Strengthening quality midwifery education

WHO Meeting Report
July 25–26 2016

In support of
Global Strategy for Women’s, Children’s and Adolescents’ Health 2016–30
Global Strategy for Human Resources for Health: Workforce 2030
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Executive Summary

Strengthening quality of care, the SDGs and midwifery education

The purpose of this two-day meeting, convened by WHO at the University of Dundee, was to bring partners together to hold the first global conversation in the new SDG era on how we can strengthen midwifery education to improve quality of care for women, newborns and their families.

SDG 3: Supporting implementation of two complementary global strategies

Recognising the unique opportunity to continue to strengthen existing achievements throughout the 15-year period of the SDGs, the meeting participants focussed on two complementary strategies which set out ambitious objectives and actions to ensure women, newborns and their families not only survive, but thrive and transform. These are the Global Strategy for Women’s, Newborn’s and Adolescents’ Health 2016–30 (1) and The Global Strategy for Human Resources for Health: Workforce 2030 (2). Improving quality of care (QoC) is critical to achieving the objectives of both these global strategies.

Increasing evidence that inadequate midwifery education is resulting in poor QoC

The meeting was convened in the context of increasing evidence to indicate that a consistent barrier to the provision of quality midwifery care is inadequate midwifery education, often reduced to a matter of weeks without qualified faculty and lacking in practical application (3). There are potential links between poor education, poor clinical care and mistreatment of women in facilities (3). The State of the World’s Midwifery Report (SOWMy) 2014 (4) notes that of the 73 countries from which data were gathered, only four countries have the workforce numbers to provide the care needed by women in their reproductive years, and by newborns. In response to these gaps and barriers, Bharj et al (2016) (5) set out a new “agenda” to improve the quality of midwifery education. The evidence and the new “agenda” justify the focus on development of a new, collective, global, 15-year approach to action on midwifery education.

Objectives

The objectives of the meeting were threefold:

i. to draft a coherent approach through which to strengthen evidence-based midwifery education,

ii. to review existing monitoring and evaluation frameworks for quality midwifery education,

iii. to agree a collective division of roles and responsibilities on how best to implement, monitor and evaluate the above.

The meeting was facilitated using a highly active and participatory methodology. Everyone played their part.
Outcome of the consultation: 5 urgent actions agreed, with responsibilities allocated:

i. A “Global Platform for Action” to be established (with a steering committee/steering group for midwifery education, name tbc), with potential for regional and country platforms to follow: WHO to coordinate collective action.

ii. A “Global Strengthening Midwifery Education Action Plan 2016–30”, to include monitoring and evaluation to be drawn up: Stakeholders of the Platform for Action to take the lead.

iii. Global mapping of two key areas:
   — Mapping of midwives educated to International Confederation of Midwives (ICM) Midwifery competencies, to be based on the ICM definition of a midwife and the ICM essential competencies for basic midwifery practice: To be determined with ICM.
   — Mapping of existing education materials amongst partners, with potential for developing a global midwifery education toolkit: Jhpiego and University of Manchester to initiate action.

iv. Evidence based ICM updated competencies to be drawn up (in process) to ensure alignment with the evidence from the Lancet Series on Midwifery and the two global strategies mentioned above: WHO, University of Dundee and TBD with ICM.

v. Leadership roles and responsibilities for key partners at global, regional and country levels to be clarified to support a collective, unified midwifery position and voice: UNFPA to coordinate collective action.

Participants agreed on 5 longer term actions:

vi. Research evidence and dissemination: develop a synthesis of available and on-going research and evidence on midwifery education to guide investment at all levels. Develop a system for easy dissemination and access, such as a Maternal and Newborn Education Resource System (MANERS).

vii. Advocacy: ensure midwifery education is part of the emerging WRA-WHO-ICM Global Midwifery Advocacy Strategy, and link advocacy on education to other ongoing advocacy platforms.

viii. Human rights based approach: further develop a rights-based approach to drive improvements in midwifery education.


x. Gender analysis: develop a gender analysis of midwifery to identify gender transformative actions that will help overcome, the professional, economic and socio-cultural barriers to the provision of quality midwifery care.
Supporting the implementation of the Global Strategies for Women’s, Newborn’s and Adolescents’ Health 2015–2030, and Human resources for health: Workforce 2030.

1.1 Background

Significant achievements have been made over the past few decades in reducing maternal and newborn mortality and morbidity (6). Under Sustainable Development Goal (SDG) 3, two complementary strategies set out ambitious objectives and actions to ensure continuing improvements in the health and well-being of women, newborns and their families, so as to ensure that they can not only survive, but thrive and transform. These are the Global Strategy for Women’s, Newborn’s and Adolescents’ Health 2016–30 (1) and The Global Strategy for Human Resources for Health: Workforce 2030 (2).

The Lancet Series on Midwifery (7) sets out the evidence base for what women and newborn’s need. It defines midwifery as “skilled, knowledgeable and compassionate care for childbearing women, newborn infants and families”. All women and their babies need midwifery care, irrespective of whether, or not, they are experiencing an uncomplicated pregnancy, birth and post-natal period, or require emergency or specialist medical obstetric and/or neonatal care.

There is increasing evidence to indicate that a consistent barrier to improving maternal and newborn health has been the poor Quality of Care (QoC) provided by midwives, nurses, doctors and other health workers. In a systematic mapping of barriers to the provision of quality care by midwifery personnel, the issue of poor midwifery education, which is often reduced to a matter of weeks without qualified faculty and lacking in practical application, was identified as a major constraint (3). The State of the World’s Midwifery Report (SOWMy) 2014 (4) notes that of the 73 countries from which data was gathered, only four countries have the workforce capacity to provide the care needed by women in their reproductive years, and to provide care for newborns. Additionally, many of the education programmes described, lack basic training such as infection prevention and respectful care, leading to possibilities of links between poor education, poor clinical care, sepsis, and mistreatment of women in facilities (3). Barriers to achieving high quality sustainable midwifery education programmes include economic and political restrictions to exercise the full scope of midwifery practice, and social and cultural norms which mitigate against women’s rights, education and employment (8). The result of this is that, the preparation of practitioners and provision of maternal and neonatal care are variable, across and between low, middle and high resource countries.

Positive efforts to improve quality education have been made by many partners under the leadership of ICM, FIGO and IPA, and through UN agencies, donors and foundations, and major international and national NGOs. However, educators (midwives, nurses and doctors) remain challenged in providing learning opportunities to ensure that future practitioners acquire necessary practical competencies to deliver quality maternal and neonatal care. In response to these gaps and barriers, Bharj et al (2016) (5) have set out a new “Agenda” to improve the quality of education. This includes developing intensive, sustainable collaborations between education programmes, practice settings, and government systems for supporting midwifery education. The evidence and the new “agenda” justify the
focus on urgent development of a new, collective, global, 15-year approach to action on midwifery education. There is now a unique opportunity to support the implementation of the two global strategies 2016–30, through improving midwifery education from the start of the SDG era. Together, we can help guide governments and partners as they strengthen education for all those who provide midwifery services. This will enable fulfilment of the right to quality care for all women, newborns and their families: to ensure that they survive, can thrive and that their lives can be transformed.

