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# BUILDING THE ENABLING ENVIRONMENT FOR MIDWIVES

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A CALL TO ACTION FOR POLICYMAKERS



*DEVELOPED WITH SUPPORT FROM ARIADNE LABS*

**Recommended citation:** International Confederation of Midwives (2021)  
*Building the Enabling Environment for Midwives: a call to actions for policy makers*, The Hague: ICM

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# BUILDING THE ENABLING ENVIRONMENT FOR MIDWIVES

## A CALL TO ACTION FOR POLICYMAKERS

*“The lack of a clear and shared understanding of what **constitutes** an enabling environment is a major obstacle to mobilizing concerted, strategic action to **providing one.**”<sup>1</sup>*

### OVERVIEW

Midwives do much more than support women to birth babies. They deliver accessible, equitable, and high-quality sexual, reproductive, maternal, newborn, and adolescent health (SRMNAH) care in diverse settings across the globe, across the childbirth continuum, and across sexual and reproductive health and rights (SRHR). According to the World Health Organization, United Nations Population Fund, and other global authorities, there is an urgent need for SRMNAH care to be delivered by professional midwives who have expertise that is not currently supported in most health systems.

**Midwives are a cost-effective, critical solution to improve health outcomes and experiences for women and newborns, reduce health inequities in access and quality, and provide the continuum of SRMNAH care.** Yet, the majority of countries across the globe encounter barriers in developing and sustaining the **enabling environment** required to scale midwife-led continuity of care. This brief defines the enabling environment for midwives as one that supports the **infrastructure, profession, and system-level integration** needed for midwives to effectively practise their full scope of work. This brief also identifies the necessary policies to enhance the enabling environment for scaling midwife-led care.

There is growing momentum to advance high-quality, respectful maternity care through scaling midwife-led care. Social justice movements, such as for gender equality and racial justice, have further fuelled the call to action for midwives across the globe.<sup>2</sup> This began with the *State of the World's Midwifery Reports* (2011 and 2014),<sup>3,4</sup> *The Lancet Series on Midwifery* (2014),<sup>5-8</sup> and *Midwives' Voices, Midwives' Realities* (2016),<sup>9</sup> and culminated with the World Health Organization designating 2020 the Year of the Nurse and the Midwife,<sup>10</sup> the publication of a modelling study that documented the impact of midwives in saving lives,<sup>11</sup> and the *State of the World's Midwifery 2021*.<sup>12</sup> The growing demand for midwives is clear.

The 2030 Agenda for Sustainable Development includes 17 new Sustainable Development Goals (SDGs), the aim of which is to ensure universal health coverage (UHC),<sup>13</sup> and midwives are central to delivering universal SRMNAH care. UHC2030 is a related movement that similarly depends on midwives to build stronger health systems through collaboration, advocacy, and learning.<sup>14</sup> Looking forward to 2030, it is essential that countries harness the skills and contributions of midwives everywhere to achieve the SDGs, ensure UHC, and drive improvements in health care

quality. In particular, establishing and sustaining an enabling environment for midwife-led continuity of care will accelerate progress towards SDG 3: ensuring healthy lives and promoting well-being at all ages; SDG 5: achieving gender equality and empowering all women and girls; SDG 8: promoting sustained, inclusive, and sustainable economic growth, full and productive employment, and decent work for all; SDG 10: reducing inequality within and among countries; and promoting peaceful and inclusive societies for sustainable development, providing access to justice for all, and building effective, accountable, and inclusive institutions at all levels.<sup>13</sup>

As a relatively low-cost,<sup>15</sup> evidence-based solution to reducing disparities and improving outcomes, midwives are the backbone of the healthcare system and are best suited to drive large-scale improvements to the health and well-being of pregnant women, mothers, and newborns, globally. Despite this, midwives everywhere face barriers to practising their full scope of work due to the lack of an enabling environment. With a robust enabling environment, the midwifery profession can be scaled so that midwife-led continuity of care is the dominant model of SRMNAH care delivery, so that millions of lives are saved, and SDGs and UHC are achieved. Given that the midwifery profession is composed almost entirely of women,<sup>16</sup> governments must align the current zeitgeist for gender equality with strengthening the midwifery profession through sustained investment in the enabling environment to scale midwife-led continuity of care.

