40 per cent attend health facilities for delivery. The reasons are various and complex; but one that stands out is that few health facilities, especially those close to the community, operate a 24-hour service.
- Argentina complained that the background paper had excluded some of the countries in Latin America and the Caribbean with a history of midwifery, such as Peru, Ecuador, Uruguay and Paraguay. It was agreed that the background paper would be amended accordingly.

COUNTRY PRESENTATIONS

Themes for country presentations were assigned according to their place in group work. All country presentations can be found in full on the accompanying CD-ROM.

SESSION 1. GETTING ON THE POLITICAL RADAR SCREEN

Getting on to the political radar screen is urgent but not easy. Midwifery is a low-status profession in many low- and middle-income countries, and predominantly female, which does not improve the chances of success in the political arena. However, there are historical as well as contemporary ex-

amples of countries which have used political advocacy to promote midwifery; among the best-known are Sweden, Sri Lanka and Indonesia.

Countries with experience of embarking on political advocacy included India, Cambodia, Haiti and Malawi.

India's individual states can be as big as many countries. Issues include ANM's (Auxiliary Nurse Midwives) lack of sufficient qualifications and experience to provide skilled maternal health care in the community. This is being addressed in collaboration with WHO, SIDA and other organisations.

One of India's greatest recent achievements by far has been to connect maternal deaths to human rights, a great achievement.

Cambodia gave an overview of the history of midwifery in their country and statistics indicating improvement in skilled attendance at birth from 32 to 44 per cent.

The Ministry of Health, the Office of the Council of Ministers, Council of Administrative Reform and other concerned ministries and institutions, with the Cambodian Midwives Association, jointly organized a high-level midwifery forum with support from UNFPA in 2005. According to the Cambodian team, following the high-level meeting the Royal Government of Cambodia is now highly committed to midwifery issues. The findings of the comprehensive midwifery review, one of the many outcomes of the high-level forum, are now part of the mid-term review of the health sector strategic plan. As a result there is every hope that future efforts to strengthen midwifery will be integrated into the next health sector strategic plan.

Other outcomes of the high-level midwifery forum include:

- improved salary grades and scales and allowances;
- legislation for establishing the midwifery council (pending royal signature);
- implementation of the recommendations of the comprehensive midwifery review.

Haiti gave a detailed overview of maternal mortality, the highest in the region, and discussed the scope of midwifery. Midwives have little impact on institutional care because of laziness and lack of commitment to work; political instability; lack of norms and protocols; inadequate institutional organisation, and a non-conducive working environment. Midwifery in the community suffered from similar problems: lack of commitment, shortage of human resources and inadequate finance. The report did not describe the political climate.

Malawi is addressing the extremely high MMR and HIV/AIDS by providing maternal health care in the community, partly by nurse midwives but

also by community nurses. Midwifery students are now being allocated to the community and operate from health centres to gain community-midwifery clinical experience.

Traditional birth attendants still conduct about 26 per cent of all births in the community, and professional midwives mainly conduct institutional deliveries. Malawi suffers from a huge deficit of all human resources for health, including physicians, where the ratio is 1.6 to 100,000 population.

Major challenges were inadequate tutors and clinical preceptors; resources (books, journals, models, Internet, computers) and infrastructure to accommodate a large number of students. The response is to: expand training institutions to accommodate more students; increase enrolment of nurse/midwife trainees and other healthcare providers, and scale up the reproductive health community-empowerment programme, for which community guidelines are in draft form.

DISCUSSION

A crucial issue appeared to be the lack of experience and competence in how to conduct political advocacy, as expressed by Dr. Prakashamma from India. She pleaded for assistance from the international community for training midwives in political advocacy so that they can argue their case to the national leadership.

Participants agreed to make time available in the programme to address this in greater detail. Ms. Henrietta Aswad, UNFPA media and communication officer for the Arab region who was working with the Forum's secretariat, agreed to give a short presentation on advocacy. The presentation focused on the importance, strategy and nature of advocacy, and was much appreciated by participants.

SESSION 2. ENSURING THAT THE POOR AND HARD TO REACH HAVE MIDWIFERY CARE

Research has found that childbearing women in poor and vulnerable populations are subject to inadequate infrastructure and medical supplies, and to negative attitudes among health care professionals. Some aspects of the challenges of ensuring that the poor have access to midwifery care were presented and discussed by Mexico, Nepal, Mozambique and Southern Sudan.

Mexico: A presentation from CASA, an NGO working with indigenous populations, showed impressive reduction of maternal mortality by training indigenous women as professional midwives. The school of midwifery was

initiated by TBAs who wanted their daughters and women from rural communities to have access to professional midwifery education. The Ministry of Health and the Ministry of Education accredits the school. After a four-year course, graduates are licensed as professional autonomous midwives. The country team said that new ideas and initiatives need to be carefully monitored, evaluated and documented to build a stronger evidence base for what works and what does not work.

Nepal outlined the history of the country's national skilled birth attendant policy. Dr. Naresh Pratap K.C. presented a national road-map for training skilled birth attendants, upgrading both MCH workers and ANMs. The plan has benefited from regional meetings, which led to careful planning at national level, including the development of a concrete action plan.

Southern Sudan: The presentation by the Ministry of Health in the southern part of Sudan outlined the difficulties of re-establishing the midwifery workforce and health care services after a 27-year civil war which left the country devastated and the southern part of the country void of human and physical resources. MMR in the southern part of Sudan is estimated to be more than 1700/100,000 live births; around 90 per cent of women give birth without skilled assistance. Attempts are being made to survey the situation. Action has begun to re-establish midwifery in the south and a programme initiated to train community midwives. The presenter, herself a nurse-midwife, called for international assistance to rebuild the system, and recalled how she herself lost a younger sister as a result of pregnancy complications.

Mozambique: The presentation described Mozambique's efforts to incorporate access to skilled care as part of the national health policy. The national strategy to reduce maternal mortality is based on increasing the numbers of maternal and infant health nurses at various levels of care.

Mozambique reminded participants of the importance of continuous education, which is needed to build and maintain high quality evidence-based care. The presenter underlined the importance of sharing good news such as a new Midwifery Association (APARMO), who was in the process of being accepted as a member of the ICM, highlighting the critical role of professional associations in strengthening the profession.

SESSION 3: EDUCATION MATTERS: TRAINING APPROACHES, CURRICULA AND TRAINING OF TEACHERS

There are four types of pre-service training to prepare professional midwives:

- a) apprenticeship, where the trainee works and learns under the direct supervision of a professional midwife;
- b) vocational, in a training institution, with clinical experience under the supervision of a qualified tutor, midwifery practitioner, nurse or doctor;
- c) academic programmes, based in universities or other institutions of higher education, and
- d) pre-service preparation, for those already trained as nurses.

All four types have been shown to produce competent midwives. Programmes for those without nursing training (direct entry) usually last between 18 months and five years, with a mean of three years. They usually require ten years schooling as an entry requirement, although one or two countries have reduced this requirement.