Quality midwifery care and 2 Global Strategies

Purpose of meeting
The purpose of convening this two-day meeting was to hold the first global conversation in the new SDG era, on how to strengthen midwifery education to improve quality of care for women, newborns and their families over the 15-years of the two global strategies (see above).

Objectives
The objectives of the meeting were to:

i. Draft a coherent approach through which to strengthen evidence-based midwifery education.

ii. Review existing monitoring and evaluation frameworks for quality midwifery education and determine what may be required for accountability in support of SDG 3.

iii. Agree a collective division of roles and responsibilities on how best to implement, monitor and evaluate the above.
1.1 Introduction

The meeting was formally opened by Shona Robison, the Cabinet Secretary for Health, Scotland. The Cabinet Secretary welcomed the participants to the meeting and to Scotland, and described Scotland’s strong history of leadership, research and political support in improving maternal and child health through midwifery. This included Scotland’s historical and ongoing collaboration on midwifery in Malawi, currently involving support to 60 qualified midwives. The critical role of midwives at the centre of quality care for women and newborns in all countries was emphasised, with Scotland continually reviewing standards of care and developing a national “Quality Improvement Collaborative”. This was reinforced by the words of the UN Secretary General, Ban Ki-moon, emphasising the need for “the right care for every woman and every newborn, everywhere”. The Cabinet secretary closed by wishing the group every success in the meeting.

‘All women require good quality services and midwives are at the heart of this and have been in Scotland for more than 100 years.’

1.2 Meeting objectives and setting the scene:

Purpose and objectives

The purpose and objectives of the meeting were discussed and agreed without revision. There was consensus that midwifery education should remain the focus (whilst acknowledging wider issues of regulation and strengthening associations) and that midwifery education would be approached in the context of the two global strategies developed under WHO leadership:

— The Global Strategy for Women’s, Children’s and Adolescents’ Health 2016–2030 (1)
— The Global strategy on human resources for health: Workforce 2030 (2)

It was agreed that, by the end of the meeting, the following should be achieved:

i. Priorities for the development of a coherent approach to midwifery education identified.

ii. How progress in midwifery education could be measured through improved monitoring and evaluation, starting from where we are now, considering where we are going, and where we want to be in 15-years explored.

iii. Next steps to develop unified voice on, and take collective action, to improve midwifery education.

‘Working together to achieve what we want to see’.
‘We need to identify what our concrete practical steps need to be.’

1.3 Setting the scene for the next 15 years: a series of “Spark Talks”

Anthony Costello, Director, Department for Maternal, Newborn and Adolescent Health (MCA), WHO: The Global Strategy for Women’s, Newborn’s and Adolescents’ Health 2015–2030’:

Opening with a short film on the Global Strategy for Women’s, Children’s and Adolescents’ Health, Costello highlighted the focus on women and children’s health, and the
opportunities that now exist for midwives to be at the centre, and to take the power they need. An example of midwifery in Nepal was given; a place where auxiliary nurse-midwives (ANMs) are central to healthcare and to women’s and newborns’ lives. Costello described midwifery as unique in being relational, rather than hierarchical (as traditional medical care can be), and noted that the place of midwives in society reflect the status of women in society. Costello emphasised the public health function of midwives (or example in advocating breastfeeding), and questioned why there has been so little investment in midwifery. https://youtu.be/OFy4Rk9iUIk

Jim Campbell (via video link) Director, Department for Health Workforce: The Global Strategy for Human Resources for Health (HRH): Workforce 2030:

Campbell emphasised that the SDG era is one of opportunity and we need to push forward through an inter-sectoral lens to support the “leave no one behind agenda”. He stressed the need for better evidence to advance the cause and the ambition to improve health care for women, newborns and adolescents. The evidence in the Workforce 2030 agenda includes a process of “transformative education”. Campbell noted that although a three-year education programme for midwives may be the ultimate objective, not all countries are currently ready for that: the global midwifery community need to adapt education, for the current, as well as future needs of countries. Importantly, over 40,000 new jobs will be created in the health sector from 2016–2030, and these need to be developed to enable proper career progression. Midwives, for example, can be enabled to progress from bachelors to a master’s degree and a PhD to reach their full potential.

Petra ten Hoope Bender, UNFPA: Achievements in midwifery education from the perspective of the UNFPA:

Ten Hoope Bender explained how UNFPA collaborated with ICM in a midwifery programme from 2008–2013, and successfully increased collaboration at country level. There are now 65 countries where UNFPA has Policy Advisers supporting midwifery, 325 midwifery schools have been provided with skills laboratories and additional supplies and equipment, and 10,000 new midwives have been educated. The UNFPA bought together partners (including WHO, ICM and Jhpiego) in a Young Midwifery Leaders (YMLs) Symposium in May 2016, bringing a much-needed focus to the future of young midwifery leaders. Midwifery was emphasised as being at the core of the health workforce, as described in the State of the Worlds Midwifery Reports 2011 and 2014 (4). The evidence in the Lancet Series on Midwifery 2014 (7) has been critical to increased financial and technical support. These issues are all driving forward a new UNFPA midwifery strategy which will be finalised in 2016.

Sheena Currie, Sr Maternal health Adviser, Jhpiego: Achievements and challenges in midwifery education from the Jhpiego perspective:

Jhpiego supports midwifery education in many different settings, including improving quality of education using evidence based standards, developing competency based materials including curricula, learning packages and assessment tools and resources e.g. PSE framework.

Currie presented the example of achievements in Afghanistan. The participants learnt how working closely with the Ministry of Health in developing a comprehensive midwifery education system, improvements were made in the quality of education using evidence-based standards linked to an accreditation system. The midwifery faculty has been
strengthened and educational resources have been made available to staff. Political will and commitment were essential for these changes, and they have proved helpful for the retention of Community Midwives.

Common challenges experienced in countries include variations in scope of practice, quality of the clinical learning environment, and the influence of the unregulated private sector.

Address Malata, University of Malawi, and Kamuzu College of Nursing, WHO Collaborating Centre: Midwifery in Malawi:

Malata spoke of midwives being at the core of midwifery services and emphasised their important role in saving lives. The challenges facing midwifery in Malawi were explained: internal and external migration; high maternal mortality (675 per 100,000), and the quantity and quality of midwives. Malata said that the quality of education is particularly important. She noted that good midwives may not necessarily be good teachers, and that focus needs to be given to strengthening faculty. We heard how partnerships can be beneficial in improving education; however agendas must be aligned for maximum benefit to the host country.

‘We can make a real difference, working together, building on existing partnerships and developing further.’

Mwansa Nkowane, Focal point for Nursing and Midwifery, HWF Department, WHO – quality midwifery education and the “WHO Strategic Directions on Strengthening Nursing and Midwifery 2016–2020”:

Nkowane explained that nursing and midwifery programs needed strengthening. She said that consistency is a requirement to ensure that quality in nursing and midwifery is maintained. Currently, there are many different sets of educational standards for nurses and midwives. Nkowane emphasised the need to ensure quality education in midwifery, particularly through implementation of the WHO Midwifery Educator Core Competencies. She raised the need for improvements in education for educators and stressed the importance of progress in midwifery to align with the WHO “Strategic directions for nursing and midwifery 2016–20” (9).


