Table of contents

1 MIDWIFERY SERVICES FRAMEWORK

1. Background
2. Why is midwifery so important?
3. The Midwifery Services Framework
4. How the Guiding Framework functions
5. How to use the framework
6. Preamble to using the MSF
7. Who is a midwife?
8. What does a midwife do?
9. What is the continuum of care
10. What is quality Maternal and Newborn Care

2 Midwifery Services Framework – The steps

Preparatory Step 1: Essential Background data collection
Preparatory step 2: Monitoring and Evaluation
Service Development Step 2 - Agree how services should be organised
Service Development Step 3: Develop the workforce and create an enabling environment
Ongoing activity: develop or strengthen the midwives association
Service Development Step 4: Test, monitor, evaluate and adapt, to population and health system needs
1. Background

Sexual, Reproductive, Maternal and Newborn Health (SRMNH) services are crucial to the health of women and children and a core component of every health system. In the light of discussions about sustainable and affordable health care across all regions of the world, the International Confederation of Midwives (ICM) has developed the Midwifery Services Framework (MSF) to help countries apply the latest evidence, standards and guidance to improve their policy and programming environment for developing and implementing SRMNH services provided by midwives.

The MSF sits at the operationalization level of a variety of global dialogues and initiatives that include The Every Woman Every Child movement that supports efforts to speed up the achievement of MDGs 4 and 5, the Strengthening Midwifery Symposia of 2010 and 2013, the UNFPA/ICM strengthening midwifery programme, the State of the World’s Midwifery 2011 and 2014 reports, the Lancet series on Midwifery, a large number of WHO resolutions on nursing and midwifery and the Midwifery Workforce Assessments undertaken to date within the H4+ High Burden Country Initiative (HBCI). Standards and Guidance documents developed by the ICM, such as the Global Standards for Midwifery Education and Regulation and the Essential Competencies for Basic Midwifery Practice, underpin many of these technical discourses. This large and growing collection of articles, reports and standards provides an opportunity to assess the status of midwifery services in all countries and spur the debate on the importance of midwives in the delivery of integrated SRMNH services and the role midwifery services play in the SRMNH agenda for the post 2015 era in countries with high maternal and newborn mortality and morbidity.

The MSF is aligned with the Global Investment Framework for Women’s and Children’s Health, which demonstrates how investment in women’s and children’s health can bring strong health, social and economic returns and is poised to become the investment and impact framework for the coming 15 to 20 years.

2. Why is midwifery so important?

The Lancet series on Midwifery defines the practice of midwifery as:

“...skilled, knowledgeable, and compassionate care for childbearing women, newborn infants, and families across the continuum throughout pre-pregnancy, pregnancy, birth, post partum, and the early weeks of life. Core characteristics include optimising normal bio-

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logical, psychological, social, and cultural processes of reproduction and early life; timely prevention and management of complications; consultation with and referral to other services; respect for women’s individual circumstances and views; and working in partnership with women to strengthen women’s own capabilities to care for themselves and their families”.

Although all health care providers in SRMNH should provide care that improves the health and well-being of women and children, the Lancet series showed that midwifery was associated with improved efficient use of resources and outcomes when provided by midwives who were educated, trained, licensed, and regulated, and that midwives were most effective when integrated into the health system in the context of effective teamwork, referral mechanisms, and sufficient resources.

The International definition of a midwife/ICM definition⁶ states that a midwife is a person who has successfully completed a midwifery education programme that is duly recognized in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title ‘midwife’; and who demonstrates competency in the practice of midwifery⁷. The midwife is recognized 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 care for children in the early years of life. A midwife may practise in any setting including the home, community, hospitals, clinics or health units.

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Midwives work along the full continuum of care, both from a life cycle and a home to hospital perspective. Midwives work close to women and their newborn infants and are ideally placed to save many lives. Recent research on midwife-led models of practice has shown positive health and well-being benefits, including fewer episiotomies, less intra-partum analgesia/anaesthesia, fewer instrumental births, and lower health-system costs. Empowerment of birthing women can be effec-

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tively facilitated in midwife-led practice because of midwives’ own sense of autonomy and agency. Building relationships with women is a core part of midwife-led care, increasing empathy and attentiveness to women and providing presence and support. Whether in midwife-led models or in traditional (specialist) settings, midwives combination of technical competence and empathy is vital and often not used to full capacity.

Making sure that midwifery services are available and easily accessible to families in the communities where they live can strengthen existing SRMNH health system infrastructure by overcoming fragmentation and improving seamless coordination of care across all levels of the health system. For instance at primary level family planning, screening for sexually transmitted infections (STI) and voluntary counselling and testing (VCT) for HIV can be provided by midwives as well as postpartum care provided close to home, combined with newborn care, breastfeeding support and post-partum family planning. Midwives identify pregnancy and childbirth complications early, provide first line management (basic emergency obstetric and neonatal care - BEmONC) and prompt transfer for hospital for back-up care when needed, reducing delays to the next level of care and allowing for greater efficiency along the continuum.

3. The Midwifery Services Framework

The goal of the MSF is to lay a foundation of pragmatic steps and supporting tools that can be used by health care decision makers in all countries, whether high, middle or low income, to initiate, develop, strengthen, or monitor and evaluate their midwifery services. It can be used by all parties interested in improving SRMNH, be they health systems and health workforce developers and planners, policy makers, health care professional organisations and unions, educators and regulators, UN agencies, NGOs or CSOs. Countries that have midwives and those that do not (yet) can use the MSF to mainstream equity-based approaches to expand the availability, accessibility, acceptability and quality (AAAQ) of midwifery services and the essential interventions for SRMNH.

The MSF is a living document that can and will be regularly updated to include new tools and approaches as well as lessons learned from country implementation. As more countries and organisations use the MSF, its contents can be enriched with national or regional adaptations of tools and success stories.

The specific objectives of the MSF are to:

- Provide detailed guidance on how to set up or develop midwifery services that fit a country’s specific health system, health workforce, and population needs.
- Operationalise the common understanding of the fundamental role that midwifery services play in improving women's and children’s health
- Build on the current commitment to reducing maternal, newborn and child mortality and morbidity with a practical approach to making access to midwives available to all families.
- Position ICM as a technical leader in advancing the availability of quality midwifery services to all women and families.
4. How the Guiding Framework functions

The MSF (Figure 1) contains a set of steps that can be used in sequence or individually, to set up or further develop midwifery services within a specific national health system. It guides the user through challenges and bottlenecks that affect the coverage and impact of midwifery services and supports informed decision-making on strategic policy and implementation.

Figure 1: MSF flowchart

The MSF consists of several steps that build upon each other to set up or strengthen midwifery services. It provides support for initiating discussions, conducting situation analyses to identify action areas, developing and regulating the required midwifery workforce, with continuous monitoring and evaluation to fine-tune midwifery services to the national and local context. The development or strengthening of the national midwifery association is seen as an ongoing activity that runs in parallel with service and workforce development. Though this process is led by the profession, support and regular interaction with the Ministry of Health and with other important groups such as women’s or user groups, other health care professional groups and the education and regulation authorities is important and advised.