## MOTIVATION FOR SCALING MIDWIFE-LED CONTINUITY OF CARE

Midwives can solve the three greatest challenges in SRMNAH today: preventing neonatal deaths, stillbirths, maternal deaths, and poor outcomes; eliminating inequities in access, experience, and outcomes for women and newborns; and reducing the cost and use of over-medicalised maternity care.

Midwives are experts in physiologic labour and birth, which is characterised by spontaneous onset and progression of labour and birth without routine medical intervention.<sup>17</sup> With an emphasis on maintaining the normal physiology of the mother, midwives are trained to view birth as a normal life process, which makes them unique among other health professionals. Intrinsic to midwifery is promoting health, in addition to preventing and managing complications and dealing with emergencies. Analyses in the 2021 *State of the World's Midwifery* (SoWMy) report indicate that **fully educated, licensed, and integrated midwives, supported by interdisciplinary teams and an enabling environment, can deliver about 90% of essential SRMNAH interventions across the life course.**<sup>12</sup> Yet, midwives account for less than 10% of the global SRMNAH workforce compounded further by a global shortage of 900,000 midwives.<sup>12</sup> To make a significant impact on health outcomes and experiences in the health care system, midwives must be supported by an enabling environment.

Since the first SoWMy report in 2011, the body of evidence demonstrating the return on investment in midwives has grown. Investing in midwives not only promotes positive birth experiences but also improves health outcomes, ensures the necessary SRMNAH workforce, favours inclusive and equitable care for women and their children, reduces cost of care, and can have a positive macroeconomic impact.<sup>12 18,19</sup>

# Midwife-led Continuity of Care is Associated with Improved Outcomes and Cost Savings

## Problems

Neonatal deaths, maternal deaths, & poor outcomes

Inequities in access, experience, & outcomes for mothers & babies

High cost of over-medicalized maternity care



## Solutions



Universal access to midwives saves lives, reduces suffering, & improves outcomes



Midwives integrated into the health care system reduce inequities & improve experiences



Midwife-led continuity of care is associated with cost savings

## 1. SAVING LIVES

Global partnerships and in-country efforts have led to the reduction of the maternal and neonatal mortality rates in nearly every nation over the past two decades.<sup>12,20</sup> Despite this progress, it is estimated that 810 maternal deaths occur each day,<sup>21</sup> one stillbirth every 16 seconds,<sup>22</sup> and 2.4 million newborn deaths each year.<sup>23</sup> When examining why women and newborns are dying at such alarming rates, experts often cite two extreme situations: too little care, too late, or too much care (over-medicalisation), too soon.<sup>24</sup> The problem is defined in terms of the quantity of medical intervention delivered rather than the quality of care received. While it is essential that women receive the care they need, when they need it, it is equally important that care is delivered in a way that respects, protects, and promotes human rights,<sup>24</sup> as quality of care is a driver for both improved outcomes and positive experiences of care.

Increasing access to midwives--who provide the continuum of high-quality childbirth care--could save millions of lives each year. A 2021 *Lancet Global Health* modelling study used the Lives Saved Tool to estimate the number of deaths that would be averted by 2035 if midwife-led care were scaled in the 88 countries that account for the vast majority of the world's maternal and neonatal deaths and stillbirths.<sup>11</sup> The authors estimated that, relative to current coverage of midwife-led care, universal coverage of midwife-delivered interventions would avert two-thirds (67%) of maternal deaths, neonatal deaths (64%), and stillbirths (65%), with 4.3 million lives saved annually by 2035. Even a modest scale-up (10% increase in midwifery coverage every five years) would avert 22% of maternal deaths, 23% of neonatal deaths, and 14% of stillbirths, saving 1.3 million deaths per year by 2035.<sup>11</sup> The authors further acknowledged that to scale midwife-led continuity of care, midwives must work in an enabling environment.