Renfrew presented the evidence-informed QMNC Framework and noted its importance in setting out the evidence on the needs of women and babies globally (in contrast to what interventions will be provided as is typical in other quality frameworks). The QMNC evidence highlights that prevention of adverse outcomes is critical through organisation and continuity of care for all women and newborns, not only for the treatment of those who experience complications. All components of the QMNC should be considered together when thinking about quality of care. The scope of midwifery and the ICM Essential competencies for basic midwifery practice have been mapped and matched to the QMNC framework, and future research also needs be mapped to the QMNC Framework, to ensure that all aspects are covered.

‘Without midwifery the health system is struggling. Midwifery is pivotal to the approach’.
Fran McConville, Midwifery Adviser, MCA Department, WHO: Placing quality midwifery education in the Global Strategy for Women’s, Newborn’s and Adolescents’ Health 2015–2030:

McConville spoke of the three pillars of professional midwifery highlighted in the State of the World’s Midwifery Report 2011 (4); “Education, Regulation, and Association” (ERA), and highlighted how ERA is critical to the achievement of the two strategies mentioned (MCA and HRH). She visually presented the nine action areas from the Global Strategy for Women’s, Children’s and Adolescents’ Health in the context of midwifery. McConville showed that midwifery care is essential to the achievement of each action point, politically, technically, and strategically. McConville emphasised the need to ensure that norms and standards are evidence-based, along with the need for an economic and gender analysis of midwifery care, given that it is a predominantly female profession. She noted the essential role of monitoring, evaluation and accountability, building upon the indicators in two global strategies and the Lancet QMNC Framework, with particular emphasis on the dissemination of this information to midwifery personnel.

‘Research needs to be heard by midwives.’
1.4 Summary of key points from “spark talks”

The SDGs provide a unique opportunity for midwives to position themselves as the main providers of maternal and newborn care, and to take hold of power over the next 15 years, not wait for it to be given to them. Gender dimensions play a significant role in the ability to provide QoC, and need to be better understood and acted upon.

There is a need for more and better evidence that demonstrates how midwifery works in different contexts (most current midwifery research is from high income countries). A process for continuous monitoring and evaluation must be established. Quality of care requires a holistic, woman-centred and rights-based approach and an examination of the philosophies and values underpinning midwifery care provision.

We should continue to strengthen partnerships and resources to strengthen the quality of care that we want to see for all women and newborns. Strengthened leadership, governance and accountability are critical, and agendas between partners and governments must be aligned with the evidence.

There is a need for competency based curricula aligned to the evidence from the Lancet Midwifery QMNC Framework (7) and to the key issues in the two global strategies (1,2). This requires that the two global strategies are shared at regional and country levels from a midwifery education perspective. This will involve ministries of health and education, as well as midwifery education institutions, to enable them to build progressive, evidence based midwifery education in support of the implementation of the ambitious plans set out in the SDGs.

There is now an unprecedented opportunity to increase the professional role and socio-economic status of midwives in the implementation of the two global strategies.

‘Midwives need to be at the table, they need to be at ministries of health meetings, Midwives need to be present and represent.’

1.5 Group work activity: Where are we now? Opportunities and challenges:

Participants were divided into three groups to address three questions: See Annex 3 for details.

Group 1: Midwifery education: Quality midwifery education: existing best practice:
Where do we want to go? Optimising opportunities and meeting challenges over the next 15 years.

Group 2: Research: Research and innovation for quality midwifery education:
Where do we want to go? Optimising opportunities and meeting challenges over the next 15 years.

Group 3: WHO global strategies: Supporting two new global strategies; current strengths and gaps in quality midwifery education:
Where are we now? Where do we want to go? Optimising opportunities and meeting challenges.

1.6 Plenary Feedback

Group 1 Midwifery education: What would improved quality of midwifery education and training over the next 15 years look like, and how will we achieve this?

i. Where we are now: The ICM essential competencies for basic midwifery practice (in the process of being updated) and the two global strategies are in place, and future
midwifery education must reflect these. The current culture/pedagogy of learning is often unsupportive and in need of change, in particular, around clinical midwifery education. The role of clinical preceptors was described as undervalued, with practical, clinical midwifery education being undervalued and underfunded. Transparency and accountability are needed to demonstrate competency in clinical midwifery practice.

ii. **Barriers to progress**: The positive political pressure from governments to produce more midwives must be supported with investment in strengthening the capacity for providing quality midwifery education. Midwifery competencies are globally inconsistent, they include many different cadres, education pathways and scopes of practice in different countries and between different partners. The settings are variable and the contexts are challenging, for example some competencies may be achievable in one setting, yet may be aspirational in another. We should consider how best to support countries to achieve the “gold standards” over time, based on where they are currently. For example, there may be an urgent need to equip existing community health workers with essential midwifery skills before progressing to developing Bachelor level midwifery education that meets ICM standards. There is a tendency to assess tasks rather than competencies, and a culture shift is needed to make competency the focus.

iii. **Opportunities**: The Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030) (1) and the Lancet Midwifery Series (7) were cited as opportunities, along with the focus given, in the 2011 and 2014 SOWMy Reports (4) to competency-based education, regulation and association. The development of a competency based regional curriculum prototype was recommended for direct entry and other courses. The ICM Essential competencies for basic midwifery practice were identified as critical, but it was suggested that the ICM emphasis on a 3-year education programme in all settings needs review as not all countries are in a position to offer this currently. Partnerships are opportunities for collaboration and information sharing, and competing interests and unaligned education plans need to be addressed *apriori*. Engagement with The White Ribbon Alliance (WRA) global Respectful Maternity Care (RMC) campaign to develop advocacy on midwifery education provides a significant opportunity.

iv. **Discussion**: The poor quality of secondary and tertiary education of those who become midwifery students is a constraint that is wider than health. Midwifery does not always attract the best students, as midwives are perceived to have low professional and socio-economic status. Midwifery programmes need to respond to the capacity of each region; bridging courses or other preparation programs for students should be considered, as well as a review of the entry criteria to ensure high standards are sustained. Both nursing and midwifery need to have greater appeal and need to maximise those wanting to enter the profession. The most appropriate teaching methods for the regions should be considered, e.g. web-based education may be the best option, as in Somalia. The group said they believe there is a public misunderstanding of what a midwife is and what a midwife does. This misunderstanding means that the social and professional dimensions of midwifery are undervalued and under-researched.

**Group 2 Research: What would improvements in research to support quality midwifery education look like over the next 15 years, and how will we achieve this?**

i. **Where we are now**: There is a need to clarify with WHO what additional research is needed on midwifery education and to ensure new evidence is developed. Using the ICM Essential competencies for basic midwifery practice and the WHO Midwifery Educator Core Competencies (10), a framework for midwifery education research can
be established to be adapted for all regions. Research in midwifery needs to be led and coordinated by midwives. Capacity building of research-midwives is urgently needed. The education of educators must include research, and we must ensure that midwifery students are capable of appraising research and developing leadership in application of evidence. Monitoring and evaluation of progress towards improving midwifery education is a priority.

ii. **Barriers:** There are substantial gaps between research, evidence and current practice in midwifery education. We need to consider how research in midwifery education can be linked to the nine priority actions of the Global Strategy for Women’s, Children’s and Adolescents’ Health (1). There is a lack of evidence around monitoring and evaluation in midwifery education. The lack of retention of midwives in academic and/or research institutes is a barrier to improving capacity in midwifery research as skill transfer is not possible. The lack of financial support for midwifery research is also a critical barrier.

iii. **Opportunities:** Linking midwifery research to health systems and sexual and reproductive health agendas (i.e. research about women and newborns health, not only midwives) is an opportunity for research in quality midwifery education. Women’s groups can be engaged to build a consumer understanding of the need for quality midwifery education; this will encourage consumers to demand quality. Ongoing research can be an opportunity to build capacity on midwifery research skills. The term ‘Research’ needs to be used in its broader sense, not only referring to strict methodologies (e.g. RCTs). Opportunities for documenting processes and outcomes need to be used effectively, and experiences and learning shared.