The steps in the framework start from the basic question about the kinds of SRMNH services women are entitled to, often called the minimum benefits package. This is different for every country, and more or less defined in national health plans and/or insurance packages. The second step addresses the organization of service delivery to ensure the availability, accessibility, acceptability and quality
of care provided and the midwife-led model of care. The third step is split in two; step 3a looks at how to develop the required numbers of midwives (and other professionals) to effectively cover population need, including the education and regulation needed and the core elements of effective workforce management. Step 3b deals with actions to ensure an enabling environment so that the midwifery workforce can effectively deliver the full scope of SRMNH care. As the leaders and participants for steps 3a and 3b are not the same, they have been split up, but these steps must be undertaken together and feed into each other to ensure that workforce and work environment are fully coordinated. The fourth and last step highlights the need for constant testing, monitoring and evaluating of the results of strengthening midwifery services and adapting them as needed and is initiated as preparatory step 2, to ensure M&E is developed from the start of the project.

Countries in the western hemisphere can often forego the first and second step, because midwifery services are often already well-established. However, it can be a beneficial exercise to complete those steps as part of the full sequence to ensure that women, children and families are receiving the best possible care.

5. How to use the framework

The development of each of the steps starts with the objective and a set of key questions to be answered in that step. It lists the kinds of participants that should contribute to the completion of that step and the materials needed to inform the discussions. Key questions guide participants in this exercise through the elements of the discussion and into the identification of action to be undertaken and tools that can be used for implementation. Each step is accompanied by resource page with supporting documents, background literature and tools to guide its completion. These documents and tools will also be available on the ICM website with web-based tools to guide implementation at each level.

Before entering into the process of developing midwifery services, two preparatory steps are proposed. Preparatory step 1 collects essential data on population need, the health system and the health workforce. Preparatory step 2 helps set up the monitoring and evaluation (M&E) mechanism from the start of this project.

The components of the framework can be used in sequence, or separately to strengthen or develop certain parts of a country’s midwifery services, or to evaluate their efficiency. It is important to note that the outcome of each step is a building block for the next. So when selecting a step to work on, the outcomes of the previous step should be in place.

At the first meeting on the implementation of the MSF it is important to identify a lead agency or person for the entire project, as well as lead agencies or persons for parts of or entire steps. Technical experts (national or international) need to be identified as well as funding and a communications plan to provide information on the progress, challenges and successes of the project to audiences within and outside the health system.

Women and their families are central to this process and have therefore been mentioned as participants on several steps. If services do not meet their needs and expectations, they will not be taken up and will therefore not hit the targets of quality SRMNH care that is available, accessible and acceptable to all. It is crucial that women’s views and needs are sought and considered at every level of the MSF and that they are encouraged to actively participate in shaping the services that are crucial to their health and well being and that of their families.
6. Preamble to using the MSF

Before starting to use the MSF, it is important to understand some of the core concepts around midwifery services and midwives.

A. Midwifery services are designed to fulfill the following guiding principles:

- Promote the right of all women to professional midwifery care (including emergency obstetric care) that is available, accessible and acceptable, and of good quality (AAAQ).^
- Ensure the continuum of care from adolescence through to care of the newborn and into the early weeks of life.
- Ensure the continuum of care from home to tertiary hospital
- Be sustainable within the health system
- Be sensitive to gender and culture and deliver respectful care to all women, their partners and families

They should:

1. Provide the set of evidence-based cost-effective and lifesaving interventions for family planning, maternal and newborn health, including safe abortion care outlined in the Essential Interventions.
2. Be staffed by an adequate number of competent midwives, who:
   a. meet the ICM standards for education and regulation
   b. are distributed across the country in order to ensure equitable access to their services
   c. work collaboratively with other cadres (such as medical doctors, obstetrician-gynaecologists, paediatricians and other health care workers including community health workers and traditional birth attendants) at all levels of the health system
3. Be set up to provide care for normal pregnancy and birth close to where women live with ready access to a functioning facility, operating 24 hours a day, 7 days a week, which is able to provide first line emergency management and care for women and newborn with complications and transfer for emergency back-up care (BEmONC).
4. Be supported by a functioning health system, with agreed and applied back-up and referral (back-up) pathways between levels of service, e.g. between BEmONC and comprehensive emergency obstetric and neonatal care (CEmONC) and between services, such as family planning, ante-natal care, voluntary counselling and testing for HIV (VCT) and prevention of mother to child transmission (PMTCT),
5. Have the support of an enabling environment which includes an adequate supply of medicines, supplies and equipment, communications and transport required to ensure the continuum of care, safe working conditions, safe living conditions, fair recompense, access to family support and basic amenities including schooling and childcare and measures that support the retention of midwives as well as professional support systems that enable midwives to perform to the full extent of their scope of their practice, such as continuous professional education and mandated peer review (ref from JT).
6. Have a monitoring and evaluation system in place to track progress in meeting goals for coverage, quality assurance and to hold governments and service providers accountable.

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8. UNCESC, General Comment 14, Geneva, 2000
7. Who is a midwife?

- In the scope of practice of a midwife details that 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 care for children in the early years of life.

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

- Midwives are key skilled birth attendants and providers of maternal and newborn health (MNH) care as well as sexual and reproductive health care. They work closely with other health care professionals, such as obstetricians, neonatologists, nurses, general practitioners and non-physician clinicians (NPCs), and are often with support from community-based health workers.

8. What does a midwife do?

The evidence-based Essential Competencies for Basic Midwifery Practice include:

COMPETENCY #1: Midwives have the requisite knowledge and skills from obstetrics, neonatology, the social sciences, public health and ethics that form the basis of high quality, culturally relevant, appropriate care for women, newborn infants, and childbearing families.

COMPETENCY #2: Midwives provide high quality, culturally sensitive health education and services to all in the community in order to promote healthy family life, planned pregnancies and positive parenting.

COMPETENCY #3: Midwives provide high quality antenatal care to maximize health during pregnancy and that includes early detection and treatment or referral (back-up) of selected complications.

COMPETENCY #4: Midwives provide high quality, culturally sensitive care during labour, conduct a clean and safe birth and handle selected emergency situations to maximize the health of women and their newborn infants.

COMPETENCY #5: Midwives provide comprehensive, high quality, culturally sensitive postpartum care.


care for women.

COMPETENCY #6: Midwives provide high quality, comprehensive care for the essentially healthy infant from birth to two months of age

COMPETENCY #7: Midwives provide a range of individualised, culturally sensitive abortion-related care services for women requiring or experiencing pregnancy termination or loss that are congruent with applicable laws and regulations and in accord with national protocols.

9. What is the continuum of care

The “Continuum of Care” for sexual, reproductive, maternal and newborn health (SRMNH) includes integrated service delivery for women and children from pre-pregnancy to delivery, the immediate postnatal period, and the early months of life. The Continuum of Care recognizes that safe childbirth is critical to the health of both the woman and the newborn child—and that a healthy start in life is an essential step towards a sound childhood and a productive life.

What are the dimensions and importance of the Continuum of Care?
The first dimension of the Continuum of Care is time - from pre-pregnancy, through pregnancy, childbirth, and the early days and months of life (Figure 1. Connecting care giving across the Continuum for maternal, newborn and child health12).

Figure 2: the Continuum of Care

The second dimension of the Continuum of Care is place - linking the various levels of home, community, and health facilities (Figure 2. Connecting care giving between households and health facilities to reduce maternal, newborn, and child deaths12).

Linking interventions in this way is important because it can reduce costs by allowing greater efficiency, increase uptake and provide opportunities for promoting related healthcare elements (e.g. postpartum/postnatal and newborn care). Midwives provide care along both of these continua.