A *Cochrane Review* found that where midwives were the primary healthcare provider, fetal loss or infant deaths fell by 16%.<sup>25</sup> In the U.S., better midwife integration into regional health systems across all settings was associated with significantly higher rates of spontaneous vaginal delivery, vaginal birth after caesarean, and breastfeeding, and

significantly lower rates of caesarean, preterm birth, low-birthweight infants, and neonatal death.<sup>26</sup> In high-income countries, midwife-led continuity of care models lead to reductions in neonatal deaths and preterm births.<sup>27</sup> In Cambodia, extensive scale-up efforts throughout the 1990s and 2000s have resulted in nearly 1,500 health facilities offering comprehensive SRMNAH services, with at least one midwife at each facility. Since then, Cambodia's maternal mortality ratio dropped from 488 deaths per 100,000 live births in 2000 to 160 in 2017.<sup>12</sup>

## 2. REDUCING INEQUITIES AND IMPROVING OUTCOMES

Scaling up midwives would increase access to midwife-led care for all, particularly for groups that have been socially or economically marginalised. Increased midwife integration is associated with significantly higher rates of physiologic birth, fewer obstetric interventions, fewer adverse neonatal outcomes, higher rates of breastfeeding at birth and at six months, and lower rates of neonatal mortality overall and for specific racial/ethnic groups.<sup>26</sup> Compared to other models of care, women who receive midwife-led continuity models of care were less likely to experience intervention (epidural, episiotomy, operative births)<sup>28</sup> and more likely to be satisfied with their care, with no increased risk of harm.<sup>18,29</sup> Compared with standard maternity care provided by different midwives working in the community, children's centres and/or hospital, women at increased risk of preterm birth who received midwife-led continuity of care from a primary midwife report increased perceptions of trust, safety, and quality of care.<sup>30</sup>

In communities that are most at risk for adverse outcomes, increased access to midwives who are integrated into the healthcare system may improve both health outcomes and experiences of care.<sup>31</sup> In Canada, midwife-led care for women of low socioeconomic position has been associated with significantly reduced incidence of preterm birth, low birthweight, and other adverse outcomes.<sup>26,32,33</sup> In the U.S., where Black women are three times more likely to die from a pregnancy-related cause than white women,<sup>34</sup> access to midwives across settings and density of midwives were also significantly lower in states with a higher proportion of Black births.<sup>26</sup> In Australia, where First Nations families experience inferior maternal and infant healthcare and worse outcomes, Indigenous women who received care from a community-based, midwifery group practice by a caseload midwife (midwife-led continuity of care) attended more antenatal visits, were less likely to birth a preterm infant, and were more likely to exclusively breastfeed on discharge from hospital.<sup>35</sup>

The midwife-led continuity of care model emphasises community-based care, close relationships, antenatal and postpartum wellness, and avoiding unnecessary interventions that can lead to life-threatening complications.<sup>31</sup> Situating midwives close to communities improves access to high-quality healthcare for all, allowing for safe home births for low-risk women who may face transportation barriers to healthcare facilities or who have preferences to give birth at home. Licensed midwives can solve shortages of maternity care that disproportionately affect rural and low-income women, many of them women of colour.<sup>31,36</sup> The midwife-led continuity of care model needs to be integrated across the health system, ensuring that women who need additional, higher-level care continue to receive care from their midwife in collaboration with an obstetrician.<sup>18,19,37</sup>

Investing in midwives further reduces gender inequities by providing an opportunity to increase women's employment in the health profession.<sup>12</sup> Recruitment of diverse individuals into the midwife workforce is an opportunity to build representation of the population they serve, which is critical for positive experiences of care, especially among marginalised groups.<sup>38</sup>

