

THE STATE OF THE  
**WORLD'S MIDWIFERY**

2014

A UNIVERSAL  
PATHWAY.  
A WOMAN'S RIGHT  
TO HEALTH



REPRODUCTIVE HEALTH



PREGNANCY



CHILDBIRTH



POSTNATAL

# CONTRIBUTORS AND ACKNOWLEDGEMENTS

## STEERING COMMITTEE

**Co-chairs:** Frances Day-Stirk, Laura Laski, Elizabeth Mason.

**Members:** Jean Barry, Benedict David, Luc de Bernis, Peter Johnson, Louise Holly, Tina Lavender, Gillian Mann, Betsy McCallon, Anders Molin, Arulkumaran Sabaratnam, Carole Presern, Simon Wright.

## CORE GROUP

**Coordinator:** Luc de Bernis

**Members:** Jim Campbell, Catherine Carr, Sheena Currie, Caroline Homer, Petra ten Hoop-Bender, Peter Johnson, Zoë Matthews, Fran McConville, Nester Moyo, Mwansa Nkowane, Grace Omoni, Francisco Pozo-Martin, CN Puradane, Amani Siyam, Laura Sochas.

## COUNTRY SURVEY, DATA ANALYSIS AND TECHNICAL SUPPORT

**UNFPA:** Luc de Bernis, Susana Edjang.

**Secretariat:** *ICS Integrare, University of Southampton, University of Technology Sydney:* Aferdita Bytyqi, Jim Campbell, Vincent Fauveau, Stephanie Fletcher, Maria Guerra-Arias, Caroline Homer, Sofia Lopes, Zoë Matthews, Joanne McManus, Andrea Nove, Francisco Pozo-Martin, Anna Rayne, Hishiv Shah, Laura Sochas, Andrew Tatem, Petra ten Hoop-Bender.

**Technical contributions:** Edson Araújo, Deborah Armbruster, Albert Arnó, Patsy Bailey, Jean Ball, David Benton, Ismat Bhuiya, Ties Boerma, Jim Buchan, Amos Channon, Asiful Haidar Chowdhury, Laurence Codjia, Mario Dal Poz, Kim Dickson, Gilles Dussault, Tim Evans, Lynn Freedman, Sennen Hounton, Louise Hulton, Marge Koblinsky, Teena Kunjumen, Mandy La Fleur, Thierry Lambrechts, Christophe Lemièrre, Jacqueline Mahon, Adriane Martin-Hilber, Laura Matthews, Allisyn Moran, Sarah Neal, Juliette Puret, Kathrin Radke, Charlotte Renard, Rachel Sanders, Susheela Singh, Jeff Smith, Ann Starrs, Wim Van Lerberghe, Marie Washbrook.

**Country contributions:** Many thanks to the heads of the UNFPA and WHO country offices, their staff, and the people that coordinated, completed, and verified responses to the *State of the World's Midwifery* country survey. In particular, thanks to the country focal points: Hissani Aboubacar, Kodjovi Edotsè Adjeoda, Anna af Ugglas, Jamil Ahmed, Guy C. Ahialegbedzi, Arlette Akoueikou, Fernanda Alves, Mary Nana Ama Brantuo, Nazira Artykova, Zulfia Atadjanova, Amalia Ayala, Farid Babayev, Radouane Belouali, Jeannette Biboussi, Zainab Blell, Malin Bogren, Edith Boni Ouattara, Rayana Bou Haka, François Busogoro, Gillian Butts-Garnett, Felister Bwana, Jean-René Camara, Alicia Carbonell, Jose Manuel Carvalho, Rene Alberto Castro, Ahmed Chahir, Maria José Costa, Thierno Ousmane Coulibaly, Hironcina Cucubica, Evelyne Degraff, Pilar de la Corte Molina, Saliou Dian Diallo, Sadio Diarra, Aicha Djama, Dudu Dlamini, Javier Dominguez, Dat Van Duong, Marie Sheyla Durandisse, Musu Duworko, Henriette Eke Mbula, Hala El Hennawy, Kerstin Erlandsson,