10. What is quality Maternal and Newborn Care

The Framework for Quality Maternal Newborn Care (QMNC\textsuperscript{13}) provides a context to discuss the care women and infants need because it differentiates between what care is provided, how it is provided, and who should provide it, in all settings. It considers the elements of quality maternity care, identifies how the health system should be organised in order to provide quality SRMNH care, the philosophy and values with which that care should be provided and by whom. It is also a very useful framework planning workforce development, resource allocation or education curricula. And it can help identify evidence gaps for future research, structure analyses of health services provision or plan new services.

The framework identifies the care that can be provided by a midwife, including health education, information and promotion; assessment, screening, and care planning; promoting normal processes and preventing complications; and the first line management of complications should they arise. It can be used to design components of a health system needed by childbearing women and newborn infants so that midwives who are adequately educated, licensed and regulated are integrated into the health system and work in inter-disciplinary teams to provide continuity of care (see Step 2).

Figure 3: The QMNC Framework
Some of the crucial elements of the QMNC framework are:

- The values of care: respect, communication, community knowledge and understanding, care tailored to women’s circumstances and needs.

- The philosophy of care: to optimise biological, psychological, social and cultural processes, strengthening woman’s capabilities and the process of expectant management (using only interventions only when indicated)
Each of the steps introduced above is presented in greater detail in a separate discussion module and structured into objectives with key questions to guide the discussion on input, process, output/outcome and action for achieving that step. There are two preparatory steps, four service development steps and one ongoing activity in the framework:

Preparatory steps:

1. Collect essential background information
2. Set up the M&E mechanism

Midwifery service development steps:

1. Agree on the package of SRMNH care that women and families should receive and define the services that midwives will provide
2. Discuss how SRMNH services should be organised to deliver midwife-led care with effective back-up
   a. The midwife-led model of care
   b. Guarantee available, accessible, acceptable and quality care
3. Workforce and enabling environment
   a. Develop the workforce
   b. Create an enabling environment
4. Test, monitor, evaluate, adapt midwifery services

Ongoing activity: set up and strengthen the midwives association.

The purpose of these steps is to guide strategic planning discussions for key decision makers working together to resolve the questions and achieve the strategic objective laid out in each module. Guidance is provided on:

- The strategic objective of the module
- The key questions to answer
- Who should participate
- Any resources, background materials, or supplies needed to complete the activity, which are collected in a resource page that is hyperlinked into the step.

At the end of each step it is important to identify the coordinating person or agency, agree a timeline with fixed coordination meeting dates, define the technical roles participants have in the completion of this step or sections of it, create a plan for engagement with the relevant stakeholders (women and their families, policy makers, health system developers and planners, midwifery associations, other health care professionals, other stakeholders) and agree communication moments and deliverables to groups working on other steps and to the overall project lead.
Preparatory Step 1: Essential Background data collection

Before starting on these modules it is important to conduct a basic needs assessment for SRMNH services and the environment within which these services are provided. A basic set of data elements is provided below.

<table>
<thead>
<tr>
<th>input</th>
<th>process</th>
<th>output/outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expected pregnancies in the short, medium and long-term GIS data on the spread of the population across the country</td>
<td>Identify expected pregnancies for 2, 5 and 10 years ahead (TFR x number of women of reproductive age x spontaneous abortion rate) and use geographic information system (GIS) data or other relevant geographical information to identify the regions where the numbers of pregnancies are expected to rise/fall/remain the same.</td>
<td>Number of expected pregnancies identified per region to focus service development</td>
</tr>
<tr>
<td>Population profile (SES, wealth quintiles, urban/rural/urban poor, female/male education, legal age of marriage)</td>
<td>Identify population groups (SES, level of education, rates of early marriage/adolescent pregnancy)</td>
<td>Population characteristics: age, SES profile, fertility rates captured to focus service development</td>
</tr>
<tr>
<td>Health system profile (facilities, public/private, EmOC capacity, funding, National Health plan, SRMNH plans or roadmaps)</td>
<td>Identify where the health system is fully functional (full SRMNH services, EmONC capacity, communication, referral, transportation along the continuum of care, equipment and supplies), areas where the health system is not fully functional and what needs to be improved. Identify where SRMNH staff are working using the national Health Human Resource Information System (HRIS) and match this with facilities using GIS data.</td>
<td>Health system capacity and availability close to women and families.</td>
</tr>
<tr>
<td>Health workforce and labour market profile (professional groups, roles and responsibilities, age characteristics, place of work, urban/rural, working conditions, deployment mechanisms, workforce pipeline)</td>
<td>Carry out an SRMNH workforce assessment to determine the workforce needed, available and additionally required to meet population needs.</td>
<td>Clear understanding of the gaps between population SRMNH needs and available staff Labour market intelligence to identify problems with recruitment/deployment, retention and career paths</td>
</tr>
</tbody>
</table>

15. UNDP Human Development Index http://hdr.undp.org/en/content/human-development-index-hdi
16. Government Health System Information data
17. From UNFPA/AMDD Emergency Obstetric Care Assessments
18. Census/government data
Preparatory step 2: Monitoring and Evaluation

Monitoring and evaluation (M&E) need to be built into programme development and implementation from the start. Using an M&E mechanism that is already in place for health system and programme assessment is the best way to ensure that results are comparable across the system and at national and sub-national levels. If a new M&E system is needed for midwifery services, a selection of options can be found under step 4. In many cases, M&E frameworks will start with a situational analysis. The essential background data collected in Preparatory step 1 will already inform a lot of that analysis.

Involving relevant midwifery stakeholders such as educators, association leaders, council/board members, Government ministries (ministries of health, education and human resources), civil society, donors/development partners, parliamentarians, academics, religious associations, and the private sector, etc. in the situational analysis process, helps to build better understanding, agreement, engagement and programme sustainability.

The objectives of the M&E preparatory step are to:

- Set reasonable and measurable midwifery service programme targets
- Agree how to measure the predefined midwifery service programme targets
- Agree the indicators for each step of the midwifery services development using either qualitative or quantitative methods
- Obtain the data needed to feed ongoing M&E cycles
- Agree when and where the results will be discussed and how and under who’s responsibility they will impact on the further development of the midwifery services
- Measure user access to and satisfaction with midwifery services
- Regularly compare results with national, subnational, regional and international statistics
- Avoid duplication of systems, tools and activities for data collection, analysis, dissemination and utilization

Instructions:
At the start of each step of the service development framework it is important to:

- Determine the baseline
- Describe and collect the indicators that will be used to measure project success
- Define the quality standards and by what they are determined
- Set objectives
- Select strategies,
- Agree the timelines for next measurement,
- Identify who is responsible for collecting and reporting the data, and who will analyse them and
- Develop an operational plan to address gaps identified in the assessment
- Agree on the time and place for the communication of M&E results to stakeholders (community, health care professionals, government etc).

If an existing and sustainable data collection mechanism for health outcomes and health workforce is available, the M&E process for midwifery services can be incorporated into it.

With the preparatory steps completed and the M&E mechanism at hand, work can begin on the actual development, strengthening or fine-tuning of the midwifery services.
Service Development Step 1 – Agree on the package of SRMNH care that women and families should receive and define the services that midwives will provide

**Objective:** to discuss and agree with the government, service users and national stakeholders, the exact package of SRMNH care women are entitled to and what the extent of the role of the midwife should be, given her competencies and the roles and competencies of other health care professionals along the continuum of care.