## 3. COST EFFECTIVENESS

Investment in midwives to achieve improved outcomes is cost-effective for women of any risk<sup>39</sup> in diverse settings. In Australia,<sup>40</sup> public caseload midwifery costs 22% less than other models of care.<sup>41</sup> In Bangladesh, a value assessment

revealed a 16-fold return on investment for the future deployment of 500 community-based midwives.<sup>4</sup> Across contexts, midwives promote physiologic birth with fewer medical interventions including fewer caesarean deliveries and inductions,<sup>26,42</sup> reducing the cost of peripartum care.<sup>43,44</sup> A modelling study of 58 LMICs using the Lives Saved Tool showed that increasing midwifery alone or when integrated with obstetrics is more cost-effective than scaling up obstetrics alone, and that when family planning was included, the midwifery model was almost twice as cost-effective as the obstetrics model (\$2,200 versus \$4,200 per death averted).<sup>45</sup>

Receiving care from a midwife also enables women to give birth at home or in a midwife-led birth centre, increasing their options for the location of their care and significantly reducing health expenditures associated with giving birth in a hospital. Low-risk births at home are associated with a reduction in caesarean rates, fewer inpatient bed days, and fewer hours in intensive care units, allowing for resource savings associated with time, staffing, and cost.<sup>46</sup>

## SOLUTION: ENHANCING THE ENABLING ENVIRONMENT FOR MIDWIVES AND QUALITY MATERNAL-NEWBORN CARE

### DEFINING THE ENABLING ENVIRONMENT

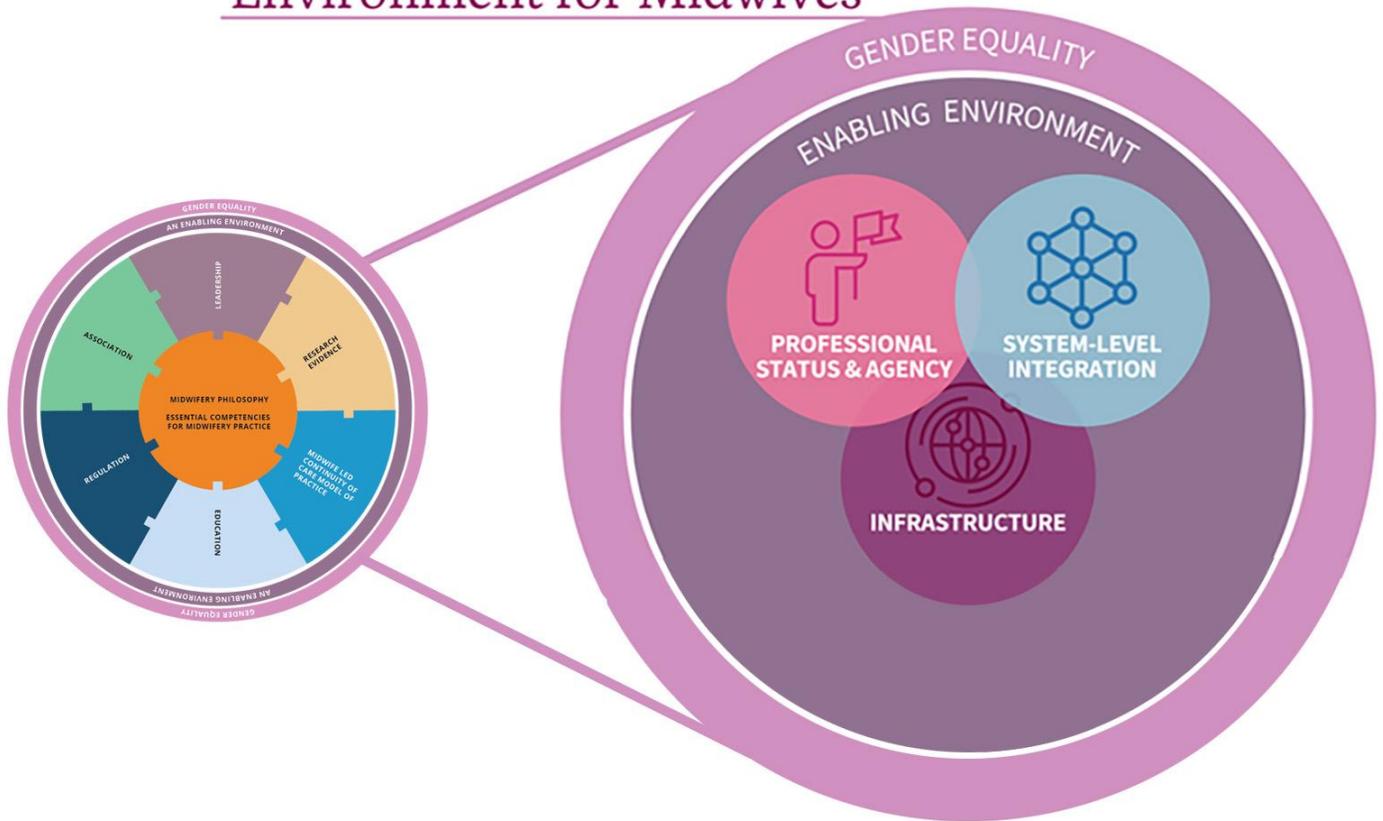
The enabling environment for midwives is an environment which values and respects midwives, and values and respects women.<sup>47,48</sup>