Nicole Eteki, Mahamat Malloum Fatime, Feruza Fazilova, Rustini Floranita, Monica Fong, Daniel Frade, Paul Francis, Suzie Francis, Dina Gbenou, Rodolfo Gomez, Kemal Goshliyev, Raymond Goula, Nada Hamza, Fredrica Hanson, Sharifullah Haqmal, Gilbert Hiawalyer, Grace Hiwa, Bang Thi Hoang, Aboubacar Inoua, Bakary Jargo, Theopista John Kabuteni, Elizabeth Kalunga, Leonard Kamugisha, Selly Kane Wane, Trevor Kanyowa, Bahtygl Karryeva, Stoele Patricia Keba, Magdy Khaled, Zareef Khanza, Kyu Kyu Khin, Eunyoung Ko, Ibroh Kouboura Abba Moussa, Alhagie Kolley, Sathyanarayana Kundur, Busisiwe Kunene, Mohammed Lardi, Joyce Lavussa, Dorothy Lazaro, Ana Leitão, Amadou Ouattara Liagui, Ornella Lincetto, Elvira Liyanto, Jean-Pierre Lokonga, Fernanda Lopes, Achu Lordfred, Juliana Lunguzi, Primo Madra, Yolande Magonyagi, Agnes Makoni, Sarai Bvulani Malumo, Margaret Mannah-MacCarthy, Lucy Sejo Maribe, Michel Mbemba Moutounou, Pauline McNeil, Yordanos Mehari, Willam Michel, Michaela Michel-Schuldt, Happiness Mkhathswa, Kuban Monolbaev, Maria Mugabo, Khin Aye Myint, Azzah Nofly, Daphrose Nyirasafali, Geoffrey Okumu, Mohamed Boubacar Ould Abdel Aziz, Taiwo Oyelade, Haydee Padilla, Anchita Patil, Jiong Peng, Sano Phal, Zulfia Pirova, Philderald Pratt, Maria Quaresma Dos Anjos, Ginette Josia Rabefitia, Nargis Rakhimova, Thabelo Ramatlapeng, Masy Harisoa Ramilirijaona, Rabiatu Sageer, Mahamoud Said, Geneviève Saki-Nekouressi, Elfeky Samar, Aminata Seguetio, Olive Sentumbwe, Alejandro Silva, Nurgul Smankulova, Sokun Sok, Gracia Subiria, Areej Taher, Fatim Tall, Kabo Tautona, Afrah Thabet, Meera Thapa Upadhyay, Luwam Teshome, Augusto Viegas, Chumen Wen, Souleymane Zan, Aoua Zerbo, Assefash Zehaie.

A full list of the names of all those who contributed is available on page 198 of this report.

**COMMUNICATIONS AND MEDIA:** Cole Bingham, Amy Boldosser-Boesch, Julie Cornell, Adam Deixel, Christian Delsol, Etienne Franca, Rachel Haynes, Louise Holly, Ian Hurley, Cathrin Jerie, Omar Kasrawi, Mandy Kibel, Etienne Leue, Ann LoLordo, Joy Marini, Brigid McConville, Patrick McCrummen, Lori Lynn McDougall, Lothar Mikulla, Michelle Park, Sruti Ramadugu, Charlene Reynolds, Alanna Savage, Marta Seoane Aguilo, Ann Starrs, Petra ten Hoop-Bender, Veronic Verlyck, Julia Wiklander.

**DESIGN, LAYOUT AND PRINTING:** Prographics, Inc.

**TRANSLATIONS:** Michel Coclet, Mohammed Khawam

**FINANCIAL SUPPORT:** Bill & Melinda Gates Foundation, Foreign Affairs, Trade and Development Canada, Johnson & Johnson, Maternal and Child Health Integrated Program, United States Agency for International Development, Ministry of Foreign and European Affairs (France), Norwegian Agency for International Development, Swedish International Development Cooperation Agency, United Nations Population Fund.

Our appreciation is extended to ICS Integrare and Prographics, Inc. for their support in the research, development, writing and production of the report, and all accompanying materials.

## ABBREVIATIONS AND ACRONYMS

<b>AAAQ</b>	availability, accessibility, acceptability and quality
<b>AVD</b>	assisted vaginal delivery
<b>B-EmONC</b>	basic emergency obstetric and newborn care
<b>C-EmONC</b>	comprehensive emergency obstetric and newborn care
<b>CHW</b>	community health worker
<b>CMDP</b>	Community-based Midwifery Diploma Programme
<b>EC</b>	emergency contraception
<b>EmONC</b>	emergency obstetric and newborn care
<b>GIS</b>	geographic information system
<b>GPS</b>	Global Positioning System
<b>HCPAs</b>	health-care professional associations
<b>HRH</b>	human resources for health
<b>ICM</b>	International Confederation of Midwives
<b>ICN</b>	International Council of Nurses