**Key questions:**
1. What is the package of SRMNH care and interventions that women are entitled to?
2. What are the needs, perspectives and concerns of women with regard to SRMNH care and interventions?
3. How does the package of care address women’s needs and perspectives?
4. Which elements of the package should be provided by midwives?
5. Which elements of the package can midwives currently provide given their defined scope of practice and competencies?
6. Which additional roles and competencies do midwives need to obtain in order to be able to provide all the elements of the SRMNH package of services identified in question 1?

**Participants:** Ministry of Health, development partners, health insurance companies, midwives association, other health care professional associations, consumers/women’s groups

**Materials:** National Health Plan, SRMNH health plan, SRMNH needs assessment, SRMNH workforce scopes of practice. Additional resources, literature and tools can be found on the resource page for this step (hyperlink)

**Background**
This module focuses on understanding the needs of the population, particularly women of reproductive age, the current health system capacity to meet those needs and the package of care midwives are able to provide along the continuum of care.

All women should have access to quality reproductive, maternal and newborn care. The Minimum Benefits Package for Sexual, Reproductive, Maternal and Newborn Health (SRMNH) includes services on prevention of STDs, family planning advice and delivery, pre-pregnancy, pregnancy, childbirth and postnatal care and care in the early months of life. The package of care will vary according to population demography and health status, the available resources, and a variety of political, social,
and cultural factors. The perspectives, needs and concerns of women should be at the centre of the considerations when discussing and agreeing the package of care.

Preparatory activity:
As a precursor to the activity of defining the essential benefits package, take 10 minutes to have each participant individually write a description of the ideal vision for SRMNH care. Refer to the content in the Introduction [QMNC philosophy and values, ICM Vision, etc]. Discuss as a group, and write a vision statement to describe the care the SRMNH system will hopefully provide to women and families.

Process:
• Discuss the SRMNH package of care that is, should be or will be provided to women of reproductive age
• Using the QMNC framework, the Essential Interventions for RMNCH\(^{21}\) and the ICM Competencies, identify the practices midwives should be able to provide throughout the continuum of care, from pre-pregnancy through the early months of life and from home to hospital
• Discuss which practices midwives currently can and do provide and what actions are needed to expand the national scope of practice to allow midwives to maximize the care components in the package that they can deliver within the globally recognized midwifery scope of practice\(^{22}\).
• Discuss and agree the values of the SRMNH services: Respect, communication, community knowledge and understanding, care tailored to women’s circumstances and needs.
• Identify what actions are needed to ensure that midwives can provide all the elements of the identified essential services package that are within the globally recognized midwifery scope of practice with the agreed philosophy and values of care.
• Discuss and agree the roles and responsibilities of the various stakeholders, a timeline, a communications plan and a budget.
• Set baseline and outcome indicators to feed into the M&E cycle

Conclusion:
This step has laid out the scope and remit of the midwifery services framework and forms the core of what will be developed in subsequent steps. Agreements reached and decisions taken in this step will have an impact on the health system as a whole, but specifically on SRMNH services and those who are connected to them. Having agreed not only what the content of the SRMNH care will be but also how and by whom it will be provided needs to be very clear, supported at all levels of the political and health systems and pro-actively communicated to all stakeholders, including women. The key decisions made in this step must be easily accessible to all participants in the midwifery service development project and continued support for understanding and implementing them needs to be provided and carried by all the leaders of this project.

The agreed package of care will be the essential guidance for service development throughout the next steps of this framework.

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21. Essential Interventions, Commodities and Guidelines for Reproductive, Maternal, Newborn and Child Health
A global review of the key interventions related to reproductive, maternal, newborn and child health,
The Partnership for Maternal Health, Newborn and Child Health and the Aga Khan University, WHQ, 2011
22. Ibid, Ref 7
Service Development Step 2 - Agree how services should be organised

Objective: to discuss and agree how SRMNH services should be organised to ensure that all women of reproductive age have reliable access to acceptable, quality midwife-led care with referral level back-up.

Key questions:
1. What is the current/desired midwifery model of practice for the woman and newborn?
2. Are midwives available in sufficient numbers?
3. Are midwives accessible, both geographically and financially?
4. Are the services midwives provide socially and culturally acceptable?
5. Are midwives able to provide the QoC required and described in the QMNC framework?

Participants: Ministry of Health (including departments for workforce, planning, health system development, SRMNCAH), development partners, health insurance companies, midwives association, other professional associations, consumers/women’s groups

Background material: The agreed package of SRMNH care, National Health Plan, SRMNH health plan, SRMNH needs assessment, SRMNH workforce scopes of practice, health system organisation and staffing plans. Additional resources, literature and tools can be found on the resource page for this step (hyperlink)

Step 2 is divided into:
2a) Models of Practice: discussing and agreeing the service delivery models for midwife-led care
2b) How SRMNH services should be organised: discussing and agreeing how to ensure that midwifery services are available, accessible, acceptable and of consistent high quality

Step 2a: Models of practice

Background
The midwife-led model of care
The midwife-led continuity model of care is based on the premise that pregnancy and birth are normal life events. The midwife-led continuity model of care includes: continuity of care; monitoring the physical, psychological, spiritual and social wellbeing of the woman and family throughout the childbearing cycle; providing the woman with individualised education, counselling and antenatal care; continuous attendance during labour, birth and the immediate postpartum period; ongoing

support during the postnatal period; minimising technological interventions; and identifying and referring women who require obstetric or other specialist attention\textsuperscript{23}. The underpinning philosophy of a midwife-led model of care is normality and the natural ability of women to experience birth without routine intervention.

Midwife-led continuity of care has been defined as care where ‘the midwife is the lead professional in the planning, organisation and delivery of care given to a woman from initial booking to the postnatal period’\textsuperscript{24}. Some care may be provided in consultation with medical staff as appropriate while midwives, in partnership with the woman, remain the lead professional with responsibility for the assessment of needs, planning of care and management of complications or referral to other professionals as appropriate. In some models, midwives provide continuity of midwifery care to all women from a defined geographical location as lead professional for women whose pregnancy and birth is uncomplicated, and, in partnership with other professionals, continuing to provide midwifery care to women who experience medical and obstetric complications.

Some models of midwife-led continuity of care provide continuity of care to a defined group of women through a team of midwives sharing a caseload, often called ‘team’ midwifery. Thus, a woman will receive her care from a number of midwives in the team, the size of which can vary. Other models, often termed ‘caseload midwifery’, aim to offer greater relationship continuity, by ensuring that childbearing women receive their ante, intra and postnatal care from one midwife or practice partner\textsuperscript{25}.

The midwife-led model of care is flexible and can be delivered in a variety of settings, ranging from care in the community as stand-alone midwife-led units with back-up from the next referral level, or with outreach and support from CHWs and TBAs, to facility-based midwife-led units on or close to health facility/hospital premises, or in hospitals as part of a team of care providers using task-shifting/sharing arrangements. The best option will be dependent on women’s needs and choices as well as geographical setting (rural, semi-rural, peri-urban and urban) and health system capacity.

Key questions:
1. What is the current model of practice for the midwife?
2. What are the successes and failures of the current models?
3. What is the desired model of practice as per the needs of women, the capacity of the midwives and the capacity of the health system?
4. Where are midwifery services provided?
   a. Home
   b. Community
   c. Health care facility
   d. Hospital
5. How much time would be involved in providing care at the levels mentioned in question 4?
6. How many midwives are needed to enable the midwife-led model of care at each of the levels mentioned in question 4? (use national staffing plans if available or the Birth Rate Plus tool - BR+)\textsuperscript{26}
7. What are the barriers to the success (i.e. regarding service delivery, referral, continuity of care, community involvement etc) at each of the levels mentioned in question 4 and how can they be overcome?