An enabling environment means that midwives:<sup>12</sup>

- > can practise to their full scope,
- > are accountable for independent decisions within a health professional regulatory system that recognises and upholds their autonomy and accountability,
- > have access to continuing professional development, career pathways and supportive professional mechanisms,
- > work within a functional health infrastructure with adequate human resources, diagnostic services, equipment and supplies,
- > have access to timely and respectful consultation, collaboration and referral, including transportation and communication systems,
- > are safe from physical and emotional harm, and
- > have fair and equitable compensation, including salary and working conditions.

The enabling environment for scaling quality midwife-led care is inclusive of, but also distinct from, the enabling environment for quality maternal and newborn care.<sup>8</sup> While the latter, such as infrastructure, concerns all healthcare workers, the enabling environment for midwives, specifically, is needed to address the unique barriers they face. The enabling environment for midwife-led care is focused on promoting the midwife profession and system-level integration. An enabling environment for midwives must be grounded in a broader movement for gender equality given the make-up of the workforce and clients. The categories required to build the enabling environment are listed in the table below.

# Creating an Enabling Environment for Midwives



**Enabling Environment Domains**

**Includes the following categories:**

## GENDER EQUALITY



### **Empowerment and respect for women and birthing people:**

Voices are heard, rights are upheld, and preferences are respected

### **Empowerment and respect for midwives:**

- > Increased employment and respectful working environment for midwives
- > Professional autonomy and scope of midwife practice is recognised and respected
- > Midwives are viewed as community leaders and SRHR advocates in addition to healthcare professionals

### **Social, physical, and psychological safety:**

- > Safety and security in the workplace and when traveling to and from
- > Social well-being of midwives, including mental health and other supports

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## INFRASTRUCTURE



### **Supply & resource availability:**

- > Access to functional health facilities, beds, diagnostic services, equipment, drugs, and supplies
- > Access to amenities including toilets, water, and hygienic changing facilities

### **Communications and transportation systems:**

Communications and transportation systems are in place to enable efficient and respectful referral pathways across the continuum of care

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## PROFESSIONAL STATUS & AGENCY



### **Professional autonomy:**

- > Midwives have occupational autonomy and flexibility, so that they can control, organise and prioritise their own work; reflect on practice with peers and colleagues; share ideas and information; and optimise service provision
- > Midwives can interact with and be supported by the health system in the same way as obstetricians, nurses, and other health professionals
- > Midwives are supported to work independently within their defined and protected full scope of practice and responsibilities
- > Midwives have access to continuing professional development, career pathways and professional support

### **Awareness and demand:**

Wide-scale demand generation to ensure social awareness and recognition of midwives, what they do, and how they improve care