Under this heading, Zimbabwe, Pakistan and Northern Sudan presented an overview of the historical and current situation.

Zimbabwe, where the MMR increased between the years 1994 and 1999 from 283 to 695, presented different approaches to training: 1) Pre-service (PCN, SCN, RGN, undergraduate); 2) Practical attachment (hands-on experience); 3) Diploma in midwifery (the pre-requisite of two years' experience has been waived); 4) In-service (for EmONC), 4) On-the-job support (mentoring by a skilled midwife).

Efforts to build teaching capacity resulted in a diploma in nurse education, a BSc in nursing and a MSc with a major in maternal and child health.

Efforts to improve midwifery services include:

- MNH assessment to map the human resource capacity and competence;
- EmOC equipment and an inventory of communication and transportation means;
- Increasing skilled attendance; training of trainers in EmONC, decentralized training of nurses, midwives and doctors; training of auxiliary staff such as laboratory workers and ambulance drivers.

The major challenges in Zimbabwe are the high attrition rate; inadequate midwife tutors; competition from better-paid jobs, for example theatre nurse; lack of recognition for the profession, and lack of resources.

Pakistan: Mrs Imtiaz Kamal, president and founder of the new Pakistan Midwifery Association outlined initial steps to train community midwives. Midwifery in general appears to be having a renaissance in Pakistan as a result of groundwork by all stakeholders since 2000. However, effective

functioning of midwives calls for additional steps such as improved education, better access to referral, and personal protection.

The Government is receiving international and bilateral assistance on this issue, for example from DfID (the British development agency). The Midwifery Association, which is about to become a member of ICM, has been very active and contributed to the revisions of the midwifery curriculum and the Nursing Act which are in progress. ICM is assisting a project to train teachers of midwives.

Plans include: renovation and equipment of maternity units, emergency obstetric care units and midwifery schools; teaching and learning materials in the national language, and building partnership between midwives and obstetricians, which has started with a few small joint projects.

Northern Sudan started to rehabilitate midwifery services in 2005 following the results of a rapid situation analysis of village midwifery services, using the WHO toolkit and ICM competencies as the standard. The analysis found a number of gaps in the skills of the village midwives. There was consensus on the need for a general update of midwifery education including:

- Revision and updating of the basic training curriculum based on the competencies needed for SBAs;
- Training for a core group of 23 midwifery school tutors on the new village midwife curriculum
- Upgrading training of 133 out of 234 tutors from 38 midwifery schools on the new curriculum.

DISCUSSION

There was consensus that the major challenge in most countries is to update both education programmes and teachers. Specifically, there is need for training of trainers and preparation of midwife teachers to ensure that both trainers and students are able to demonstrate core midwifery competencies.

SESSION 4: SUPERVISION - MODELS FOR SUPERVISING THE COMMUNITY MIDWIFERY WORKFORCE

Supervision is a remarkably neglected area and has unfortunately become associated with a checklist from provincial and national health offices, often completed by an individual who possesses neither knowledge nor experience of midwifery. Supervision is crucial to promoting midwifery in the community, particularly where midwives are working as autonomous practitioners.

Bangladesh, Yemen, Burkina Faso and Niger contributed presentations under this heading.

Bangladesh has designed its new community skilled birth attendant (CSBA) programme to respond to circumstances in which 90 per cent of all mothers give birth in the home, and only 13 per cent with a skilled attendant. CSBA training is in three separate modules: The initial six-month training is followed by a supervised period of nine months or longer of practical work in the field, with a three-month course to complete the programme. The supervisors are family welfare visitors (FWVs) who have received special training in supportive supervision. An important part of supportive supervision is a logbook in which CSBAs reflect on their experience during their supervised practical work. Supervisors go through the logbooks, discuss issues of clinical practice, and provide on-the job training for areas of perceived weakness.

Yemen currently has a multitude of cadres practising midwifery at all levels: despite this, there is a shortage of midwives in rural areas. A decision has been taken to train 1500 community midwives and decentralize training institutions. Two aspects of supervision were presented, including a checklist to facilitate the supervision of community midwives.

Burkina Faso described the different levels of the health system. Auxiliary nurse-midwives with a two-year training provide most of the midwifery care in the first level of care. The country has decided not to allow TBAs to conduct childbirths, and has redefined their role. Higher levels of care supervise lower levels and a multi-professional expert team supervises the hospitals. The primary health care centres should be supervised quarterly and the hospitals twice a year.

Niger described experience from a south-south collaborative project with Morocco. The project, in one district, introduced active management of the third stage of labour and showed positive results.

Midwifery education in Niger has two paths, both of three years' duration but with different entry requirements. The supervision system is similar to that in Burkina Faso. Visits to primary health care facilities should be conducted every month. Coverage of midwives is still inadequate.

DISCUSSION

The discussion focused on constraints on supervision. Burkina Faso acknowledged that staff shortages and logistics meant that they were able to conduct only two or three of the planned supervision visits during 2006.

Other topics raised during the discussion were deployment of the differ-

ent cadres in Yemen and the acceptance of male midwives, which was not seen as a problem in countries such as Burkina Faso and Chile.

SESSION 5: ENABLING FACTORS

More attention has been given in recent years to the importance of an enabling environment for pregnancy and childbirth care. A theoretical competence which does not correspond to real-world circumstances leaves newly-trained midwives unable to function. An enabling environment includes infrastructure, equipment, supporting and competent staff, as well as an organised working place; in other words, the possibility of responding to actual demands.

A presentation on behalf of ICM and FIGO by Ms. Nester Moyo (ICM) dealt with the importance of collaboration between midwives and obstetricians, the key members of the maternal health care team. Angela Kamara Sawyer from Regional Prevention of Maternal Mortality Network (RPMMN) in Africa gave a brief outline of their work across Africa. She shared some of the lessons RPMMN have learned about working collaboratively to ensure an enabling environment for skilled care. (See “Other Presentations” below)

Bolivia described cultural issues that prevent women from accessing professional care during birth. Despite the introduction of a successful social insurance scheme that makes care affordable to much of the population, families are reluctant to use maternity services, especially in rural areas. This, plus a lack of skilled midwifery providers, has highlighted the need for a new midwifery cadre, the more so as there are too few nurses who could be trained as midwives.

Maternal health care providers have little knowledge or appreciation of traditional birthing customs and beliefs, which are still strong in rural Bolivian communities. Mothers find it difficult to communicate with professional cadres. A new project between the ministry of health and one of the main universities will train community midwives, who will also be able to work in other settings. The project collaborates with Chile, and parts of the Chilean model of midwifery will be adapted. The new curriculum has been developed and training of potential midwife teachers commenced.

Tanzania has a widespread and relatively well-organized maternity care system, yet only 47 per cent of births take place with a skilled attendant. Many healthcare providers in the community do not meet the definition of a skilled birth attendant.