\textsuperscript{26} www.birthrateplus.co.uk
Process:

- Collect, discuss and assess the current models of midwifery care, focusing specifically on whether they satisfy women’s needs, are (cost)efficient and effective, provide quality care as per the QMNC framework and create health as well as save lives.
- Using the agreements reached in Step 1, discuss and agree what would need to be added or changed to existing midwifery services (or created if midwifery services are not yet available) for midwives to be able to carry out the agreed scope of practice, keeping in mind the agreed values and philosophy of care.
- Using a planning tool and national or global benchmarks, calculate the time investment needed for providing the full scope of midwifery practice close to women and families (remember the impact of skilled, supportive and preventive care on reducing complications, need for referral and need for medical interventions such as caesarean sections).
- Identify potential barriers and risks and now to mitigate them.
- Set targets for starting the implementation of the agreed model of care and discuss and agree the roles and responsibilities of the various stakeholders, a timeline, a communications plan and a budget.
- Set baseline and outcome indicators to feed into the M&E cycle.

Step 2b: How SRMNH services should be organised

Background

For the midwife-led model of care to be fully functional, it needs to be recognised by and anchored into the health system. This includes consideration of the optimal, most effective service delivery model given:

- Volume/demand/need for services
- Levels of acuity (from primary preventive services through to the tertiary level acute care services)
- Women’s preferences for care settings, from home to hospital
- Care coordination to enable effective consultation, collaboration, and referral between SRM-NH care providers

These considerations will inform the discussion of the service network that must be amended or designed and implemented to ensure effective delivery of full scope midwifery services to the population based on their needs, values and preferences.

Availability, Accessibility, Acceptability and Quality (AAAQ)

The AAAQ framework identifies availability, accessibility, acceptability and quality of health care facilities, goods and services as essential elements of the right to health. This framework was used in the United Nations High Commissioner for Human Rights’ technical guidance on a rights based approach for reducing maternal morbidity and mortality. The AAAQ framework is a good starting point for service development and strengthening.

**Availability** – How to organize midwifery services so that they are reliably available to women in all areas of the country. That there are enough facilities and providers. That all care settings are adequately staffed and stocked. And that all facilities are able to provide care that is timely and available when it is needed.

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27. Ibid., ref 13
Accessibility – How to organize that midwifery services are geographically and financially accessible. And make them equally accessible to all who need them without discrimination.

Acceptability – How to ensure that the services in the package are those that users want and value. That they are provided in ways (in settings, by people, in a style) that meet the needs, values, and preferences of those that they are designed to serve. And that the service delivery model is culturally sensitive and respectful of all women and their families, no matter their cultural, socio-economic, religious or racial background.

Quality – How to ensure that quality standards are defined for each of the services in the essential care package. Agree how quality is measured, and how quality improvement and quality assurance activities are built into the service delivery model.

AAAQ and the midwife-led model of care

Availability: Are midwives available in sufficient numbers, are they fully competent to provide midwife-led care, regulated effectively, paid and retained and integrated into the health system?

Accessibility: How is the geographic access in rural, peri-urban and urban areas distinguishing between the services/facilities that women can access and those that they do access. Financially: are all services (provided) covered by health insurance, free or affordable through other means. Time: Are services close to women and communities?

Acceptability: are services culturally appropriate, also to migrant or under-represented populations? Are services respectful to both care-seekers and care-providers? Do services provide dignified, humane care irrespective of culture, religion, ethnicity, wealth status or other social determinant?

Quality of care: are there quality improvement mechanisms in place, including near-miss audits or maternal death surveillance and review systems (MDSR29)? Is there an effective regulation mechanism that supports licensing and re-licensing of care providers? Do services provide effective peer-support and mentoring mechanisms (ref)?

Key questions:
1. How will the SRMNH services be organised to ensure availability (coverage)?
2. How will the SRMNH services be delivered to ensure acceptability? How to ensure the participation of consumers of care in the design and evaluation of the service delivery model?
3. What are the barriers to access that need to be overcome and how will care be organized to address them?
4. How will the quality of care be ensured at each level of care delivery in the system, and across the service delivery network?
5. Where will each of the services in the essential service package be delivered (consider each setting from home to hospital from the vantage point of AAAQ)?
6. What communication and transportation mechanisms must be available to midwifery services to ensure timely and effective collaboration with other health services?
7. How will the service delivery model ensure that integrated care is encouraged and enabled through effective collaboration among the various professional teams along the continuum of care?
8. How will the philosophy of care described in the vision statement be reflected in the delivery of services in the health system?

Process:
• Discuss the AAAQ of the current SRMNH services and how these could be improved.
• Discuss and agree where midwifery services can be delivered as close to women and families as possible (home, community, health centre) taking into consideration the different needs of rural, peri-urban and urban settings and how QMNC can also be provided to women who need to access referral levels of care.
• Use the detailed descriptions for setting up midwife-led models of care from the resource page to inform the discussions on how to insert them into the national health system.
• Discuss and agree the required (changes in) communication and transportation needed to ensure safe and timely referral to next level care from all settings.
• Set targets for starting the implementation of the agreed changes to the organization of care and discuss and agree the roles and responsibilities of the various stakeholders, a timeline, a communications plan and a budget.
• Set baseline and outcome indicators to feed into the M&E cycle

Conclusions from Steps 1 and 2
The information from preparatory step 1 and the agreements from services development steps 1 and 2 lay the basis for the development of the workforce and the enabled environment within which it will be working. Further details are worked out in service development steps 3 and 4.

Items that have been agreed during these steps include:
• The expected number of pregnancies
• The required nature and number of SRMNH services
• The SRMNH service components the midwife will deliver
• The number of midwives needed in the agreed level and number of service-delivery settings
• The levels of the health system at which the midwife-led model of care is to be established
• The measures through which the midwife is supported in using the midwife-led model of care
• The communication and transportation mechanisms that will be developed or improved to support the midwife-led model of care close to women and their families
• The methods that will be put in place to support continuity of care, effective referral and integrated care provision among the SRMNH professionals at all levels of the health system
Service Development Step 3: Develop the workforce and create an enabling environment

This step contains two sections. The first one focuses on the number of midwives needed and what is required to educate them and regulate their practice. The second step is targeted to the environment they work in and what makes that most conducive to the provision of quality midwifery services. Though these are very different topics with different programme developers and stakeholders, they need to be developed at the same time so that both the work force and the work environment are ready and able to provide the quality maternity care women and their families need.

**Step 3a: Develop the workforce**

**Objectives:** To determine the size and distribution of the midwifery workforce needed (number of midwives) and where they need to be working (types of facilities and geographic areas). To determine the additional educational and regulatory capacity required to prepare and regulate the projected number of midwives (for 5 and 10 year horizons).

**Key questions:**
1. How many midwives are needed to provide the SRMNH care package agreed in Steps 1 and 2
2. How much additional education capacity is needed to develop sufficient numbers of midwives to provide the agreed model of practice?
   a. Are there sufficient secondary education facilities that meet pre-registration standards for midwifery education?
   b. Are there sufficient midwifery education facilities that can provide quality theoretical and practical pre-service education?
3. Do the current legal framework and regulatory mechanisms allow for the effective regulation of the midwife-led model of care and the larger numbers of midwives?