### **Financial fairness and support:**

- > Financial fairness and support including payment parity with health professionals of similar skill level and education, or doing work of equal value
- > Opportunities for career and salary progression for midwives
- > Government, NGO, or grant funding to promote and sustain the enabling environment

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## SYSTEM-LEVEL INTEGRATION



### **Continuity of care across levels of the health system and other sectors:**

- > Midwives are integrated across and throughout all levels of the health system
- > Effective and respectful systems and processes for consultation and referral to midwives and other medical professionals, and to higher levels of care
- > Midwives are integrated in communities, education system, and other sectors

### **Interdisciplinary collaboration and professional development:**

- > Teamwork throughout the continuum of care
- > Collegial support, including coaching, mentorship, and opportunities for feedback from peers and more experienced healthcare professionals
- > Continuous learning opportunities for career development

### **Midwife system-level governance:**

- > Midwives in positions of power, leadership, and influence
- > Midwives included in decision-making and policy-making

# POLICY CHANGES TO ENHANCE THE ENABLING ENVIRONMENT FOR MIDWIVES

**Building an enabling environment is critical to successfully scaling midwife-led continuity of care models, which are foundational for improving the well-being of women and newborns worldwide.** In order to efficiently allocate time and resources to building the enabling environment, policymakers must prioritise among the many areas outlined in the framework above and commit to policies that uniquely strengthen the midwife workforce. As detailed in the Communication Guidance (slides 14-30), we recommend the following roadmap to generate a prioritisation scheme for policymakers, where in-country development partners, midwife leaders, other decision-makers and stakeholders complete their own needs assessment to strengthen the enabling environment. Countries will then prioritise enabling environment activities and organise them according to **time, cost, impact, and political will**.

As we learn more through the piloting and implementation of this policy brief, ICM continues to be the country-level leader and referent organisation for technical support and consultancy to governments who aim to implement the enabling environment to scale midwife-led continuity of care.

## ROADMAP

### 1 ASSESS THE LANDSCAPE

Assess the current, in-country landscape of midwife-led care by reviewing *Countdown 2030* profiles,<sup>49</sup> *State of the World's Midwifery 2021* country profiles,<sup>50</sup> and other sources.

### 2 REVIEW AND ANALYSE

Review the enabling environment activities and complete a gap analysis to determine which activities need to be strengthened in-country.

### 3 IDENTIFY ACTIVITIES

Identify 3-5 enabling environment activities for focused investment and strengthening.

### 4 EVALUATE ACTIVITIES

Evaluate the activities by relative time, cost, potential impact, and political will or buy-in required.

### 5 DEVELOP POLICIES AND PLANS

Develop policies to align with identified priorities as well as costed and time-bound action plans to implement identified priorities.

### 6 GAIN APPROVAL

Follow the in-country political process for gaining approval.

## CASE STUDIES

Countries around the world are taking strategic action to strengthen the enabling environment for midwives. Other countries can look to them as examples of how small policy changes can create large-scale improvements in the education, deployment, and practices of midwives.

## Government Chief Midwifery Officers (GCMOs) or National Chief Midwives

In 2019 and 2020, the National Health Service for England and the Colegio de Matronas y Matrones de Chile appointed their first chief midwives, a position distinct from that of the chief nurse.<sup>51-53</sup> The chief midwife is the most senior midwife in the country, responsible for providing professional, strategic, and clinical leadership to colleagues working across the country.<sup>53,54</sup> In Paraguay, Sandra Recalde, a midwife, leads the Paraguayan Ministry of Public Health's obstetrics division.<sup>55</sup>

## Deployment of midwives to public sector health facilities

Bangladesh did not have dedicated professional midwives in public sector health facilities until 2018, when the country initiated a nationwide programme to educate and deploy diploma midwives to public facilities. A follow-up mixed methods study published in 2020 revealed that the programme's midwives were highly motivated, satisfied with many aspects of their current jobs, and had adequate knowledge and skills.<sup>56</sup>