Tanzania has a relatively enabling environment, for example:

- political stability;
- a conducive policy environment;
- increased provision of comprehensive RCHS, EmOC, post-abortion care, essential obstetric and neonatal care;
- a number of midwives trained in life-saving skills;
- support from different international partners and agencies;
- schools adequate in number, training midwives at different levels;
- supplies of basic equipment for maternity care;
- standards, protocols and providers' reference materials at facility level;
- regular and supportive supervision;
- renovation of some health facilities;
- a midwifery regulatory body.

Challenges include:

- staff shortage, particularly in peripheral facilities;
- insufficient in-service training in life-saving skills;
- weak management information system;
- inefficient communication system;
- ineffective referral system;
- midwives unwilling to be posted in most rural areas remain unemployed;
- high maternal morbidity and mortality;
- limited access to delivery services (especially in Zanzibar).

A response to the challenges calls for: continued advocacy for deployment of more midwives; implementation of policy, protocols and guidelines; better communication systems; scaling-up delivery of maternity services at all levels.

SESSION 6: MONITORING AND EVALUATION

Permanent monitoring and periodic evaluation of large “midwifery in the community” programmes is a very important but neglected area. Very few programmes have built-in evaluation, and there is uncertainty about their health outcomes.

Indonesia reported on an evaluation study that had just been completed in collaboration with IMMPACT. The programme “Midwifery in the village” was launched in West Java in 1989. In 2000, 10 years later, about 63 per cent of villages had a midwife and deliveries attended by SBA went from 22 per cent to 55 per cent in rural areas, MMR was reduced from 390 to 307, and caesarean sections also decreased. The main problems identified with the community midwives were:

- insufficient prior practical experience;
- lack of an enabling environment;
- low utilization of midwifery services by the community;
- short-term contracts for midwives;
- low retention rate;
- no accommodation in the village, so midwives available only in the mornings.

As the results of the IMMPACT evaluation were not final, only preliminary findings of the case control study of risk factors for “near-misses”, caesarean sections and maternal deaths could be presented. The two most significant factors in reducing maternal mortality were: a midwife residing in the village, and the length of the midwife’s work in the village. The full report was to be presented at the IMMPACT symposium in February 2007.

Morocco presented a new method of quality improvement for maternal health work in the community, called “clinical and community support”.

Moroccan midwives have three years of training without a specific focus on community midwifery. Very few are posted or retained in remote health centres, because they lack communication, accommodation, social integration and support from the medical establishment.

Clinical and community support visits by district teams include social (empowerment, integration), clinical (competency and self confidence) and managerial (capacitating) functions. A manual has been issued as a result of their experiences. Morocco is building experience in maternity waiting homes and in community-based insurance schemes.

Lessons learned in Sub-Saharan Africa:

presented by Family Care International (FCI)

FCI presented the results of a five-year, three-country skilled care initiative in Burkina Faso, Tanzania and Kenya.

Inputs of the programme were on policy environment, providers' training and delegation of authority; equipment and medicines; quality of care; communication system; emergency referral system; behaviour change, communication and community mobilization.

Monitoring and evaluation was based on performance and facility records and on household surveys (baseline and after three years).

After three years, the proportion of births attended by SBA increased from 25 to 56 per cent in the intervention district in Burkina Faso and from 44 to 54 per cent in Tanzania, while no significant changes were found in comparison districts. The proportion did not increase in the intervention district in Kenya, but increased from 32 to 37 per cent in the control district where some partial interventions had been implemented. High prevalence of HIV may explain the lower impact in Kenya. Institutional delivery rates remain the same, except in Burkina Faso. There was a positive relationship between the safe motherhood awareness index (respondents being able to mention at least three danger signs requiring immediate referral to an EmOC facility) and institutional delivery. A full report of findings is available on the FCI web site: www.familycareintl.org

The three case studies had a common characteristic; the inclusion of their monitoring and evaluation plan had been critical from the onset of the project and always included a strategy for presentation and dissemination, and an advocacy plan to ensure wide knowledge of their findings.

OTHER PRESENTATIONS

Presentations by a number of experts provided an additional resource for group work. Some were included under the relevant theme, others as plenary sessions during group work, to provide the opportunity for the three groups to maintain contact and share ideas. All presentations appear on the accompanying CD-ROM.

Inter-professional collaboration

by Ms. Nester Moyo, representing ICM & FIGO

One of the important issues for scaling up midwifery in any country is the need for consensus and good collaboration between professional groups. Ms. Moyo began her presentation by discussing the importance of collaboration based on mutual respect and understanding between midwives and obstetricians. Understanding and respecting each other's role is imperative for harmonious working relationships and is critical to ensure safety of both women and newborn before, during and after childbirth. Increasingly it is acknowledged that a skilled multi-professional team is necessary to meet women's needs during pregnancy and childbirth. The needs continue until the mother and her new baby are fully integrated into the family unit.

Key factors for successful collaboration include mutual trust, respect and support; clear demarcations of professional roles; the ability to listen; willingness to consider another point of view; horizontal communication, and discussion on level ground. A successful collaboration requires a good working knowledge of each other's professional area, based on a willingness to learn from each other rather than stereotyped, historical or prejudiced beliefs.

Ms. Moyo concluded by reminding participants that collaboration is all about seeking synergy. It is only when everyone's contribution has been put on the table that care for women during birth becomes complete and we can hope to reduce numbers of mothers and newborns that die.

- Collaboration is a must—there is no alternative.
- Collaboration has proved benefits for women, newborns and children.
- It is the maternity team which makes a difference to the lives of women and newborns in the community, providing supportive supervision to members of the team and working in a close relationship with the community and the families they serve.
- Only true collaboration will save women's and newborn babies' lives and protect them from injury!

The RPMM Network: strengthening the enabling environment – lessons learned

The final presentation under the theme of the enabling environment was given by Ms. Angela Sawyer, founder and director of the Regional Prevention of Maternal Mortality (RPMM) Network, a network of NGOs working to reduce maternal and neonatal mortality in more than 20 countries in sub-Saharan Africa.

The objectives of the RPMM Network are:

- To build and strengthen capacity of national teams to act as catalysts to reduce maternal deaths.
- To expand RPMM approaches and interventions in sub-Saharan Africa.
- To provide technical support and consultancy services.
- To disseminate the Network's research results.

The Network's approach is to build multi-disciplinary, cross-sectoral teams in which all stakeholders focus on reducing maternal mortality. The key strategy is capacity-building and strengthening of all links in the chain required for an effective health system, to provide affordable, effective and acceptable maternal health care to all women.

The methodology always includes a needs assessment based on the "Three delays" model. Interventions are designed with monitoring and evaluation plans integrated from the outset. Implementation of interventions is also accompanied by supportive supervision and technical assistance. All interventions are evaluated and there is regular feedback to communities, stakeholders & RPMM coordinators.