**Participants:** Ministry of Health, Ministry of Education, Ministry of Planning (or other concerned ministries), main participants in Steps 1 and 2, health system developers, secondary education authorities, health education authorities and facilities, regulatory bodies, councils and experts, health care professional organisations for midwives and other health worker cadres.

**Materials needed:** number and distribution of expected pregnancies (5- and 10-year projections), Midwifery workforce assessment, agreements reached in Steps 1 and 2 regarding the package of SRMNH services and how they should be organised, ICM Global Education standards, ICM Global Regulation standards, ICM standard curriculum for midwifery education. Additional resources, literature and tools can be found on the resource page for this step (hyperlink).
Background
Number and distribution of midwives
To identify the number of midwives needed to deliver the agreed SRMNHP package of care, it is essential to understand the needs of the population for the coming 5 – 10 years. Considering midwives’ roles along the continuum of care from pre-pregnancy to the early months of life, it is important to base calculations on the number of expected pregnancies, rather than the (historic) number of live births. Examples of how to calculate expected pregnancies can be found in the State of the World’s Midwifery report 2014 and the Handbook for an SRMNAH Workforce Assessment. Either a national or the current global benchmark can be used to calculate the number of midwives needed to cover population need.

Once the required number of midwives is known, it can be compared with the number currently in practice and the current rate of attrition to feed the discussion how many more are needed, where they should be placed and what the education and regulation needs are to make these professionals fully functional.

To develop agreed additional number of midwives, one should start by making sure that the secondary education system enables prospective midwifery students to meet the pre-registration requirements for midwifery education.

Education
Then identify and assess current midwifery education capacity to provide quality theoretical and practical education that meets international and national guidelines and standards. Important elements in these assessments are the numbers of student midwives per cohort, the time to graduation and the graduation rate. The ICM Standards for Midwifery Education provide a sound basis for the development of education capacity, content and quality.

ICM estimates that effective midwifery education ranges from 18 months for those who already hold a nursing qualification, to 3 years for those accessing a direct entry midwifery education programme. Education in competences includes acquiring essential knowledge, skills and behaviours or attitudes through a combination of theoretical and practical training, The goal is a competent midwife (Knowledge, Skills, and Abilities) who combines their clinical knowledge and skills with interpersonal and cultural competence.

30. Ibid., Ref 2
31. Ibid., Ref 18
32. The current benchmark is 6 midwives per 1000 live births as per World Health Report 2005, but is currently being revised by WHO and partners. Other tools for calculating the required numbers of midwives can be found in Birth Rate Plus, see ref 24.
ICM Global Standards for Midwifery Education

The education standards were developed in tandem with the update of the Essential Competencies for Basic Midwifery Practice (2010) that define the core content of any midwifery education programme and should be used in conjunction with the midwifery standards of practice and regulation (See web links to these other documents). The Education standards are founded upon the guiding principles and represent the minimum expected for a quality midwifery programme, with emphasis on competency-based education rather than academic degrees.

Regulation

Regulation needs to fit closely with the midwifery model of care and should have the capacity. Both administrative and legislative, to set and enforce practice standards that provide protection and security for the women and their families as well as for midwives themselves. The ICM Global Standards for Midwifery Regulation\(^\text{35}\) provide a sound basis for the development of regulatory capacity, content and quality. The aim of regulation is also to support midwives to work autonomously within their full scope of practice by defining and protecting their scope of work and responsibilities. Regulatory bodies often also oversee accreditation of educational institutions and continuous professional development requirements for licensing and re-licensing.

ICM Global Standards for Midwifery Education

The goal of the Regulation Standards is to promote regulatory mechanisms that protect the public (women and families) by ensuring that safe and competent midwives provide high standards of midwifery care to every woman and baby. The other aim of regulation is to support midwives to work autonomously within their full scope of practice. By raising the status of midwives through regulation the standard of maternity care and the health of mothers and babies can be improved.

Process:

Based on the conclusions reached in Steps 1 and 2:

- Project the numbers of midwives necessary to cover population need for the SRMNH package agreed in service development step 1. Using the current global benchmark (175 births per midwife per year (WHO 2005)) or a national benchmark, calculate the total number of staff required. From the essential background data collected in preparatory step 1, lift the number of midwives currently practicing to calculate the additional numbers that need to be educated.
- Alternatively, conduct a full SRMNAH workforce assessment (see ref 12) that will develop a set of costed policy scenarios tailored to national and subnational need and overall health system and financial capacity.

Education

- Assess whether current secondary education provides students with the pre-registration requirements for midwifery education and whether midwifery is known and accepted as a vocational option.

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• Assess whether existing education programmes (public sector, private-sector, faith based organizations, NGOs) have sufficient faculty, theoretical and practical teaching spaces and skills labs/practicum availability to provide quality education and full competence to the (additional) numbers of midwives required. Assess their spread around the country to ensure that students from all regions can access midwifery education. Identify gaps that need to be filled and strategies to fill them.
• Assess the accreditation system for these facilities to ensure that quality education is provided according to national and international standards. Identify gaps that need to be filled and strategies to fill them.
• Assess the curricula to ensure that midwives can be competent to deliver the full scope of practice as per the ICM scope of practice, the QMNC framework and along the full continuum of care. Identify gaps that need to be filled and strategies to fill them.
• Assess whether there are pathways to advanced level education so that midwives can research and lead the development of their profession and have access to a possible career pathway into education, research, management, mentoring or other fields.

Regulation
• Assess current legislation for midwifery care against the requirements for the agreed model(s) of practice including title protection, full competency, scope of practice and autonomy.
• Assess the current national processes for the competency-based certification, licensing and re-licensing of midwives and disciplinary measures.
• Identify and put in place the required regulatory authorities and councils and assign roles, responsibilities, levels of authority, transparency and accountability.
• Develop a code of ethics and a code of conduct for midwives

Upon conclusion of the processes for the development of midwifery education and regulation:
• Set targets for starting the implementation of the agreed changes to the education and regulation of midwives and discuss and agree the roles and responsibilities of the various stakeholders, a timeline, a communications plan and a budget.
• Set baseline and outcome indicators to feed into the M&E cycle

Conclusion:
The number of midwives required to cover population need, including existing and newly educated ones, has been established. How the midwife-led model of care will translate into models of practice at various levels of the health system has been assessed and agreed. Pre-registration, pre-service and in-service education capacity has been assessed and measures to strengthen capacity and quality have been agreed. Regulatory systems have been assessed against the needs of midwife-led care and practice models and measures to strengthen capacity and quality have been agreed.

Developing the workforce goes hand in hand with developing its enabling environment. Many of the issues discussed in step 3b are informed by the agreements reached in 3a and previous steps. It is therefore important to work on these steps simultaneously to ensure workforce and working environment function seamlessly together.
Step 3b: Create an enabling environment

Objective: To enable working environments for midwives and other members of the SRMNH team that respect both care seekers and care providers and are conducive and supportive of the high-quality, high-performance midwife-led care identified in Step 1.