## Midwifery Services Framework

The Midwifery Services Framework, developed by ICM, is an evidence-based process and set of resources to guide countries through the process of improving their SRMNAH services through strengthening and scaling of midwife-led care. Six countries -- Afghanistan, Bangladesh, Ghana, Kyrgyzstan, Lesotho, and Togo -- piloted the MSF, identifying priority work areas and establishing technical working groups to target the priorities. The MSF opened new channels of communication between ICM, national ministries of health, and other key stakeholders, and helped national midwifery associations gain visibility among policy- and decision-makers.<sup>57</sup>

## Government-led national midwifery task force

In 2018, India established the country's first government-led national midwifery task force. The task force brought together stakeholders and enabled midwives to play a key role in developing national policy. The task force also provided critical inputs to the government's first *Guidelines on Midwifery Services in India 2018*. Subgroups have since been established to address specific topics such as revising the curriculum to meet international standards.<sup>52</sup>

## Engaging midwives in advocacy

Midwives received support from ICM and the Young Midwife Leaders programme that enabled them to contribute to Malawi's and Namibia's COVID-19 response, which did not initially include midwives. The networks generated through ICM enabled midwives to have a seat at the table in responding to the COVID-19 pandemic.<sup>12</sup>

## Identifying and addressing the needs of women

The global *What Women Want* campaign, led by the White Ribbon Alliance, sought to identify what women wanted for their own maternal and reproductive health care, and to demand that their needs are met. In 2016, India launched the campaign, working with over 100 partners to hear from almost 150,000 women across 24 states. The campaign has since been launched in many more countries, including Kenya, Malawi, Mexico, Nigeria, Pakistan, Uganda and the United Republic of Tanzania. *What Women Want* calls for policy- and decision-makers at all levels to hear the voices of women and to act on them to improve health services and outcomes.<sup>12</sup> The final report, released in 2020, showcased "increased, competent, and better supported midwives and nurses" as the fourth highest demand across 1.2 million open-ended responses.<sup>58</sup>

## Identifying and addressing the needs of midwives

In early 2020, the Latin America and Caribbean Regional Office of the UNFPA administered an online survey of midwives to explore the pandemic's impact on their work and identify additional support needed. Receiving over 1,000 responses from 12 countries, UNFPA developed a template to document innovative adjustments to service delivery for in-country professional midwife associations; held video conferences with midwives' association leaders 2-4 times per month; and, in some cases, provided grants to remotely support midwives' professional development during the COVID-19 pandemic.<sup>12</sup>

## Integration of midwives in communities, the education system, and other sectors

From 2000 to 2017, maternal deaths fell by 63% in Morocco.<sup>59</sup> As more professional midwives joined the workforce, births became safer. Today, nearly 90% of births in Morocco are assisted by professional midwives.<sup>60</sup> In Morocco, midwives do more than assist women during childbirth. They provide preventative care to mothers and children; health education to the entire family; family planning, vaccination, health education, and management of menopause; and confidential, nonjudgmental care to marginalised women and girls.<sup>60</sup>

The Netherlands boasts a maternity care system with integrated midwifery care, where births with a midwife account for over 75% of all women giving birth.<sup>12</sup> Maternity care is organised around community-based primary care such that midwives are the sole caregiver in 57% of births.<sup>12</sup> 72 percent of midwives in the Netherlands work as independent community midwives in primary care, and the other 28% work as clinical midwives in hospitals, under the supervision of an obstetrician.<sup>61</sup> Women refer themselves to a midwife for maternity care, which keeps demand for midwives high, and receive their primary maternity care in the community and deliver at home.<sup>12</sup> Women also are provided with a maternity assistant who aids midwives during birth and then stays with the new mother for part of the postnatal period to ensure continuity of care and referral for complications.<sup>62</sup>