> ‘We know what we don’t know’, we just need to work out what is going on, and use the evidence and the gaps identified in strategies.’

Research needs to be integrated into clinical practice and midwifery education coursework. Midwifery research role models could be utilised, as currently there are more midwives within research and with higher degrees than ever before. The two global strategies, initiatives and SDGs provide opportunities to support research; these can be built upon to drive the agenda forward. The Lancet Midwifery Series QMNC framework was cited as an opportunity to move forward on the research agenda.

iv. **Discussion:** Research is needed on the most effective pedagogical approach in midwifery education. The need to create a strong academic environment for quality education was emphasised, with a need to move beyond the small research projects that midwives currently manage. The need for developing midwifery leaders was highlighted; a suggested method was the addition to pre-service education of short courses on “Midwifery Leadership”. The evaluation of midwifery education policy and strategies, to ensure they are evidence based, is vital. WHO Collaborating Centres (CC’s) in Midwifery and allied topics could be used to conduct evaluations; this would strengthen the role and efforts of the collaborating centres. A health systems approach linking midwifery research to other outcomes (such as non communicable diseases) was suggested as helpful to encourage inter-professional and interdisciplinary research. The possibility of linking midwifery research to broader development issues was suggested as an avenue to pursue, as development budgets are often larger.

> ‘There are more opportunities currently than ever before, more of our workforce is in research, there is more funding in research, we have people’s attention, the atmosphere for midwifery research is positive and supportive right now.’
Group 3 WHO global strategies: What is needed to ensure that quality midwifery education supports the implementation of the “Global Strategy for Women, Children and Adolescents’ 2016–2030” and “Workforce 2030”, and how will we achieve this?

i. Where we are now: We need to understand better how midwifery education can support the implementation of the two new global strategies. A baseline (starting point) is needed from which progress will be measured. The need to protect ‘what we have where it works’ is important. Midwifery education needs to be communicated in the context of health systems strengthening, and to link not only to midwives but all cadres providing parts of midwifery care (i.e. nurses, doctors, auxiliary nurse-midwives etc). A common education agenda that all parties contribute to is needed. The Lancet QMNC Framework is a foundation, and all of the nine areas can be used as opportunities. Quality midwifery care requires teamwork, and strong midwifery leadership will be vital to further change, including overcoming institutional hierarchies.

ii. Barriers: The main barriers to overcome in the SDG period will be disparate midwifery leadership and limited health financing. These two components were described interdependent (i.e. stronger collective leadership would bring greater investment). Gender inequality is a prominent barrier, with the low status of nurses and midwives needing to be addressed amongst wider social and economic issues, as well as strengthening leadership skills. The separation of global maternal and newborn health programmes has been unhelpful. Women, newborns and their families must be considered together in strengthening the competencies required in midwifery education. A lack of dissemination of evidence and research to lower facility levels was noted.

iii. Opportunities: Opportunities mentioned in the feedback from the two previous groups also applied to this topic. In addition, it was agreed that engaging with healthcare professionals other than midwives, need be seen as an opportunity rather than a barrier. We need to work with all relevant professionals, as partners in a team as equals supporting our autonomy. Inter-professional learning must be used to promote this, educating students of all cadres together. The two global strategies are key opportunities to promote improvements in transformative, inter-professional education and better research. Regulation is critical to ensure accountability for the standard of care being provided. Interpretation and dissemination of evidence was suggested to be problematic. The development of an easily accessible, pre-critically appraised format of on-line research findings was suggested. This should build upon the model of MIDIRS (Midwives Information and Resource Service), and a global Maternal and Newborn Education Resource System was proposed (MANERS) was proposed.

iv. Discussion: Although the two key strategies are global, the need for them to be shared and discussed with midwifery educators at national and district level was emphasised. It is important to review the two global strategies pragmatically and consider how they could be utilised for education and research. The public perception of midwives roles could be improved, with the work of midwives being valued similarly to other cadres in their respective countries. Pay parity is critical. Midwifery education programmes must empower students, so that students are confident and autonomous before registration. To aid this further, quality mentorship after registration is needed as part of continuing education and support, and as a means to address the ‘steep learning curve’ midwives experience immediately after registration. The WHO CC’s should be used as the channels through which to disseminate easily accessible research; i.e. through the proposed MANERS (Maternal and Newborn Education Research System). Leadership was again cited as critical, with the need for nurses and midwives to ‘have a place at the table’. The group agreed that sharing effective leadership models is important.
1.7 Where do we want to go? Optimising opportunities and meeting challenges over the next 15 years

This discussion was structured by the questions in Annex 3 and was feedback in a plenary, using the fishbowl methodology.

The Fishbowl Activity

The fishbowl activity is used to manage group discussion. Instead of a large group having an open discussion about something, which can be difficult to handle and often only benefits a few active participants, a smaller group (ideally 3–6 people) sits, facing each other, in the centre of a wider circle of participants. Only the people in the centre can talk; people in the outer circle listen and form their own opinions. If they wish to add to the discussion, they can move to the centre and touch one of the central participants on the shoulder. This person must then withdraw from the centre and the “new” discussant takes their place. Fishbowls are helpful in focusing discussion and sharing opinions from a wide variety of perspectives. When working with a committed group, participants are usually self-regulating, and little facilitation is needed.

The group stated that there are many opportunities to be seized and that the future of midwifery education is optimistic. It was suggested that we need to meet the challenges ahead and keep focused on where we want to go. All three group areas (education, research and the HRH and MCA global strategies) must work together for maximum progress.

1.8 Key issues arising

The need for a clear and measurable 15-year SDG action plan on midwifery education

The “Strengthening Midwifery Education Action Plan 2016-30” will need to prioritise:

i. Competency based education:

- ICM Essential competencies for basic midwifery practice are the measurable target to be achieved in midwifery education over the 15-year SDG timeline.
- ICM competencies must be based on and reflect the evidence in the Lancet QMNC framework, the two global strategies and the evidence in WHO guidelines.
- The current update of the ICM competencies is an ideal opportunity to ensure alignment to the evidence and the two global strategies.
- Public health (for example breastfeeding, family planning, anti-microbial resistance, WASH, tobacco cessation), advocacy, gender equity, and rights for women and newborns, as well as for women providing the care, must become part of the curriculum, whilst ensuring core elements are not neglected.
- We need to develop guidance for countries on ‘stepping up and phasing in’ the ICM competencies, as some competencies may be aspirational in the immediate future in some settings. Some regions may require the standards to be simplified *apriori* to avoid bottlenecks. For areas lacking formal midwifery education programmes, we suggested that the Canadian model of up-skilling lay midwives could be a possible model.
The length of time it takes to educate a midwife to have the ICM competencies is currently variable, and we need research to better understand the evidence on how long is needed in what contexts to ensure practitioners have the competencies needed.