Key questions
1) Does the facility have the rooms, beds, privacy, safety, surgery capacity, connectivity for referral and other essential elements for providing high quality midwife-led care to the population?
2) Are the commodities, drugs, equipment needed to provide the level of care defined available?
3) Are the necessary communication and transportation available to facilitate timely management or referral of complications?
4) Are the support and back-up available to secure the agreed level of care across the continuum? Is there enough referral capacity at the next level of the health system and are midwifery services integrated across those levels?
5) Can respectful, dignified and humane care be provided that strengthens women’s capabilities and supports the values and philosophy of the QMNC framework?
6) Are quality assurance mechanisms in place to guarantee the delivery of quality care?
7) Is the working environment, including the health system, respectful of its staff, whether midwives, nurses, facility support staff, administrators, CHWs or others? Issues to discuss include: recruitment and retention, remuneration, peer support and mentoring, safety in and around the working environments etc.

Participants: Ministry of Health, health system developers/planners, health system experts, facility managers, health care professionals, women’s groups,

Materials needed: details about the agreed midwife-led model of care and agreed practice modalities at all levels of the health system, facility readiness reports, reports on the functionality of communication and transportation mechanisms, examples of safe and respectful working environments, successful referral systems, equitable recruitment, deployment and remuneration systems and effective integrated services along the continuum of care that allow for inter-professional collaboration and efficient referral. Additional resources, literature and tools can be found on the resource page for this step (hyperlink).

Background
As with all health services, the success of midwife-led care stands and falls with the quality of the enabling environment. This environment impacts equally on care seekers and care providers, thereby making it a multi-stakeholder responsibility to tailor and optimise this environment to population needs and health system capacity. This environment contains a large number of elements that are influenced and controlled by different groups of stakeholders and consultation on its improve-
ment should therefore be inclusive but focused.

Key concepts mentioned in the questions above include the physical state of the facility and the commodities and connectivity it can access to ensure women and newborn are safe from pre-pregnancy to the early weeks of life (questions 1, 2 and 3). These are often checked through facility or emergency care assessments. The concepts of efficient back-up care, integrated services, respectful care and respectful working environments are equally important for quality service provision. Further details are provided below:

**Efficient back-up care**

Referral systems are key components of the environment that enables quality midwifery care. Dysfunctional referral systems increase the risk of morbidity/mortality and are a source of workforce frustration and disengagement. It is crucial that these systems are fully resourced and receive priority attention to keep them functioning optimally. Midwives work well at both first and next levels of the health system, and makes them very well suited to working in communities close to women and their families, managing complications and providing Basic Emergency Obstetric and Newborn Care (BEmONC), and referring to next levels for Comprehensive Emergency Obstetric and Newborn Care (CEmONC)\(^{36}\). However, inter-professional collaboration and clear roles and responsibilities for all health care professionals involved are important to ensure that case management can be discussed and agreed and referral managed from the sending and receiving side to optimise health and safety for women, foetus and newborns.

<table>
<thead>
<tr>
<th></th>
<th>First-level maternal and newborn care</th>
<th>Back-up maternal and newborn care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Defining feature</strong></td>
<td>Professional close to client and de-medicalised</td>
<td>Referral level technical platform</td>
</tr>
<tr>
<td><strong>For whom?</strong></td>
<td>For all mothers and newborns</td>
<td>For all mothers and newborns presenting problems not solved by first-level care</td>
</tr>
<tr>
<td><strong>By whom?</strong></td>
<td>Preferably by midwives; alternatively by other skilled attendants (doctors or nurses)</td>
<td>Best by a team that includes gynaecologists-obstetricians and paediatricians; alternatively, appropriately trained doctors or mid-level technicians</td>
</tr>
<tr>
<td><strong>Where</strong></td>
<td>Preferably in midwife-led facilities; also in hospitals with maternity wards</td>
<td>In all hospitals</td>
</tr>
</tbody>
</table>

Table 1: First-level maternal and newborn care and back-up maternal and newborn care\(^{37}\)

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37. WHO 2005, World Health Report: Make Every Mother and Child Count
**Integrated services** as per the WHO definition\(^{38}\) means: ‘The management and delivery of health services so that clients receive a continuum of preventive and curative services, according to their needs over time and across different levels of the health system’. Professional integration happens when different health professions or specialties work together to provide joined-up services. An obvious example is coordinating the timings of ante-natal and child health clinics. The first challenge in professional integration is to have the appropriate range of skills available in the health service; the second challenge is to ensure that different professional groups collaborate effectively. Skill mix can be tackled by employing a number of different types of professional or by assigning a broad range of tasks to one specific cadre.

**Respectful maternity care**
Respectful care means care that is free from violence and discrimination\(^{39}\) respects women’s dignity, culture, religion or ethnicity and as such is an essential component of quality care. Some of the practices that accompany respectful care are outlines in the WHO statement and include: social support through a companion of choice, mobility, access to food and fluids, confidentiality, privacy, informed choice, information for women on their rights, mechanisms for redress following violations, and ensuring high professional standards of clinical care. If women’s perceptions of their care do not meet their needs, they are less likely to access services\(^{40}\). The Respectful Maternity Care Charter provides detailed information on how to ensure that the care women receive is respectful.

**WHO statement\(^{41}\)**: Every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care.

**Respectful working environments**
In principle, respectful maternity care also respects the care provider. This means that they are not only provided with a fully functional and safe work environment (facilities, equipment, commodities, safe staff housing, respect for their role and position), but also with fair and timely remuneration, access to peer-support and mentoring, continued professional development and a to masters or doctoral degrees.

**Peer support and mentoring** - Facilitating safe, fair, confidential, trusting, effective learning and clinical practising environment in which practice development is fostered, evaluated and disseminated. Cultivate a culture supporting critical inquiry and evidence-based practice. Maintain competence through continuous and cyclical support and training with CPD to ensure empowered midwives able to empower women.

**Process:**
- Assess facility readiness using existing reports or EmOC assessments, focusing on where midwife-led care will be provided and where women with complications will be referred to. Identify gaps that need to be filled and strategies to fill them.
- Assess the referral system from home to hospital recognising that midwives can prevent and manage a large number of complications that then no longer require referral to the next level. Identify gaps that need to be filled and strategies to fill them. Determine barriers to midwife-led services and referral bottlenecks.
- Assess whether the midwifery workforce has the tools (checklists and feedback loops) and

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40. Ibid, ref 13
41. Ibid., ref 36
the functioning environment to provide quality care.

- Assess whether how and where care is provided is respectful of women’s circumstances, culture or religion and tailored to their individual needs? Identify gaps that need to be filled and strategies to fill them.
- Assess whether the working environment is respectful of its health care workers?
  - Fair mechanisms for recruitment, deployment (including transportation to duty station, housing, education etc.
  - Timely and appropriate remuneration mechanisms, and standards and guidelines relevant to appropriate workload
  - Incentives (financial or other) for midwives working in remote areas or less desired environments to ensure appropriate distribution of midwifery care providers.
  - Peer support and mentoring with a focus on improving quality of care and stimulating continuous professional development (CPD) as well as debriefing and mentoring the emotional health of practitioners.
- Set targets for starting the implementation of the agreed changes to the enabling environment and discuss and agree the roles and responsibilities of the various stakeholders, a timeline, a communications plan and a budget.
- Set baseline and outcome indicators to feed into the M&E cycle

**Conclusion**

This step concludes the elements of the project that are geared to developing midwifery services. Many of the discussions and decisions taken in this step are also important to other health services and success stories from changes to SRMNH services can inform wider changes across the health system.