Key lessons learned are:

- Tenacity of purpose to achieve results;
- Promoting sustainability by mobilizing and utilizing local resources;
- Need for continuous monitoring to maintain quality and effect of interventions;
- Success breeds more success; failures offer useful lessons for future success;
- Starting small and growing big makes more sense and ensures sustainability;
- Maintain focus – advocate for equitable allocation of resources for MNH.

Recommendations for priority action include:

- Establish an in-country catalyst group to keep issues on the public agenda.
- Consolidate national ownership of programmes to sustain interventions.
- Think big, start small, and act now to grow!

M & E: Measuring what? Why Monitoring and Evaluation?

Presentation by Dr. Julia Hussein, IMMPACT

Dr Hussein argued in her presentation that “a goal cannot be met or missed unless it is measured.” She emphasized how the different components in M & E also relate to rights: the right to measure, the right to be counted and the right to equity.

The discussion related mainly to the cost of evaluation, particularly measuring the maternal mortality ratio, which requires a substantial sample. Dr. Hussein reminded participants that an evaluation may be as big or small as those responsible require, but it must be there.

It is matter of choice whether or not to measure MMR: first, it is not always feasible; second, MMR may not be the right parameter to monitor and evaluate the desired outcome of a programme. In general it will pay to focus and narrow evaluations. A confidential inquiry, for example, may be very valuable in identifying points for action to improve quality of care. One can also choose to join an ongoing survey by adding specific parameters. A document is available at <http://www.abdn.ac.uk/immimpact>, outlining the confidential inquiry method.

Participants asked about new indicators to measure maternal health and guidelines to assist in monitoring the MDGs. Participants argued that there were still doubts concerning skilled assistance at birth as an indicator, because the definition of “skilled” is not universally consistent.

Dr Hussein responded that at the country level, the UN indicators are the ones most commonly used. In monitoring the global level, a group called “Countdown 2015” is working on global measures. The group will publish their proposal on indicators in the Bulletin of World Health, January 2007. There are no surprise new indicators.

Other questioners asked 1) how to measure quality of midwifery care; 2) how to contact IMMPACT for assistance, and 3) whether IMMPACT is a commercial institution.

Dr Hussein responded that the first question relates to Indonesia’s presentation from the previous day. Random trials were not the reality here. Measuring quality of care need not necessarily be about attribution but could be quality of association. You could conduct stepped wedged studies in some random districts and save others for later. Evaluation plans, however, needed to be included right from the start of a programme.

Anyone may contact IMMPACT if they need assistance or want to collaborate on M & E issues. The steps are:

1. E-mail Julia Hussein or Pascale Baraté a short note stating that that you are interested in conducting an evaluation and explain or ask what is the scope of evaluation.
2. IMMPACT will then put together a multidisciplinary team based on the scope. This can be a focused team designed to fulfil the needs of the country in question.
3. The team will then contact national research institutions.
4. Proposal will be formulated.
5. Funding will be researched.

IMMPACT is becoming a profit making organization. Most of the profit however is put back into research and into service provision to improve quality in the methods and performance of IMMPACT. See www.abdn.ac.uk/impact

Dr Hussein concluded her presentation by reminding everyone that there is no magic bullet to evaluation. It needs to be tailored to the programme, and the evaluation must fit the design.

Advocacy

by Ms. Henrietta Aswad, Communication and Media Adviser, Division of Arab States, UNFPA, Amman

Ms. Aswad defined advocacy as an action needed for support, commitment to and recognition of – in this case – midwifery, from policy and decision-makers, opinion and community leaders and the general public. Advocacy she said, should address the three W's:

1. What is wrong, missing or needed?
2. Why does it matter?
 - a. Responses should be rights, evidence and gender based
 - b. Cost of action compared with the cost of no action
3. What should be done about it?
 - c. Provide solutions and support for the issues, aimed at changing ideas and creating positive change.

In developing an advocacy strategy it was important to keep in mind the five I's:

1. Integrated – from the very beginning. Advocacy must not be an aftermath activity.
2. Issue driven – the issue needs a human face.
3. Informative – advocacy must emphasize the linkages to other issues, while maintaining a persuasive aim.
4. Innovative – advocacy should convey the urgency, neutralizing possible negativity and minimizing resistance.
5. Inclusive – need for building alliances and consensus.

Case Study group work

Group work on Days 3 and 4 was based on three case scenarios developed by groups with the help of experienced facilitators. Case scenarios were fictitious but based on real country data to represent typical conditions in different regions (Annex 3). To keep group work on track and maintain cohesiveness, the groups reported back to each other at regular plenary sessions in which they briefly discussed emerging issues. This methodology allowed clarification of issues as they arose.

Participants and facilitators were assigned to groups based on experience in addressing the specific conditions in the different scenarios, except where simultaneous translation (English, French and Spanish) was required.

Group 1: A large low-income country with high maternal mortality and, low proportion of births by skilled birth attendants (SBA).

Participating countries: Bangladesh, India, Indonesia, Kenya, Malawi, Tanzania and Zimbabwe.

Facilitators: Nester Moyo, Anneka Knutsson, Della Sherratt.

Group 2: A medium-sized low-income country with rapid urbanization and mal-distribution of skilled birth attendants.

Participating countries: Bolivia, Mexico, Guatemala, Morocco, Haiti, Niger, Burkina Faso

Facilitators: Margareta Larsson, Vincent Fauveau, Corinne Kaeser, Ivelise Segovia.

Group 3: A small country with a collapsed or close to non-existent infrastructure.

Participating countries: Cambodia, Mozambique, Nepal, Pakistan, Yemen, Sudan

Facilitators: Karen Odberg Pettersson, Barbara Kwast, Atf Gherissi.

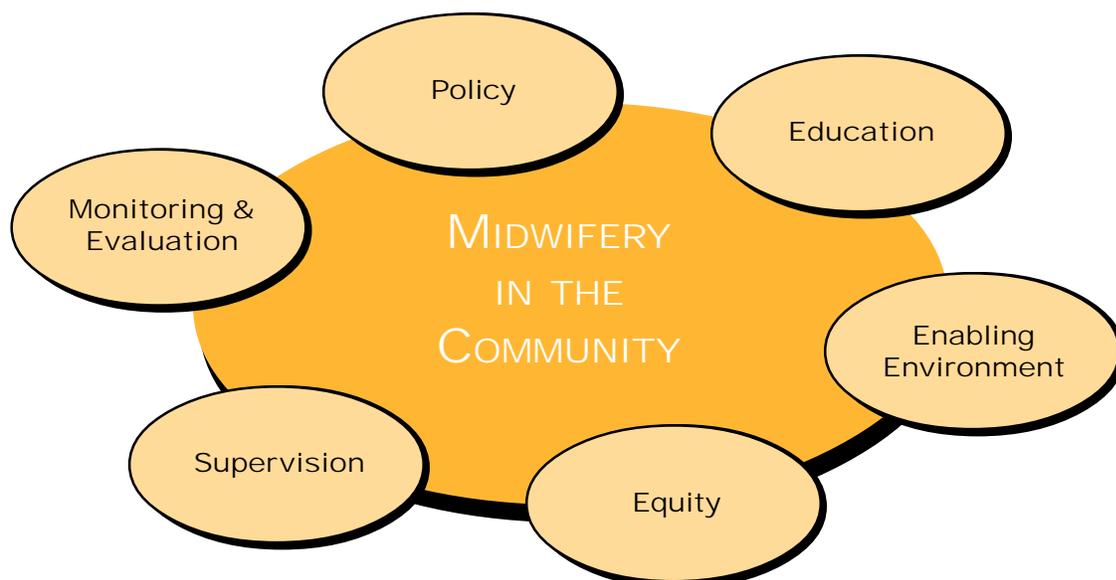
Summary of group work

Groups were asked to use the framework applied during the first two days as the basis for their work. They were each asked to consider the same six headings (Figure 1) and answer the following questions:

Assuming that the government has made a firm commitment that it wishes to reduce maternal and infant mortality, with a specific focus on those living in poverty:

- a) What factors should the government be considering to strengthen midwifery services in the community, to increase the number of women and newborns with access to a skilled attendant capable of providing quality midwifery care, and able to make appropriate referrals for obstetric and neonatal problems and complications?
- b) What consideration must be given to improving the quality of the country's midwifery training?
- c) How can the supervision of the community midwifery workforce be strengthened?
- d) What monitoring and evaluation framework and indicators could be proposed?

FIGURE 1. FRAMEWORK FOR GROUP WORK ON CASE SCENARIOS



CONCLUDING SESSION – DAY 5

Kathy Herschderfer, secretary-general of ICM, chaired the final session. She opened the session by commending everyone for their hard work and particularly noted the late hours put in. Della Sherratt from the Forum secretariat gave a short synthesis and summary of the commonalities and differences presented by the three groups and outlined how the guidance document, which would be based on the group work, would be developed.

Dr Arletty Pinel, UNFPA gave a short comment on the groups' work.

SUMMARY OF COMMONALITIES FROM GROUP WORK

It appeared from the group presentations that there were four sets of issues common to all countries wishing to scale up midwifery in the community, and only a few context-specific concerns.

First set: Access to “competent” midwifery care as a basic human right.

- All groups highlighted the importance of acknowledging that all women and newborn must have access to a midwife or others with midwifery skills during pregnancy, childbirth and the post-partum period. All groups emphasized that this is a basic human right and that access to a competent and confident midwifery provider, backed by quality EmOC, should be made explicit in country health plans, even as a long-term goal.
- All groups felt that merely referring to “midwifery care” was too weak. Midwives must conform to an internationally agreed set of core competencies, including authority to provide some life saving interventions. There was general agreement that these should be the core competencies as defined by ICM and endorsed by FIGO and WHO, which are evidence-based.
- All groups agreed that it was very important to stress that the midwife working in close proximity to women should have all the core skills and be an expert practitioner—not a junior or new graduate—especially if backup services for EmONC were not close at hand.

ICM ESSENTIAL COMPETENCIES FOR BASIC MIDWIFERY CARE

ICM recognizes six areas as the midwife's core competencies, based on rigorous Delphi studies validated in 21 countries: general; prenatal; labour and childbirth; postnatal; newborn care, and community. They should be used to guide country programmes as they scale up midwifery. These core competencies have been used by WHO as the basis for identifying the skills required for all skilled birth attendants – see joint statement by WHO ICM, FIGO (WHO 2004) – and have been adopted in most of the WHO regions.

Second set: policy development and capacity-building for more innovative education and training.

- National MNH policies and programmes should incorporate the policy and legal framework for midwifery provision and practice (including midwives in senior positions, to build career opportunities).
- National standards and regulations for midwifery should comply with international standards and regulations.
- Pre-and in-service training curricula should be competency-based.
- All midwife teachers should be competent midwives with additional education and teaching skills.
- Capacity of education and training institutions should be improved, including effective accreditation systems to ensure the quality of institutions and programmes.
- Parallel action is needed on short- and long-term human resources strategies

Third set: providing an enabling environment

- Supervision of midwifery should be supportive as opposed to punitive, and include peer support by competent midwives.
- Midwives working in the community should be able to count on support and an enabling environment.
- Each midwife in the community should work as part of a team, linked to a quality facility offering maternity care.
- Midwives should assist families to ensure a skilled-care environment for all births.

Fourth set: collaboration, consensus and better evidence of what works

- The collaboration and involvement of all stakeholders is essential, including public-private partnerships.
- Data should be based on evidence, derived from :
 - base-line assessment of resources and needs for midwifery in the community;
 - permanent monitoring system using appropriate and relevant indicators;
 - periodic evaluation, including health outcomes, using both quantitative and qualitative methods.
- Data should drive programmes and policy.
- The midwife in the community should be an integral part of the monitoring system.

Issues specific to individual groups

- South-South cooperation is valuable, especially to address weak or broken systems: countries with recent experience of similar problems are in the best position to offer practical and realistic solutions. (Group 3)
- Midwives should be involved in operational research where the system is not functioning. (Groups 1 and 2)
- Where there is decentralization, regional centres are the only way forward for large countries; change cannot be driven from the centre. (Group 1)
- Some countries need to increase awareness of midwifery as important work and make it more visible. (Group 2)
- Group 2 also expressed the need for:
 - Regular assessment of employment of midwives to track migration;
 - Regulation of private education and practice;
 - Social insurance.

Commenting on the group work, Dr. Arletty Pinel regretted that other commitments precluded her presence at all sessions. She deduced from the excellent presentations that there had been a rich discourse, and assured participants that the Forum's conclusions would be of benefit to UNFPA and other partners.

All of the presentations clearly indicated the need for clarity on the meaning of the midwifery provider working in the community, which would in turn assist identifying priorities for action. Dr. Pinel highlighted the importance of the midwife's core competencies, which she said made clear the skills and knowledge needed for a midwife to function in the community in any country, and could be used as a universal benchmark.

UNFPA recognised the necessity for the community-level provider to be a professional midwife. However, in order to attract excellent candidates to midwifery education, Dr. Pinel said, midwifery needed to be professionalized and accorded a valued status, as many countries had recognized.

Dr Pinel noted that all families in all countries wanted the best care for mothers and newborns—a skilled midwife, based as close as possible to where families lived. The midwife must be experienced and seen by the community as an essential part of the maternity team. The midwife must be able to refer women for comprehensive care whenever needed. Midwifery education must not be compromised: there was ample evidence that short pre-service training courses could not provide midwives with the capacity to reflect critically upon their work, make quick and crucial decisions and take appropriate action.