<b>ISCO</b>	International Standard Classification of Occupations
<b>MDG</b>	Millennium Development Goal
<b>MMR</b>	maternal mortality ratio
<b>NMR</b>	neonatal mortality rate
<b>MNH</b>	maternal and newborn health
<b>NGOs</b>	non-governmental organizations
<b>PMNCH</b>	The Partnership for Maternal, Newborn & Child Health
<b>SRMNH</b>	sexual, reproductive, maternal and newborn health
<b>SoWMY</b>	State of the World's Midwifery
<b>STIs</b>	sexually transmitted infections
<b>TBA</b>	traditional birth attendants
<b>UNFPA</b>	United Nations Population Fund
<b>UHC</b>	universal health coverage
<b>WHO</b>	World Health Organization

**Cover photos** (left to right): Viviane Fortaillier, Viviane Fortaillier, ICM/Liba Taylor, Save the Children

# A UNIVERSAL PATHWAY. A WOMAN'S RIGHT TO HEALTH

<b>Foreword</b>	<b>ii</b>
-----------------	-----------

<b>Executive Summary</b>	<b>iii</b>
--------------------------	------------

## CHAPTER 1 INTRODUCTION 1

About this report	3
-------------------	---

## CHAPTER 2 THE STATE OF MIDWIFERY TODAY 5

Evidence of progress	5
Availability	12
Accessibility	16
Acceptability	22
Quality	24
Summary	31

## CHAPTER 3 MIDWIFERY2030 33

Looking towards 2030	33
Drivers of health, health systems and health financing	34
<i>Midwifery2030: A pathway for policy and planning</i>	36
Realizing the pathway	36
Building from country findings	42
<i>Midwifery2030: Inspiring global action</i>	45

## CHAPTER 4 COUNTRY BRIEFS 49

How to read the country brief	50
-------------------------------	----

<b>State of the World's Midwifery Country Survey Respondents</b>	<b>198</b>
--	------------

<b>References</b>	<b>201</b>
-------------------	------------

<b>Annexes</b>	<b>205</b>
----------------	------------

<b>1 Glossary</b>	<b>205</b>
<b>2 General methodology</b>	<b>208</b>
<b>3 Methodology for modelling effective coverage of the essential interventions for sexual, reproductive, maternal and newborn health care</b>	<b>209</b>
<b>4 Estimating women's and newborns' need for the 46 essential interventions</b>	<b>212</b>
<b>5 Decision rules</b>	<b>216</b>
<b>6 Mapping of subnational distributions of populations, women of reproductive age, pregnancies and live births</b>	<b>217</b>
<b>7 Tasks within the scope of midwifery professionals according to the International Standard Classification of Occupations</b>	<b>218</b>

## BOXES

<b>1</b> Three-year direct-entry midwifery education introduced as Bangladesh recognizes professional midwives	7
<b>2</b> Examining the midwifery workforce through the lens of effective coverage	10
<b>3</b> The geography of SRMNH: advances in geo-information systems	17
<b>4</b> Emergency obstetric and newborn care: from designation to readiness	19
<b>5</b> Reaching the poorest 40%	20
<b>6</b> Country actions in Afghanistan, Sierra Leone and Togo	21
<b>7</b> Respectful care in maternity services	22
<b>8</b> Ensuring acceptability of service through accountability	25
<b>9</b> Drivers and changes in health	35
<b>10</b> Protecting the public: a renewed paradigm	40
<b>11</b> The impact of investing in family planning	44
<b>12</b> Midwives: a "best buy" for primary health care	45

## TABLES

<b>1</b> ACTIONS reported by countries that relate to the BOLD STEPS identified in <i>SoWMy 2011</i>	6
<b>2</b> Reasons why women do not seek care or feel uncomfortable about seeking care	23
<b>3</b> How <i>Midwifery2030</i> responds to the key findings from <i>SoWMy 2014</i>	42
<b>4</b> Global initiatives and objectives in sexual, reproductive, maternal, newborn and child health	48