## Midwife-led continuity of care models

In New Zealand, midwife-led continuity of care (MLCC) is the typical model of maternity care.<sup>63,64</sup> In 1990, New Zealand reinstated midwife autonomy and a direct entry midwifery education pathway to midwifery registration and commenced the implementation of a MLCC model.<sup>63</sup> Four out of five mothers (81.1%) in New Zealand receive midwife-led care, compared to 5.5% of women receiving obstetric-led care.<sup>65</sup> Each provider type is paid equally by the New Zealand government based on the services provided.<sup>65</sup> Midwives provide care to women across all settings, including in their home, and continue to care for their clients when women need additional care as well as if the woman chooses to have or requires a hospital birth.<sup>66</sup> Parts of Palestine,<sup>67</sup> the UK, Australia<sup>68</sup> Canada, Sweden, Norway, the Netherlands, and Denmark<sup>19</sup> also have an MLCC model but these are not yet fully integrated in the same way as in New Zealand.

## CONCLUSION AND CALL TO ACTION

Midwives are the most effective means of accomplishing worldwide goals to save lives, reduce morbidity, and improve inequities in access, experience, and health outcomes. Until midwife-led care is fully integrated into health systems and supported through an enabling environment, women and newborns will continue to suffer traumatic birth experiences, hyper-medicalised childbirth, and preventable morbidity and mortality. Governments across the globe must prioritise the enabling environment for scaling midwife-led care now to respond to demands for gender equality in healthcare. By identifying, prioritising, and implementing policies specific to the enabling environment, healthcare systems can begin to take strides towards a safer, more equitable, and more positive birthing experience for women everywhere.

## DEFINITIONS

### Midwife

A midwife is a person who has successfully completed a midwifery education programme that is based on the ICM Essential Competencies for Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education and is recognised in the country where it is located; who has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery and use the title ‘midwife’; and who demonstrates competency in the practice of midwifery.<sup>69</sup>

### Midwife Scope of Practice

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.<sup>69</sup>

### Midwifery

Midwifery is the profession of midwives, only midwives practise midwifery. It has a unique body of knowledge, skills and professional attitudes drawn from disciplines shared by other health professions such as science and sociology, but practised by midwives within a professional framework of autonomy, partnership, ethics and accountability.<sup>69</sup>

### Midwife-led continuity models of care

Midwife-led continuity of care (MLCC) models, in which a known midwife or small group of known midwives supports a woman throughout the antenatal, intrapartum and postnatal continuum, are recommended for pregnant women in settings with functioning midwifery programmes.<sup>12</sup> The midwife-led model of care is woman-centred and based on respect for human dignity, compassion, the promotion of human rights, and the premise that pregnancy and childbirth are normal life events.<sup>18,70,71</sup>

MLCC enables each woman and her midwife (or small team of midwives) to get to know each other and to build a relationship based on trust, equity, informed choice, shared decision-making and shared responsibility. Relationships are negotiated between the partners, and are dynamic and empowering for both.<sup>12</sup>

MLCC provides education, counselling, and antenatal care adapted to each individual’s specific needs; continuous care during labour, birth and the immediate postpartum period; and ongoing support during the postnatal period. It promotes birth as a normal process and advocates for a minimum of interventions. In case of complications, women are appropriately referred and the midwife continues to provide care in collaboration with the medical specialist.<sup>18,72</sup>

## ACKNOWLEDGEMENTS

We would like to thank the following collaborators for their invaluable feedback and guidance on this project:

We would like to thank the following people from ICM: Sally Pairman, Shree Mandke, Franka Cadée, and ICM Board members from the following regions: Western Pacific, Eastern Mediterranean, Anglophone Africa, Francophone Africa, Europe, and Latin America.

We would also like to thank the following individuals: Holly Powell-Kennedy, Petra ten Hoop-Bender, Robyn Churchill, Cristina Alonso, Courtney Massaro, Saraswathi Vedam, Eugene Declercq, Sarah Bar-Zeev, Kate Somers, and Fran McConville.

We would like to thank the following individuals from Ariadne Labs for their contributions to research, writing, and graphic design: Rose Molina, Aizpea Murphy, Victoria Paterson, Katherine Semrau, Neel Shah, and Courtney Staples.

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