Dr Pinel argued that this view would have major repercussions. It not only called for a revision of both pre- and in-service training programmes, but demanded a dramatic change in attitude. Specifically more experienced and skilled midwives must be posted in the community rather than, as at present, junior staff or staff with limited skills without adequate support and supervision. She acknowledged that such changes take time and require innovative and phased actions; but advocacy for change should begin immediately.

CALL TO ACTION

The session ended with a *Call to Action* drafted at participants' request, following a proposal from Pakistan, Yemen and Haiti, by a group of volunteers under the direction of the Secretariat. The *Call to Action* was read out and amended following comments from the floor. Addressed to all governments, regulatory bodies, professional health care organizations,

educators, and communities worldwide, the *Call to Action* advocates for intensified action to ensure the provision of midwifery services in the community by establishing or improving the following key areas:

- Policies to ensure equitable access to midwifery services;
- Policies and regulatory systems to improve the number, deployment, status and conditions of work of midwives and others with midwifery skills;
- Competency based education and training in midwifery skills;
- Peer and supportive supervision of providers in the field;
- An enabling environment to support effective healthcare delivery, including infrastructure, communication, emergency transportation, adequate funding, equipment and supplies;
- Permanent monitoring and periodic evaluation.

Participants recorded their feeling that, having reviewed the actions from countries and the many presentations:

The above actions will strengthen midwifery as an integrated part of the healthcare in the community. In addition they will improve the continuum of care needed to protect the health of women and babies, as well as save their lives by increasing access to emergency obstetric and neonatal care (EmONC).

Finally, participants were most insistent that it is the collective obligation of all stakeholders to guarantee mothers and their newborns their human rights to safe pregnancy, childbirth, and a safe postpartum recovery, wherever they may live.

The full text of the *Call to Action* is at Annex 4.

In closing the Forum, Mr Fathi Ben Messaoud, Secretary-general of the National Board for Family and Population, stressed the importance of the outputs of the forum for better health for the women of world during pregnancy and childbirth and for mothers and their babies after birth. He paid tribute to the contribution that can and is being made by midwives. Dr. Leïla Joudane, UNFPA assistant representative in Tunisia, was also in attendance.

The Way Forward

The following framework will be applied for developing the guidance document from this Forum:

After a brief introductory session outlining the problems and issues, the document will be structured around the main recommendations from the groups:

- Advocacy for supportive policies and the necessary legal framework;
- Competency-based education and training;
- Supportive supervision;
- An enabling environment;
- Monitoring and evaluation;
- Stewardship and funding.

Follow-up actions:

1. Wide dissemination of the final report and the guidance document.
2. WHO will use the findings from the Forum to convene a technical meeting in 2007 to review the evidence and develop specific recommendations.
3. UNFPA and ICM with other partners, will hold regional workshops to assist with operationalizing the guidance document.
4. In response to participants' wishes, a plan will be developed for intensified advocacy and dissemination of the Call for Action. The advocacy plan will focus on the need for urgent and concerted action in countries with high MMR, calling on them to include the need for greater investments in midwifery in the community, as one of their urgent priority areas.

Key Messages

Having considered all the presentations and lessons learned from countries working to strengthen provisions of midwifery services in or close to the community, participants in the 1st International Forum of Midwifery in the Community concluded that:

- It is the right of all pregnant women to have access to skilled care before during and after childbirth. Care should be provided as close as possible to where women live.
- Countries with high MMR should focus on scaling up skilled attendance, with providers possessing the full range of midwifery core competencies (as defined by ICM: Essential Competencies for Midwifery Care). Midwifery skills alone are not sufficient: efforts must be driven by evidence from regular monitoring and evaluation.
- Birth attendants without full midwifery competencies must be supervised and trained by a competent midwife.
- Midwifery is different from obstetric or maternity nursing and should be respected for its discrete and unique body of knowledge.
- All midwives, including those working in the community, must function in an enabling environment, including a supportive legal and policy framework, and have back-up from a supportive fully-functioning EmONC facility; adequate housing; provision for children's education and personal security, and be part of the overall maternity care team.
- Teachers and supervisors of midwifery must be competent and experienced in midwifery, as well as in educational and training technologies.
- Men should be actively encouraged to engage more in culturally appropriate solutions to ensure access to skilled midwifery care in the community.

Annex 1: Final Agenda

DAY 1–MONDAY 11TH DECEMBER

- 8:30 Opening Ceremony & Dedication
- 8:50 Welcome & Introductions Arletty Pinel, UNFPA
- 8:55 Objectives of the workshop. Kathy Herschderfer, ICM
- 9:00 Official opening & Chair MOH Tunisia
- 9:30 Supporting Midwifery. Ms. Gunilla Essner SIDA
- 9:50 “Skilled Care’ needs a skilled attendant”
Jelka Zupan & Margareta Larrson WHO/MPS
- Break 10:15–10:35**
- 10:40 Session 1: *Background*. Chair Arletty Pinel, UNFPA
- 10:45 Skilled care at birth the Global Agenda
Ann Starrs, FCI Co-chair PMNCH
- 11:05 Just what is a community midwife Bridget Lynch, ICM
- 11:25 Overview Background paper Della Sherratt
- 11:35 Plenary Discussion
- Lunch 12:30–2:00**
- 2:00 Film
- 2:25 Session 2: *Getting on the Political Radar*.
Chair - Bridget Lynch, ICM
- 2:30 India
- 2:40 Cambodia
- 2:50 Haiti
- 3pm Malawi
- 3:10 Plenary Discussion
- 3:30 Session 3: *Ensuring the poor and hard to reach have midwifery care*.
Chair - Margareta Larrsson, WHO
- 3:35 Mexico; reaching indigenous populations (CASA)
- 3:45 Nepal; Developing a National SBA Policy
- 3:55 South Sudan: re-establishing midwifery workforce
- 4:05 Mozambique; skilled care as part of national health policy
- 4:15 Plenary
- 5:00 Close of day remarks
- 6:30 Reception by UNFPA

DAY 2–TUESDAY 12TH DECEMBER

- 8:30 Announcements
- 8:35 Session 4: *Education matters: training approaches, curricula and training of teachers* Chair - Indonesia
- 8:40 Zimbabwe
- 8:50 Pakistan
- 9:00 North Sudan
- 9:10 Plenary Discussion
- Break 10:00–10:20**

- 10:25 **Session 5: *Supervision -models for supervising the community midwifery workforce*** Chair - Zimbabwe
- 10:30 Bangladesh
- 10:40 Yemen
- 10:50 Burkina Faso
- 11: 00 Plenary Discussion
- Lunch 12:30 –2:00**
- 3:15 **Session 7: M&E** Chair - Cambodia
- 3:20 Indonesia, IMMPACT evaluation
- 3:30 Morocco - maternal mortality audits/ reviews
- 3:40 FCI, lessons learned
- 4:00 Plenary Discussion
- 4:45 Close of session
- 6:30 Market Place**