## FIGURES

<b>1</b> Key indicators for maternal and newborn health and the health workforce in 73 of 75 Countdown countries	2
<b>2</b> Pregnancies in 73 countries (1950-2099)	8
<b>3</b> Number of sexual, reproductive, maternal and newborn health visits needed, by WHO region [2012]	8
<b>4</b> Midwifery workforce: Projected need of full-time equivalent workers to deliver sexual, reproductive, maternal and newborn health services	9
<b>5</b> Midwifery workforce: Distribution in 73 countries, and by WHO region	11
<b>6</b> Midwifery workforce: roles and tasks	12
<b>7</b> Midwifery workforce: headcount versus full-time equivalent	13
<b>8</b> Percentage leaving the workforce voluntarily each year, by cadre	14
<b>9</b> Perceptions among survey respondents of the comparative attractiveness of a career as a midwife (73 countries)	15
<b>10</b> Average monthly starting salary per cadre of health worker (international \$ purchasing power parity, 2012)	15
<b>11</b> Minimum number of births to be conducted under clinical supervision	26
<b>12</b> Regulation and licensing of midwives	28
<b>13</b> Functions and responsibilities of regulatory bodies	29
<b>14</b> B-EmONC signal functions: midwives' authorized and actual roles	29
<b>15</b> Functions of professional associations open to midwives	30
<b>16</b> Midwifery workforce: from availability to quality	32
<b>17</b> Projected change in population need for SRMNH visits between 2012 and 2030, by WHO region	34
<b>18</b> Key features of first-level and next-level midwifery care	37

# Foreword



The world has reached a turning point for women's and children's health. We can now celebrate the fact that maternal, neonatal and child mortality rates are at their lowest levels in history. We are poised for even greater progress thanks to the *Every Woman Every Child* initiative, our progress toward achieving the Millennium Development Goals, as well as the ongoing discussions regarding a set of global sustainable development goals to succeed the Millennium Development Goals after their target completion date of 2015.

This report links two specific areas of focus that I care deeply about: first, maternal and newborn health, and second, the overarching principles and values of the post-2015 development agenda, providing new evidence for decision-makers.

The midwifery workforce, within a supportive health system, can support women and girls to prevent unwanted pregnancies, provide assistance

throughout pregnancy and childbirth, and save the lives of babies born too early.

With leadership and resources, the world can prevent the vast majority of avoidable yet tragically common losses of life and address the vicious cycle of impoverishment that ensues.

The *State of the World's Midwifery 2014* documents growing momentum since the first call to action in the 2011 report. Every year, more governments, professional associations and other partners are acting on the evidence that midwifery can dramatically accelerate progress on sexual, reproductive, maternal and newborn health and universal health coverage.

I fully support the Midwifery 2030 vision articulated in this report. This vision is within reach of all countries, at all stages of economic and demographic transition. Its implementation will help governments to deliver on women's right to health, ensure that women and newborn infants obtain the care they need, and contribute to our shared, global ambition to end preventable maternal and newborn deaths.

I commend this report to all those interested in joining the United Nations as we work towards the Midwifery 2030 vision and improve the future of women's and children's health.

**Ban Ki-moon**

Secretary-General of the United Nations



# Executive Summary

*The State of the World's Midwifery (SoWMy) 2014: A Universal Pathway. A Woman's Right to Health* takes its inspiration from the United Nations Secretary-General's *Every Woman Every Child* initiative and his call to action in September 2013 to do everything possible to achieve the Millennium Development Goals (MDGs) by 2015 and work towards the development and adoption of a post-2015 agenda based on the principle of universality.

*SoWMy 2014's* main objective, agreed at the 2nd Global Midwifery Symposium held in Kuala Lumpur in May 2013, is to provide an evidence base on the state of the world's midwifery in 2014 that will: support policy dialogue between governments and their partners; accelerate progress on the health MDGs; identify developments in the three years since the *SoWMy 2011* report was published; and inform negotiations for and preparation of the post-2015 development agenda.

*SoWMy 2014* focuses on 73 of the 75 low- and middle-income countries that are included in the "Countdown to 2015" reports. More than 92% of all the world's maternal and newborn deaths and stillbirths occur within these 73 countries. However, only 42% of the world's medical, midwifery and nursing personnel are available to women and newborn infants (hereafter 'newborns') in these countries.

Midwifery is a key element of sexual, reproductive, maternal and newborn health (SRMNH) care and is defined in this report as: the health services and health workforce needed to support and care for women and newborns, including sexual and reproductive health and especially pregnancy, labour and postnatal care. This enables analysis of the diverse ways in which midwifery is delivered by a range of health-care professionals and associate professionals.