The process of competency improvement needs careful measurement and monitoring.

Private and public sectors need to be examined for midwifery education and accreditation models that could be transferred across regions.

ii. Building capacity in research, applying evidence and dissemination:

- Research is needed on what education methods are most effective in which settings.
- Dissemination of evidence is vital; we need to find the best way of communication.
- We must encourage the ‘demand side’ for better midwifery education and care from midwives, women (as consumers of the care), policy makers, and politicians.
- An interdisciplinary and inclusive method of research dissemination (MANERS: Maternal and Newborn Education Resource System) needs to be established.
- Mentorship for both recently registered midwives, and those completing post-graduate education, must be implemented.
- Supporting further learning and strengthening research can be achieved through partnerships, web-based learning, webinars and mentorship (remote or local).
- The role of the ICM’s Standing Committee on Research was discussed as a potential forum to drive research forward.

iii. Monitoring and evaluating progress in midwifery competencies: getting a baseline:

- Monitoring and evaluation of the use of the ICM competencies in education is essential.
- It was acknowledged that the definition of a midwife is not used consistently across countries, and the competencies of a midwife varied. We need to clarify who is a midwife, and what competencies other cadres are being educated with and where. This will require mapping the evidence on who is a midwife with the ICM competencies, and what competencies are being taught in different education institutes in various countries and regions.
- The mapping will provide a baseline from which to monitor and evaluate progress.
- The above will create advocacy opportunities for much needed midwifery leaders.

iv. The core elements of an investment plan (global, regional, national) and an economic analysis:

- Cost effectiveness: an analysis of the cost-effectiveness of midwifery for the provision of quality maternal and newborn care, is urgently needed for the development of an evidence based economic case for policy makers and ministers of finance. This must be calculated for midwifery globally, regionally and nationally.
The economic analysis will require defining precisely who is a midwife, and what other factors are involved (e.g. the enabling environment and ability to implement the full scope of midwifery practice).

The analysis will be based upon the Lancet QMNC framework.

Demonstrating cost-effectiveness through monitoring and evaluation is essential to encourage investment in midwifery education, quality of care improvements and midwifery research. We need to begin by considering how much it would cost for a midwife to reach the gold standard of the ICM competencies. For this, models from several countries can be used as case studies.

We must proceed with caution, as there is a risk of making midwives look like the cheaper option, instead of a better option for QoC. We must focus on ‘return on investment’.

v. A human rights approach:

By focusing on women’s rights and gender inequality, the need for improvements in midwifery education can be supported through the use of ‘human rights-based language’ around preventing avoidable maternal and newborn mortality and morbidity.

vi. Moving forward and improving advocacy:

A stepwise approach is needed.

The low social, economic and professional status of nurses and midwives need to be addressed.

Media and existing platforms will be used to clarify and promote the roles of nurses and midwives.

The White Ribbon Alliance (WRA) are helping midwives to ‘tell good life-saving stories’.

Midwives should take up leadership positions and put themselves in positions of respect if we want to improve advocacy for midwives and midwifery care.

vii. Address the gender inequality experienced by midwives in providing quality midwifery care:

Gender inequality in the provision of quality midwifery care must be addressed as part of broader health system strengthening and ensuring enabling environments.

Government support and investment in women and midwives are key.

This is about human rights – women’s and children’s rights – and we must develop a global movement to demand these rights: from and for governments, midwives and all the women who use midwifery services.

viii. Regulatory support:

A strong regulatory body is needed before significant changes in midwifery education can be made.

Links between regulatory bodies and national associations are essential.

‘Midwives can lead at any level, we can do anything and we have the responsibility to do it.’
2.1 Do we have a collective vision for strengthening midwifery education?

Plenary exercise

This session brought together views rising from the previous day’s deliberations. In summary, we identified many opportunities for strengthening midwifery education yet we agreed that, as countries are at different stages, there is no ‘one size fits all’. Leadership, at all levels, is key and there is a need to demonstrate the cost-effectiveness of the midwifery model when considering all elements of the Lancet QMNC framework. We must work out how can we build on the good work already achieved and drive forward our agenda over the next 15-years. The group analysed the following areas to assess whether we had a common vision:

i. What is the vision for strengthened midwifery education about?
   - Motivation, professionalism, autonomy.
   - Advocacy.
   - Setting evidence based standards and agreed competencies on the continuum of care and the life cycle approach.
   - Addressing rights, gender equity.
   - Promoting leadership.
   - A renewed midwifery focus on keeping pregnancy and childbirth normal, enabling physiological birth and focusing on the non-medicalisation of birth, whilst being safe and preventative, and reducing mortality and morbidity.
   - A philosophy of care, being respectful, caring, person-centred and holistic in the approach.
   - Not only focusing on saving lives but supporting human rights and encouraging the transformation of women’s lives, not only enabling them to survive but also thrive.
   - The vision needs competent, capable care, with a demonstrable economic benefit.

ii. How will the vision be implemented?
   - Ministries of health and education, and other government departments, will be critical partners.
   - Implementation needs to be supported in a sustainable way, with stronger accountability and governance.
   - The use of champions and effective leadership to drive the agenda forward are crucial, as well as linking with relevant organisations, partnerships and associations.
   - Education, environments and resources will need to be adapted to enable success, with adequate financing, regulation and capacity.
   - Proposed changes need to be addressed within current health systems and within relevant clinical practices, using an interdisciplinary and inter-professional learning approach.
iii. Who is the vision for improved midwifery education about?

- The vision needs to be person-centred. It is about women, adolescents, children and newborns, as well as families and the community.
- It includes collaborations with other healthcare professionals and disciplines; it is about midwives, but also midwifery care through team work with doctors, nurses etc.

2.2 How do we monitor and evaluate progress in the vision identified to strengthen quality midwifery education?

Potential global indicators and country experience:

The session opened with a brief power point presentation highlighting existing global monitoring and evaluation indicators of relevance, to strengthening midwifery education. Relevant indicators include those from the Workforce 2030 Strategy (2), the Global Strategy for Women, Children and Adolescents 2016–2030 (1), and the WHO Global Strategic Directions for Strengthening Nursing and Midwifery 2016–2020 (9).

The majority of the participants were aware of project specific monitoring tools rather than any common regional, national or global tools. We recognised the need for effective monitoring and evaluation as they are essential to demonstrate the cost-effectiveness of quality midwifery education.