DAY 3–WEDNESDAY 13TH DECEMBER

- 8:30 **Announcements** Chair - Bangladesh
Framework for assessing capacity and prioritising action
- 8:45 Introduction to group work. Divide Della Sherratt into three sub –groups according to scenario context
- 12:00 **Session 9: Measuring what?** Chair - Nepal
Pointers for developing a M&E strategy Julia Hussein, IMMPACT
- Short time for Q& A
- Lunch 1:00 –2:00**
- 2:00 Group work continues
- 4:00 Short report from groups (10 minutes each group)
- 4:30 Plenary discussion
- 5:00 Close of day remarks and announcements

DAY 4–THURSDAY 14TH DECEMBER

- 9:00 Group work continues
- 11:30 Chair: Yemen
- Short 2- 3 minute presentation from groups and Q&A
 - Guidelines for final presentation of groupwork Della Sherratt
- Lunch 12:30 –1:30**
- 1:30 Group work continues/ or visits out
- Evening: Preparation of presentations**

DAY 5–FRIDAY 15TH DECEMBER

- 8:00** Departure Arrangements
- 8:55** *Group Photo*
- 9:15** **Session 10: Presentation of groupwork**
Chair - Ms. Gunilla Essner, SIDA; Each group to make Presentation, followed by plenary and open discussion
- 9:00** **Session 10a: Group 1**
- 9:30** **Session 10b: Group 2**
- 10:00** **Session 10c: Group 3**
Followed by plenary and open discussion
- 11:00** **Session 11: Lessons learned during workshop –**
Consensus on guidance for policy and programmatic action
Chair: Kathy Herschderfer, ICM
- 11:00** **Common themes and recommendations from groupwork**
Della Sherratt, Secretariat
- 11:15** **Responses to groupwork and discussion –**
The way forward - Arletty Pinel, UNFPA
- 11:50** **Presentation of Call to Action Participant from country team**
- Break 12:10–12:20**
- 12:30** **Closing Remarks Ministry of Health Tunisia**
- 1:30** **Lunch and Departure**

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Annex 3: Case Studies

CASE SCENARIO ONE; A low-income, high maternal mortality, low proportion of births by skilled birth attendants (SBA)

A large landlocked country with a population estimate of 100,000,000, with an annual population growth of just over 2 per cent. Despite a steady improvement in socio-economic development in the last decade, the country still faces high infant mortality rates (75 per 100,000 live births) and maternal mortality ratio (MMR) of 350 per 100,000 live births; births by a skilled attendant is estimated to be 28.1 per cent. According to the latest population census only 36 per cent of the population live in urban areas, the rest live scattered in small villages, many of which are in hilly areas that are hard to reach and often impossible to reach during certain times of the year. Mortality in the rural areas is estimated to be 4 times higher than in urban areas. 50 per cent of the current population is under the age of 15 years. According to the latest Demographic Health Survey (DHS) 2001, 60 per cent of the population does not have access to basic health care despite the best efforts of the government to site health services within a minimum of 2 hours travel for the majority of the population. Despite very low levels of use of skilled care at birth it is estimated that more than 80 per cent of women receive at least one antenatal visit and more than 78 per cent of all pregnant women receive Tetanus Toxoid (TT) vaccination. According to a recent sentinel survey, 60 per cent of women of reproductive age suffer from chronic iron deficiency.

The low status of women, poverty, geography of the country and traditional belief systems currently prohibit many women from obtaining maternal health services. In addition gender inequalities have an impact on the enrolment of girls in school. This has a consequence on female entry into professional education programmes. Currently there are no professional midwives in the country. Midwifery services at the community level are provided by a wide array of community and voluntary workers. Nurses with midwifery skills and physicians with midwifery and obstetric skills are only found in the District Hospitals. A recent review of the human resources for maternal and newborn health showed that there were many more physicians than nurses (the physician to population ratio is more than the WHO recommendations); none of the community health workers possessed the essential skills to be able to perform as a skilled birth attendant – most have very short pre-service programmes (4 to 9 months duration) and their training is primarily focused on health information and immunization; both physicians and nurses lack midwifery and life saving skills, even many of those working at the District Hospitals.

There is a weak legislative and regulatory framework for SBAs, although there is a regulatory body in existence that has the responsibility for setting standards for nursing and midwifery education and practice.

CASE SCENARIO TWO: Medium-sized low-income country with rapid urbanization and mal-distribution of skilled birth attendants

The total population is 23.7 million of which 60 per cent live in urban areas. The country is geographically divided into 9 provinces and 3 single-authority municipalities, one of which is the capital city. Each province is further sub-divided into smaller administrative units. The country has a wide spread structure for delivering health care services to the population, however many rural areas lack a skilled healthcare provider and therefore the health services in that area do not function, or if they are not functioning effectively. The government has taken steps to systematically improve the health of women and children over a number of years; however a number of natural disasters in recent years have severely challenged these efforts. Legislation is in place to protect the rights of women to both receive education, to own property and receive primary healthcare. Surveys show that while there are an increasing number of girls completing secondary education (10+years) in urban areas, the same is not true in rural areas. In theory maternal and child health services are available free of charge to those living in poverty, however, recent attempts to introduce cost sharing as part of the generalised Sector Reforms appear to be having a negative effect on the uptake and utilisation of services. In terms of health indicators, the country has seen slight improvements in infant mortality, percentage of children immunised and uptake of modern contraceptive methods. Maternal Mortality Ratio however, remains at 250 per 100,000 live births. The proportion of births by a skilled attendant is estimated to be 68 per cent overall, with a range of 81 per cent in urban areas and just over 40 per cent in rural areas.

According to a number of country reports, whilst 98 per cent of women in the urban areas receive at least 3 antenatal visits, but only 78 per cent of women in the rural areas receive any antenatal care at all. One of the pressing concerns in the country is the increasing prevalence of HIV infection rates in pregnant women.

Maternal and newborn health services are provided by relatively well-trained physicians and nurses with midwifery skills, although a recent review shows they lack training in many of the more recent advances in obstetric care, especially those for essential emergency obstetric care. Most of the physicians, nurses and midwives are located in the municipalities and major provincial cities. Many are working in private practice. A review of Human Resources for Health shows that on total numbers, there would be 1 trained person for 150 births, if all staff were undertaken maternity care, which many are not. Community midwifery, where it

exists, is provided by auxiliary nurse/midwives who have an 18 months multi-purpose training. There is very little supervision of these staff and a recent evaluation of their skills demonstrated that they do not possess the core competencies required to meet the international definition of a skilled birth attendant. The Medical Council oversees the education and regulation of all health care providers in the country. Auxiliary nurse/midwives and nurses with midwifery skills do not have the authority to practice many of the life saving skills required for safe motherhood.