*SoWMy 2014* has been co-ordinated by the United Nations Population Fund, the International Confederation of Midwives and the World Health Organization on behalf of government repre-



sentatives and national stakeholders in the 73 countries and 30 global development partners.

Tangible progress has been made in improving midwifery in many countries since the *SoWMy 2011* report: 33 of the 73 countries (45%) report vigorous attempts to improve workforce retention in remote areas; 20 countries (28%) have started to increase recruitment and deployment of midwives; 13 countries (18%) have prepared plans to establish regulatory bodies; and 14 (20%) have a new code of practice and/or regulatory framework. Perhaps the most impressive collective step forward is the improvement in workforce data, information and accountability, reported by 52 countries (71%).

The evidence and analysis in *SoWMy 2014* is structured by the four domains that determine whether a health system and its health workforce are providing effective coverage, i.e. whether women are obtaining the care they want and

It has been widely acknowledged that investing in a proficient, motivated midwifery workforce has a great impact on maternal and newborn health. (Jhpiego/Kate Holt)



Not all countries have a dedicated professional cadre focused on supporting women and newborns. (Mamaye Sierra Leone)

need in relation to SRMNH services. These four domains are: availability, accessibility, acceptability and quality.

**Availability:** *SoWMy 2014* provides new estimates of the essential SRMNH services needed by women and newborns. This need for services, in each country, can be converted into the need for the midwifery workforce.

Midwives, when educated and regulated to international standards, have the competencies to deliver 87% of this service need. However, midwives make up only 36% of the reported midwifery workforce: not all countries have a dedicated professional cadre focused on supporting women and newborns. Instead there is diversity in the typologies, roles and composition of health workers contributing to midwifery services, and many of these workers spend less than 100% of their time on SRMNH services.

The new evidence on diversity presented in *SoWMy 2014* can inform policy and planning. Firstly, the availability of the midwifery workforce and the roles they perform cannot be deduced from job titles. Secondly, the full-time equivalent midwifery workforce represents less than two thirds of all workers spending time on SRMNH services. Therefore, any analysis comparing

or correlating the midwifery workforce with SRMNH outputs/outcomes should take full-time equivalent staffing as the measure of availability.

The evidence identifies opportunities to: align job titles, roles and responsibilities; strengthen linkages between education and employment; improve efficiency; and assess and reduce high levels of turnover and attrition. In particular, progress is required on the identity, status and salaries of midwives, removing gender discrimination and addressing the lack of political attention to issues which only affect women.

**Accessibility:** Although nearly all of the 73 countries recognize the importance of financial accessibility and have a policy of offering at least some essential elements of SRMNH care free of charge at the point of access, only 4 provide a national “minimum guaranteed benefits package” for SRMNH that includes all the essential interventions. Gaps in the essential interventions include those known to reduce the four leading causes of maternal mortality: severe bleeding; infections; high blood pressure during pregnancy (pre-eclampsia and eclampsia); and unsafe abortion.

Lack of geographical data on health facilities and midwifery workers precludes reliable assessment of whether all women have access to a health worker when needed. Improving accessibility requires making all urban and rural areas attractive to health workers, and ensuring that all barriers to care, including lack of transportation, essential medicines and health-care workers, are removed.

**Acceptability:** Most countries have policies in place to deliver SRMNH care in ways that are sensitive to social and cultural needs. However, data on women's perceptions of midwifery care are scarce, and countries acknowledge the need for more robust research on this topic. Contributors to the *SoWMy 2014* workshops noted that the issue of acceptability is strongly linked to discrimination and the status of

women generally, both as service users and health workers.

**Quality** of both care and care providers can be increased by improving the quality of midwifery education, regulation and the role of professional associations. *SoWMy 2014* indicates that although the curricula in most countries are appropriate and up-to-date, pervasive gaps

remain in education infrastructure, resources and systems, particularly for direct-entry midwifery programmes.

Nearly all of the 73 countries have a regulatory infrastructure for midwifery, with prescribed standards for midwifery education, including in the private sector. Quality of care would be further strengthened by licensing/re-licensing systems that



## KEY MESSAGES

### The report shows that:

- The 73 Countdown countries included in the report account for more than **92% OF GLOBAL MATERNAL AND NEWBORN DEATHS AND STILLBIRTHS** but have only **42% OF THE WORLD'S MEDICAL, MIDWIFERY AND NURSING PERSONNEL**. Within these countries, workforce deficits are often most acute in areas where maternal and newborn mortality rates are highest.