Global strategic directions for strengthening N&M 2016-20

<table>
<thead>
<tr>
<th>Indicators on education</th>
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<tbody>
<tr>
<td>1. # countries accreditation</td>
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<td>2. # countries curricula endorsed by regulatory body or institution</td>
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<td>3. # countries data on educational institutions, regulatory bodies and regulatory information on licensing, registration and scopes of practice</td>
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<td>4. # countries Competency-based curricula</td>
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<td>5. % partners supporting regulatory bodies to M&amp;E training</td>
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<td>6. # countries implemented national standards for education, practice and nursing and midwifery services</td>
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<td>7. # countries reviewed and revised professional regulations</td>
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<td>8. Availability and status of information systems (e.g. for education, workforce, regulation)</td>
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<tr>
<td>9. # countries strategies on inter-professional education and collaborative practices</td>
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<td>10. # countries that have inter-professional web-based communities of practice</td>
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<tr>
<td>11. % partners implementing multiyear plans for strengthening education and service capacities</td>
</tr>
<tr>
<td>12. # countries updated curricula reflecting leadership training content</td>
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Discussion:

i. We acknowledged that identifying and implementing indicators in education will be a challenge, given that few midwifery education programmes to date have developed a monitoring and evaluation process. The indicators in the WHO Global Strategic Directions for Nursing and Midwifery 2016–2020 were shared and agreed as an excellent starting point to avoid duplication and support ongoing processes. The Lancet QMNC Framework was further suggested as a point of reference, along with the two global strategies. We agreed that we need to find a way of generating baselines from
which to develop impact data on how education translates into improved outcomes for women, newborns and their families, and that this must include “soft” outcomes (for example emotional support) as well as hard outcomes, such as mortality and morbidity reduction. A model that works globally is needed, not one that works only in resource-rich settings

ii. **Wider issues:** The need for monitoring and evaluation must be understood better to ensure positive approaches and motivation. Wider issues such as FGM and child marriage also need to be considered in some contexts. We will need not only to consider women and babies that survive, but include those that thrive and who then transform their own lives, those of others around them and ultimately of their community/country as a whole.

iii. **Data on competencies:** Sound data are currently lacking in this area and there is a need for a good data collection system that accurately reflects what is happening on the ground. The group believed more thought must be given to what we want to measure and how we measure it.

iv. **Confidence with monitoring and evaluation:** Few members in the group have experience with monitoring and evaluation processes for midwifery education, and it was acknowledged that capacity urgently needs to be developed at all levels.

### 2.3 Midwifery education and the Global Midwifery Advocacy Strategy

This group work session was introduced with an update on the process of developing the Global Midwifery Advocacy Strategy led by WHO, ICM and the White Ribbon Alliance. The strategy has arisen from a systematic mapping of barriers to quality midwifery care from the provider perspective, a global consultation with midwifery personnel, and a systematic review of the solutions. Three barriers were identified:

i. **Professional:** Lack of investment in education, regulation and autonomy.

ii. **Socio-cultural:** Midwifery being classed as women’s work; the gender penalty of midwifery not being afforded professional value.

iii. **Economic:** Many midwives are unable to live off the salary that they receive.

These barriers are based on deep-rooted social norms and widespread gender inequality for both the women who are childbearing and the women who provide most midwifery care. Examples of solutions identified to overcome the three barriers are: better governance and regulation; partnerships; addressing and achieving a suitable work-life balance, better pay as well as competency-based education. Addressing only one of the three barriers in isolation is not effective. For quality of care to be improved, all barriers must be addressed together.

The findings from the above, including the barriers arising from poor quality midwifery education, led to the ongoing process of developing the Global Midwifery Advocacy Strategy, led by the White Ribbon Alliance. It has been agreed that stronger midwifery leadership through a unified and collaborative voice is needed and that this voice must be heard at all levels of decision-making.
### 2.4 Who can deliver the change we want to see?

**Group work: developing a diagram of partnerships**

- **Group 1: Multilaterals, Bilaterals, Foundations**

  Those who can deliver quality midwifery care must be at the centre of decision-making around midwifery education. WHO and ICM, along with UNFPA and UNICEF, are key players.
for leadership; all organisations must work in partnership to make the desired change. Partners must include organisations, such as the White Ribbon Alliance, the Partnership for Maternal Newborn and Child health (PMNCH) as well as WHO Collaborating Centres. Faculties of education in midwifery education institutes and student associations must have a voice. Engaging with bilateral donors and Foundations, the consumers (childbearing women), academics and those who fund research, is essential.

ii. **Group 2: All other actors:**

This group also believed that those who were delivering care must be at the centre of decision-making: midwives; student midwives; educators and training institutions, as well as childbearing women as users of the services need to have a voice at the decision making table. At country level national associations can be influential in delivering change. Local leaders (religious, community, political) could assist with supporting change; however this may be dependent on context. The group believed that attracting people to the midwifery profession is important, and this can be done through career profiling using the media.

We need to be strategic and ascertain who can be an influential voice. We also need to decide who must be involved so that we can create opportunities to support and drive change. There may need to be context specific actions, depending on the type of change that we want to see, where we want to see it, and how we hope to see it. We must, however, find a way of uniting the support at all levels. Cultural and contextual variations in approach are needed across countries. The global approach for Women’s, Newborn’s and Adolescents’ Health is a starting point for change for countries, and involvement can be regionally focused. Successful models that have been used to implement successful changes can be shared and scaled-up. Bringing together the evidence, the relevant partners and the resources, will be critical for country-level support.

*We need to encourage the organic growth of change.*
2.5 What could collective action and unified voices look like?

The purpose of this session was to determine a way forward, specifically on developing a unified voice for strengthening midwifery education through the global midwifery advocacy strategy. We also began to set out how, together, we can deliver powerful collective action.

Key issues arising

Situation analysis is needed:
- Establishing a baseline on the current situation on midwifery education is vital to demonstrate future progress, a regional and country mapping of midwifery competencies is needed to begin the process.
- We need to safeguard what we have in areas where it works well.
- Where midwives are not yet established as the professional who provides most midwifery care, progressively moving from a focus on the broader definition of skilled birth attendants to the midwives may require financial and other intensive forms of support.

Competencies and tools must be brought together:
- There is a need for a synthesis (toolkit) of all the midwifery education tools currently in use.
- The toolkit must be backed by evidence and experience and contain all appropriate tools.

Monitoring and evaluation must be strengthened:
- Monitoring and evaluation, and research, must be embedded within the process to ensure emerging evidence is available.
- There is a need for collective action on research and data to manage and share this information adequately.
- Progress indicators will be reviewed in five years to ascertain if we are on target.

Stepwise approach:
- A gradual and continual, stepwise approach is needed, with different starting points in different regions depending on what stage countries are at presently.

Unified approach:
- We must have collective action and a unified voice; there is a need for a united approach.

Economic value:
- Demonstrating economic value and impact will further encourage support for a collective action.

Wider determinants of health and human rights:
- The wider determinants of health must be included, and those organisations focusing on them using the SDGs as a focus, and incorporating the ICM Midwifery Services Framework (MSF).
- We must encourage support for our agenda from broader movements of human rights and women's rights.

Collaboration and engagement:
- Engagement with donors and key organisations was emphasised as vital. We must have strong leadership for our collective vision and work in partnership for a unified voice.
Next steps on strengthening quality midwifery education

Five urgent actions were agreed, with responsibilities allocated.

1. Establish a “Global Platform for Action” (with a steering committee/steering group for midwifery education, name tbc), with potential for regional and country platforms: WHO to coordinate collective action.

2. Develop a collective 15-year “Strengthening Midwifery Education Action Plan 2016–30”, to include monitoring and evaluation: Stakeholders of the Platform for Action to take the lead.

3. Initiate global mapping of two key areas
   — Midwives educated to ICM Midwifery competencies, to be based on the ICM definition of a midwife and the ICM essential competencies for basic midwifery practice: To be determined with ICM.
   — Education materials existing amongst partners, with potential for developing a global midwifery education toolkit: Jhpiego and University of Manchester to initiate action.