CASE SCENARIO THREE: Small country with a collapsed or close to non-existent infrastructure

The country is emerging from many years of internal conflict and political stability has only just been re-established. Despite the fact that many households grow their own vegetables and have raise small livestock, mainly poultry, the rates of childhood malnutrition are high. Anaemia in women is endemic. The last population census in 2001 estimated the total population at 13.8 million with 68 per cent living in rural areas. The Reproductive Health Survey in 2002 showed an annual population growth of 2 per cent. Infant mortality is 56 per 100,000 live births, but this may be a gross under-estimation. Current estimates put the maternal mortality ratio in the region of 1000 per 100,000 live births. However, a weak health information system and the lack of an adequate vital registration system for births and deaths mean that this figure may also be under-estimation.

The country has 22 autonomous health districts and 4 municipalities, each responsible, with delegated powers, for the health services in their area. Each district has a district hospital, which acts as the referral hospital for that area and has links to one of the 4 municipal hospitals or the National Referral Maternity Hospital. In theory, all district hospitals should be able to offer emergency obstetric care, however a recent survey has shown that 60 per cent are unable to provide full, comprehensive emergency obstetric care the main reason being lack of a physician, but lack of essential supplies and amenities (water, electricity etc) are contribute to the problem. Only the National Referral Maternity Hospital has a functioning blood bank.

The Reproductive Health Survey estimated that only 46 per cent of women had access to a skilled birth attendant, with higher levels in the municipalities than in the rural areas. The survey also demonstrated that the major reason for not using a skilled health care provider during birth was because there was no such provider available, but that women would use such a provider if available. Health services are provided on a cost-sharing basis with exemptions made for those living in poverty. Infrastructure (including houses, water, sanitation, roads and bridges) is lacking or barely working. Most service providers are charging “envelope” money, which the women cannot pay. Many women return to their villages without being treated. Women choose not to seek assistance form the formal

health sector unless they can be convinced that they will be treated with dignity and not with scorn. Most will rely on self-care or care from a family or neighbour before seeking formal healthcare. While in some areas there are TBAs who assist women during birth, most families do not seek assistance from outside the family unit.

Women are also reluctant to leave their homes during night. Moreover, the internal dislocation of people has brought nurses and midwives to their health centre who do not belong to their local ethnic group, and they therefore clients do not trust these people. In addition, many families are reluctant to let their daughters leave the community to be trained as a nurse or midwife

Doctors, nurses, midwives and community health workers provide the maternal and newborn health services. The country has a shortage of all health care personnel. The few doctors that exist are mainly found in the municipal hospital. Nurses do have midwifery content during their training but as all of their training takes place in a hospital and given the low caseloads for births they lack hands-on experience for care in normal labour and birth. The midwives undertake a 2-year training with experience in both hospital and community. They too have little hands-on experience and most student midwives only conduct between 10 and 12 births during their training. Community health workers have short 10-month training and are intended to provide health education and promotion. Only four weeks midwifery is included in their programme and they are not expected to be proficient in care in normal birth, neither are they proficient in care of the newborn.

Although by law women and men have equal rights, gender inequity is a problem in the country. School enrolments for boys and girls are almost equal and there is a growing number of girls completing secondary school education (10+years) although school attendance rates remain low nationally and the government is investing heavily on establishing schools in rural areas.

QUESTIONS GIVEN TO ALL SCENARIOS

The government has made a firm commitment that it wishes to reduce maternal and infant mortality with a specific focus on those living in poverty.

- a) What factors should the government be considering in order to strengthen midwifery services in the community to increase the number of women and newborns having access to a skilled attendant capable of providing quality midwifery care and able to make appropriate referrals for obstetric and neonatal problems and complications?
- b) What consideration must be given to improving the quality of midwifery training in the actual country?
- c) How can the supervision of the community midwifery workforce be strengthened?

Annex 4: Call to Action

HAMMAMET CALL TO ACTION

ON SCALING-UP “MIDWIFERY IN THE COMMUNITY”

RESULTING FROM THE 1ST INTERNATIONAL FORUM ON

MIDWIFERY IN THE COMMUNITY

11 – 15 DECEMBER, 2006

HAMMAMET, TUNISIA

Every minute a woman dies somewhere in the world from pregnancy-related complications, and many more are left disabled, because they lack access to skilled midwifery care. Evidence shows that a midwife or other healthcare provider with midwifery skills offers the most cost-effective, low-technology but high-quality solution to achieving safe motherhood, a central component of reproductive health. In addition, midwives are crucial to help ensure newborn survival, improve maternal and newborn health and reduce the estimated 7 million perinatal deaths each year.

The 1st International Forum in Hammamet, Tunisia, on “Midwifery in the Community” concluded its week-long deliberations with a *Call to Action* for the strengthening and scaling up of midwifery in the community – to contribute to the prevention of the avoidable death and disability of mothers and their newborns, as well as promoting the health of mothers and babies.

The Forum gathered international agencies and organizations, along with midwives, nurses, physicians, health policy makers, professional associations, regulatory bodies and researchers from 23 countries around the world where maternal and neonatal mortality and morbidity remain unacceptably high. The objective was to consider how to make midwifery care more accessible, especially to women living in hard to reach and underserved areas. Having reviewed progress and constraints over these last twenty years, since the launch of the Global Safe Motherhood Initiative, participants concluded that intensified action is needed at global, regional and national levels to achieve the additional midwives needed to work in contact with communities. Midwives working in close proximity to where women live will help prevent 530,000 avoidable maternal deaths a year. In addition it will prevent many post-delivery problems such as obstetric fistula, and help to reduce the alarming rate of neonatal morbidity and mortality. In 2005 the World Health Organization estimated that 334,000 more midwives and others with midwifery skills are needed around the world. If well supported by effective health systems, midwives will help governments to achieve their fourth and fifth Millennium Development Goals by 2015.

The Call to Action says:

We, the participants of the 1st International Forum on Midwifery in the Community, call on governments, regulatory bodies, professional health care organizations, educators, and communities worldwide to ensure the provision of midwifery services in the community by establishing or improving the following key areas:

- Policies to ensure equitable access to midwifery services;
- Policies and regulatory systems to improve the number, deployment, status and conditions of work of midwives and others with midwifery skills;
- Competency-based education and training in midwifery skills;
- Peer and supportive supervision of providers in the field;
- An enabling environment to support effective healthcare delivery, including infrastructure, communication, emergency transportation, adequate funding, equipment and supplies;
- Permanent monitoring and periodic evaluation.

We believe that these actions will strengthen midwifery as an integrated part of the healthcare in the community. In addition they will improve the continuum of care needed to protect the health of women and babies, and save their lives by increasing access to emergency obstetric and neonatal care (EmONC).

We also believe that it is the collective obligation of all stakeholders to guarantee mothers and their newborns their human rights to safe pregnancy, childbirth, and a safe postpartum recovery wherever they may live.

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Annex 6: Definition of a Midwife

DEFINITION OF THE MIDWIFE

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

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

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

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

Revised by the International Confederation of Midwives Council meeting, 19th July, 2005, Brisbane, Australia.

Supersedes the ICM "Definition of the Midwife" 1972 and its amendments of 1990