- ONLY 4 OF THE 73 COUNTRIES** have a midwifery workforce that is able to meet the universal need for the 46 essential interventions for sexual, reproductive, maternal and newborn health.


- Countries are endeavouring to expand and deliver equitable midwifery services, but **COMPREHENSIVE, DISAGGREGATED DATA** for determining the availability, accessibility, acceptability and quality of the midwifery workforce **ARE NOT AVAILABLE**.
- Midwives who are educated and regulated to international standards can provide **87% OF THE ESSENTIAL CARE** needed for women and newborns.


- In order for midwives to work effectively, **FACILITIES NEED TO BE EQUIPPED TO OFFER THE APPROPRIATE SERVICES**, including for emergencies (safe blood, caesarean sections, newborn resuscitation).
- Accurate data on the midwifery workforce enable countries to plan effectively. This requires **A MINIMUM OF 10 PIECES OF INFORMATION THAT ALL COUNTRIES SHOULD COLLECT**: headcount, percentage time spent on SRMNH, roles, age distribution, retirement age, length of education, enrolments into, attrition and graduation from education, and voluntary attrition from the workforce.
- Legislation, regulation and licensing of midwifery allow midwives to provide the high-quality care they are educated to deliver and thus protects women's health. High-quality midwifery care for women and newborns saves lives and **CONTRIBUTES TO HEALTHY FAMILIES AND MORE PRODUCTIVE COMMUNITIES**.


- The returns on investment are a "best buy":

  - Investing in midwifery education, with deployment to community-based services, could yield a **16-FOLD RETURN ON INVESTMENT** in terms of lives saved and costs of caesarean sections avoided, and is **A "BEST BUY" IN PRIMARY HEALTH CARE**.
  - Investing in midwives frees doctors, nurses and other health cadres to focus on other health needs, and contributes to achieving a grand convergence: reducing infections, **ENDING PREVENTABLE MATERNAL MORTALITY** and **ENDING PREVENTABLE NEWBORN DEATHS**.

require the midwifery workforce to demonstrate continuing professional development.

The ultimate goal of professional associations is to foster a dynamic, collaborative, fit-for-purpose, practice-ready team of health-care professionals who are responsive to the needs of women and children. Although almost all countries have at least one professional association for midwives, nurse-midwives or auxiliary midwives, their role in quality improvement could be strengthened if they were enabled to contribute to policy discussions and key decisions affecting midwifery services.

There are substantial gaps in effective coverage in both the availability and quality dimensions. Reducing these gaps requires the collection and better use of workforce data and leadership to prioritize midwifery and release resources to support workforce and service planning. The minimum 10 data elements required for health workforce planning are: headcount, percentage time spent on SRMNH, roles, age distribution, retirement age, length of education, enrolments into, attrition and graduation from education, and voluntary attrition from the workforce.

**Midwifery2030:** Quality midwifery care is central to achieving national and global priorities and

securing the rights of women and newborns. *SoWMy 2014* has developed *Midwifery2030* as a pathway for policy and planning. Starting from the premises that pregnant women are healthy unless complications, or signs thereof, occur, and that midwifery care provides preventive and supportive care with access to emergency care when needed, it promotes woman-centred and midwife-led models of care, which have been shown to generate greater benefits and cost savings than medicalized models of care.

*Midwifery2030* focuses on increasing the availability, accessibility, acceptability and quality of health services and health services and health providers to achieve the three components of universal health coverage (UHC): reaching a greater proportion of women of reproductive age (increasing coverage); extending the basic and essential health package (increasing services); while protecting against financial hardship (increasing financial protection). Central to this are an enabling policy environment that supports effective midwifery education, regulation and association development, and an enabling practice environment that provides access to effective consultation with and referral to the next level of SRMNH services. This should be underpinned by effective management of the workforce, including professional development and career pathways.

Implementing the recommendations of *Midwifery2030* can lead to significant returns on investment. A value for money assessment in Bangladesh reviewing the education and future deployment of 500 community-based midwives ranked positively for economy, efficiency

Midwives can offer woman-centred and supportive care that goes beyond childbirth.  
(World Vision/  
Sopheak Kong)



预览已结束，完整报告链接和二维码如下：

[https://www.yunbaogao.cn/report/index/report?reportId=5\\_20109](https://www.yunbaogao.cn/report/index/report?reportId=5_20109)