4. Support evidence based ICM updated competencies (in process) to ensure alignment with the evidence from the Lancet Midwifery Series and the two global strategies: WHO, University of Dundee and TBD with ICM.

5. Clarify and agree leadership roles and responsibilities of different key partners at global, regional and country levels to support a collective, unified midwifery position and voice (i.e. who leads on what, how do we coordinate?): UNFPA to coordinate collective action.

Longer term actions:

6. Research evidence and dissemination: develop a synthesis of available and on-going research and evidence on midwifery education to guide investment at all levels. Develop a system for easy dissemination and access, such as MANERS.

7. Advocacy: ensure midwifery education is part of the emerging WRA-WHO-ICM Global Midwifery Advocacy Strategy, and link advocacy on education to other ongoing advocacy platforms.

8. Human rights based approach: further develop a rights-based approach to drive improvements in midwifery education.


10. Gender analysis: develop a gender analysis of midwifery to identify gender transformative actions that will help overcome, the professional, economic and socio-cultural barriers to the provision of quality care.
References


10 World Health Organization: Midwifery Educator Core Competencies. WHO: 2013
ANNEX I

Concept Note
Strengthening Quality Midwifery Education

In support of the implementation of
The Global Strategy for Women, Newborns and Adolescents Health 2016–30, and
The Global Strategy for Human Resources for Health: Workforce 2030
University of Dundee, July 25–26 2016

Background

Significant achievements have been made over the past few decades in reducing maternal and newborn mortality and morbidity (1). Under Sustainable Development Goal (SDG) 3, two complementary strategies set out ambitious objectives and actions to ensure continuing improvements in the health and well-being of women, newborns and their families to ensure that they can not only survive, but thrive and transform. These are the Global Strategy for Women’s, Newborn’s and Adolescents’ Health 2016–30 (2) and The Global Strategy for Human Resources for Health: Workforce 2030 (3).

Improving quality of care (QoC) is critical to achieving the objectives of both these global strategies. WHO defines QoC as “the extent to which health services provided to individuals and populations improve desired health outcomes” (WHO 2015) and is developing new standards on both the provision – and the experience – of care during childbirth, including the availability of water and sanitation (WASH) and other physical resources in facilities along with competent health workers. The extent to which QoC within universal health coverage can be achieved depends upon ensuring equitable access to health workers within strengthened health systems, the vision of Workforce 2030. At the World Health Assembly in 2013, Member States passed a resolution on “Transforming health workforce education in support of universal health coverage” (WHA 66.23). This sets out the need for transformative education, including the strengthening or formulating of policies, strategies, plans, assessments as well as increased resources (4). The Lancet Series on Midwifery (5) sets out the evidence base for what women and newborn’s need, and defines midwifery as “skilled, knowledgeable and compassionate care for childbearing women, newborn infants and families”. All women and their babies need midwifery care, irrespective of whether or not they are experiencing an uncomplicated pregnancy, birth and post natal period or require emergency medical obstetric and/or neonatal care.

There is increasing evidence to indicate that a consistent barrier to improving maternal and newborn health has been the poor QoC provided by midwives, nurses, doctors and other health workers. In a systematic mapping of barriers to the provision of quality care by midwifery personnel, the issue of poor midwifery education, often reduced to a matter of weeks without qualified faculty and lacking in practical application, was identified as a major constraint (5). The State of the World’s Midwifery Report (SOWMy) 2014 notes that of the 73 countries from which data was gathered, only four countries have the workforce capacity to provide the care needed by women in their reproductive years, as well as for newborns. Additionally, many of the education programmes described lack basic training such as infection prevention and respectful care, leading to possibilities of links between poor education, poor clinical care, sepsis and as well as mistreatment of women in facilitiesvi. Barriers to achieving high quality sustainable midwifery education programmes include economic and political restrictions to exercise the full scope of midwifery practice, as well as social and cultural norms which mitigate against women’s rights, education
and employment (8). As a consequence, the preparation of practitioners and provision of maternal and neonatal care are variable, across and between low, middle and high resource countries.

Positive efforts to improve quality education have been made by many partners under the leadership of ICM, as well as by FIGO and IPA, and through UN agencies, donors and foundations and major international and national NGOs. Much of this has focussed on curriculum development, training (short and long term) and more recently has begun to address the potential for mHealth and e-learning opportunities. In 2015 WHO developed “Midwifery Educator Core Competencies” which sets out 19 competencies for all educators (midwives, nurses or doctors). WHO has also developed “Global strategic directions for strengthening nursing and midwifery 2016–20” which highlights education along with policy development, leadership, intra and inter-professional partnerships and greater investment in the workforce. Yet educators (midwives, nurses and doctors) remain challenged in providing learning opportunities to ensure that future practitioners acquire necessary practical competencies to deliver quality maternal and neonatal care.

In response to the above gaps and barriers, Bharj et al (2016) have set out a new “Agenda” to improve the quality of education. This includes developing intensive, sustainable collaborations between education programmes, practice settings, and government systems for supporting midwifery education. The evidence and the new “agenda” justify the urgent development of a new, collective, global, 15 year approach to action on midwifery education. There is now a unique opportunity to support the implementation of the two global strategies 2016–30 through improving midwifery education from the start of the SDG era. Together, we can help guide governments and partners to strengthen education for all those who provide midwifery services to ensure the right to quality care for all women, newborns and their families to ensure that they survive, can thrive and that their lives can be transformed.

**Purpose**

This purpose of convening this two day meeting is to hold the first global conversation in the new SDG era on how we can strengthen midwifery education to improve quality of care for women, newborns and their families over the 15 years of the above two global strategies.

**Objectives**

The objectives of the meeting are to:

i. Draft a coherent approach through which to strengthen evidence-based midwifery education.

ii. Review existing monitoring and evaluation frameworks for quality midwifery education and determine what may be required for accountability in support of SDG 3.

iii. Agree a collective division of roles and responsibilities on how to best implement, monitor and evaluate the above.

**Expected outcomes**

i. Consensus on a draft approach for strengthening midwifery education

ii. Priorities for action in the approach identified

iii. A process through which to monitor and evaluate progress in quality midwifery education
iv. Agreement on roles and responsibilities for taking action on all of the above
v. A timeline for implementation

References


## ANNEX II
### Agenda
**Strengthening Quality Midwifery Education**

Supporting the implementation of the Global Strategies for Women’s, Newborn’s and Adolescent’s Health 2015-30, and Human Resources for Health: Workforce 2030