Appreciating the dual applicability of respect for care seekers and care providers opens new perspectives on how health systems can move from the treatment of health complications and disease to the creation of health as a joint activity of the two aforementioned groups.

42. https://www.k4health.org/sites/default/files/RMC%20Program%20Review%20Instrument_0.pdf
Ongoing activity: develop or strengthen the midwives association

Objective: to develop or strengthen an association that can represent midwives in the national and regional health arena, provide leadership for change, negotiate on behalf of the profession and enable quality assurance.

Key questions:
1. Is there a midwives association and if so, what are its roles and responsibilities?
2. How does it recruit and register its members?
3. Which percentage of registered/licensed/educated midwives that are members of professional association?
4. What are its key activities and responsibilities? Do they correspond to what members need and expect?
5. How is the midwives association funded?
6. How does it collaborate with MNH stakeholders such as women’s groups, other national health professional organizations, government and local authorities, researchers, educators, regulators at national and international levels?

Participants: practicing midwives, association members and managers, Ministry of Health, midwifery educators, regulators and researchers, HRH specialists.

Materials needed: ICM MACAT results (if available), annual report of the midwives association, overview of association programmes or activities. Additional resources, literature and tools can be found on the resource page for this step (hyperlink).

Background
Health care professional associations play an important role in the emancipation and development of a professional group and lead on a host of collective activities to strengthen and advocate for the midwifery profession. They can be a representative of their members in national health policy and health system discussions, advocate for professional education, regulation and recognition of midwives and negotiate for better working conditions if needed. They can provide Continuing Professional Development (CPD), maintain a registry of the midwifery workforce that can be used to more effectively manage its development and size. The association can also set standards of practice and quality assurance, negotiate salaries and working conditions and collaborate with other health care professional associations to promote maternal and newborn health.

Association development provides professional support, contributes to national MNH policy development and supports relationships with other healthcare professions.

The core responsibilities of a professional association include providing a visible entity that represents the profession, providing a focal point for the profession (belonging), representing the interests of the profession (legal), aggregating midwifery efforts, thoughts and ideas (identity), provid-

43. ICM, Member Association Capacity Assessment Tool (MACAT) and guidelines, http://www.internationalmidwives.org/assets/uploads/documents/Global%20Standards%20Comptencies%20Tools/English/MACAT%20ENG.pdf
ing leadership for policy change (power, credibility, collaboration), enabling quality assurance and standard setting and providing the essential guidelines, policies and protocols for practice.

**Instructions**

- Based on the profile and level of development of the professional association, discuss measures that can be taken to strengthen (or create) a midwifery association.
- Encourage midwives to gather and discuss the need for and the needs of a professional association. Member support and participation in advocacy efforts and negotiations are key to developing a strong and autonomous profession.
- In some cases, twinning with a more developed association from another country can be useful to set the next steps.
- Set targets for starting the association and discuss and agree the roles and responsibilities of the various stakeholders, a timeline, a communications plan and a budget.
- Set baseline and outcome indicators to feed into the M&E cycle

**Service Development Step 4: Test, monitor, evaluate and adapt, to population and health system needs**

**Objective:** To ensure that each of the decisions and actions taken to strengthen or develop midwifery services are successful and produce the intended results. To test the effectiveness of planned actions, adapt actions based on lessons learned, track progress, hold decision makers and implementers accountable and report to stakeholders.

**Key questions**

1. How will the health system monitor and evaluate the performance of the actions taken to strengthen the midwifery services?
2. How will the gains made in the steps above be maintained?
3. How will the lessons learned from successes and failures be used to improve programme implementation?
4. How will the adaptations be communicated to the MNH workforce and implemented together with them?
**Participants:** Government officials, planners, service users, women’s groups, midwives and other health workers

**Materials needed:** baselines set at the start of each step, progress reports, barriers and bottleneck reports, success stories, service user perspectives, service provider perspectives. Additional resources, literature and tools can be found on the resource page for this step (hyperlink).

**Background**
In setting up or developing midwifery services, it is important to regularly test whether they truly fit their purpose and make the necessary adaptations to improve quality and efficiency. The proposed cycle is to develop programmes or interventions and then test them against agreed outcomes, evaluate them and make adaptations based on those outcomes and then continuously monitor their functionality and user satisfaction rates. This cycle can inform:

- current and future programme planning;
- implementation and decision-making to consistently meet population and health system needs,
- mechanisms to hold decision makers and implementers accountable
- reporting of results to all stakeholders.

M&E leads to accountable/responsible stakeholders in the development, management and implementation of midwifery services. It produces data that can be compared within and across countries on the content, quantity and quality of services provided. M&E structures, systems and processes should be built into midwifery service development programs from the design phase and carried out regularly throughout the project. It was therefore introduced as a preparatory step in this framework and agreeing and collecting baseline and performance indicators has featured in each of the service development steps. In principle, this section should consist of feeding the agreed and collected data into an existing national M&E process for health system or health workforce monitoring. If no such process exists, a list of options is provided in the resource page that accompanies the MSF.

Monitoring tracks the actual performance against the agreed objectives and plans. It includes collecting data on the programme processes and results and recommending corrective measures to the plan. Monitoring is a continuous activity that should occur at each stage and level: policy level, project design, planning and implementation stage. It focuses on inputs, activities, outputs, implementation processes, continued relevance, progress and likely results at outcome level and alerts managers to problems and provides options for corrective action.

Evaluation is a periodic, in-depth analysis of a programme (using quantitative or qualitative methods) to assess systematically and objectively its relevance, performance and success. Evaluation is undertaken selectively to answer specific questions to guide decision-makers and programme managers and to provide information on whether inputs to programme development were valid, what worked and what did not work and why. It aims to determine the relevance, efficiency, effectiveness, impact and sustainability of a programme. Evaluations rely on data collected during monitoring activities as well as information obtained from other sources (e.g. studies, research, in-depth interviews, focus groups discussions, surveys etc.) Evaluations are typically carried out in the middle and at the end of a project and can be conducted by an external evaluator.

**Process:**
1. Bring together the process and outcome indicators for each target agreed in steps 1-3b

2. Track the progress towards the goals of the MSF using questions such as:
   a. Is the current SRMNH package of care still correct and does it respond to what women need?
   b. Does the role of the midwife cover the services agreed for her to provide?
   c. Is the midwife-led model of care fully functional and meeting expectations at the levels it is being made available?
   d. Are midwifery services available, accessible, acceptable and of the agreed quality?
   e. Are midwives available at the agreed levels in the health system and in the agreed numbers?
   f. Is the midwifery education system developing the agreed numbers of midwives with the agreed knowledge, skills and attitudes?
   g. Is midwifery regulation supporting the agreed levels of safety and protection in midwifery services and are the roles and responsibilities of those involved defined and effectively carried out.
   h. Is the enabling environment available, to the agreed standards with regard to the facility, the referral system, professional support and development and a respectful environment for care seekers and care providers?
   i. Has a midwives association been established or supported to increase its capabilities?

3. Identify the successes and failures, the supporting factors and the barriers to success of all the agreed targets to identify patterns and links.

4. Discuss lessons learned and solutions and agree how and where to adapt and strengthen the programme.

5. Re-set the process and outcome indicators to collect data for the next M&E cycle.

With this M&E step the first cycle of the MSF is concluded. However, continued monitoring of the midwifery services and their adaptation to population needs and health system capacity is a crucial part of success. M&E cycles should therefore be continuous, even when midwifery services are fully established and functional.