**July 25–26 2016, University of Dundee, Scotland**

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<tr>
<td><strong>Monday 25</strong></td>
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<tr>
<td>08:15</td>
<td>Registration</td>
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| 08:45 | TBC: Take seats by 08:45am  
Welcome, introductions and opening speech by the Cabinet Secretary, Scottish Government | University of Dundee + Sheena Crawford |
| 09:15 | **Setting the scene for the next 15 years**  
The Global Strategy for Women’s, Newborn’s and Adolescent’s Health 2015–30. Why QoC matters. WHO  
The Global Strategy for Human Resources for Health: Workforce 2030: WHO  
Achievements in midwifery education, UNFPA  
Achievements and challenges in midwifery education, Jhpiego:  
The Quality MNH Framework for quality education  
Placing quality midwifery education in the Global Strategy for Women’s, Newborn’s and Adolescent’s Health 2015–30  
Discussion | Anthony Costello, Jim Campbell, (video)  
Petra ten Hoope  
Sheena Currie  
Mwansa Nkowane  
Mary Renfrew  
Fran McConville  
Sheena Crawford |
| 10:30 | Coffee break |
| 11:00 | **Group work activity:**  
Where are we now? Opportunities and challenges  
1. Quality midwifery education: existing best practice  
2. Research and innovation for quality midwifery education: current status  
3. Supporting two new global strategies: current strengths and gaps in quality midwifery education? | Sheena Crawford |
<p>| 12:30 | Lunch (with poster presentations for those not presenting) |
| 13:30 | Plenary feedback | Sheena Crawford |
| 15:00 | Tea break (with poster presentations for those not presenting) |</p>
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<tr>
<th>Time</th>
<th>Activity</th>
<th>Facilitator/Comments</th>
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<tr>
<td>15:30</td>
<td><strong>Group work activity:</strong></td>
<td>Sheena Crawford</td>
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<tr>
<td></td>
<td>1. Where do we want to go? Optimising opportunities and meeting challenges.</td>
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<td>2. What would strengthening quality midwifery education look like and how will we achieve this over the next 15 years?</td>
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<td>3. Future research and innovation to support quality midwifery education</td>
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<td>4. Two new global strategies: how can we strengthen quality midwifery education to support implementation?</td>
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<td>17:00–18:00</td>
<td><strong>Plenary feedback: what does the next 15 years look like?</strong></td>
<td>Sheena Crawford</td>
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<td>tbc</td>
<td><strong>Dinner invitation from the Chief Midwife, Scotland</strong></td>
<td>Ann Holmes</td>
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**Tuesday 25**

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<tr>
<th>Time</th>
<th>Session</th>
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<tbody>
<tr>
<td>09:00</td>
<td>Summary of key issues arising from Day 1: Do we have a collective vision?</td>
<td>Sheena Crawford</td>
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<tr>
<td>09:30</td>
<td>How do we monitor and evaluate progress in the vision identified to strengthen quality midwifery education?</td>
<td>Sheena Crawford</td>
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<td>Potential global indicators</td>
<td>Petra ten Hoope</td>
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<td>Country experience</td>
<td>Fran McConville</td>
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<td>Sheena Currie</td>
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<td>09:50</td>
<td>Plenary discussion – next steps on M&amp;E</td>
<td>Sheena Crawford</td>
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<td>11:00</td>
<td>Coffee</td>
<td>Sheena Crawford</td>
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<td>11:15</td>
<td><strong>Group Work activity: Groups 1a and 1b:</strong></td>
<td>Sheena Crawford</td>
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<td>Who can deliver the change we want to see? What could “collective action and unified voices” look like?</td>
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<td>12:45</td>
<td>Lunch</td>
<td>Sheena Crawford</td>
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<td>13:45</td>
<td>Plenary feedback from 2a and 2b</td>
<td>Sheena Crawford</td>
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<td>15:00</td>
<td>Tea</td>
<td>Sheena Crawford</td>
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<tr>
<td>15:30</td>
<td>Next steps on Strengthening Quality Midwifery Education</td>
<td>Sheena Crawford</td>
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<tr>
<td>16:00–16:30</td>
<td>Wrap-up, and closing</td>
<td>Fran McConville</td>
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ANNEX III
List of participants

1. ANN HOLMES
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ANNEX IV
Group work questions

**Group 1: What would improved quality of midwifery education and training over the next 15 years look like, and how will we achieve this?**

**Background:** The MDGs enabled a positive focus on improving maternal and newborn health with a targeted approach on increasing access to SBAs and EmONC, with the aim of reducing maternal and newborn mortality. There has, more recently, been an increase in political and technical support for midwifery globally, as well investment in a limited number of countries. However, the SOWMy Report 2014 noted that only 4 of the 73 countries from which data was analysed have the workforce with the capacity to provide the SRMNCAH health care that all women and their newborns need.

The SDGs provide a significant opportunity for increasing access to quality midwifery care. Midwifery is critical to the achievement of the “Survive, thrive and transform” agenda and the 9 pillars of the “Global Strategy for Women, Children and Adolescents 2016–30”. Midwifery is equally critical to the implementation of the “Workforce 2030” Strategy. Both strategies are about improving equitable access to and quality of care.

1. Where are we now?

**Quality midwifery education: existing best practice. Opportunities and challenges**

- The ICM has a well-established definition of the professional who is “the midwife”.
- WHO-ICM-FIGO agreed a Joint Statement on the “skilled birth attendant” in 2004, which includes all those who provide elements of midwifery care.
- The Lancet Series on Midwifery defined “midwifery” in 2014.
- SOWMy 2014 reported on current status of Pre-Service Education (PSE) programmes in 73 countries

**Questions**

i. Do we have an agreed set of midwifery competencies?

- The ICM has developed *7 Essential Competencies for Basic Midwifery Practice (updated 2013)* as well as core documents and guidance to support implementation of standardised midwifery pre-service education programs
- The *WHO-ICM-FIGO Joint SBA Statement* (2004) provides a list of 29 skills and abilities needed by all those provided skilled attendance at birth *(however there has been wide interpretation of this globally)*

ii. What specifically does “educated and trained to proficiency” mean in terms of quality midwifery education and training? What specifically does “demonstrate competency in the practice of midwifery mean” (ICM) and how is this assessed?
iii. Are there any gaps in current midwifery education?

iv. Do we have the right messages for advocacy on midwifery education?

2. Where do we want to go? Optimising opportunities and meeting challenges over the next 15 years.

Questions

i. What would strengthening quality midwifery education look like and how will we achieve this over the next 15 years?

ii. What would a “gold standard” (benchmark) of midwifery education look like in the future, taking on board issues such as changing epidemiology (obesity, diabetes), increasing humanitarian needs, gender discrimination, respectful maternity care and human rights, mental health and emerging diseases such as Zika.

iii. How could or should countries which are not in a position to move immediately to “gold standard” midwifery, provide intermediary competencies, over what time frame and in what settings? What factors need to be considered in increasing the academic level (Diploma to Degree)

iv. How can we ensure that all components of the midwifery education system which contribute to preparing competent ‘fit for purpose graduates’ are in place – enabling policies and regulation (accreditation), adequate clinical practice sites in terms of caseloads and quality etc.

v. How can ensuring all SBAs (midwives, nurses, doctors, clinical officers etc...) have the basic competencies of a midwife be achieved at national, regional and global levels? How long should midwifery education and training take, and do we have the evidence? How can practical education be provided as well as theoretical teaching? Who should be teaching midwifery and why? Is there a global consensus?

vi. How can midwifery competencies, and the process for achieving them, be clearly described to a Minister of Health who is uncertain about investing in midwifery over the next 15 years? How can this be set out regionally, and how described for an investment plan at all levels?

How can we strengthen advocacy for quality midwifery education over the next 15 years?

Expected outcomes

1. A clear and measurable description of the essential competencies needed for the provision of midwifery care over the next 15 years.

2. Options for countries for introducing (or strengthening) midwifery, over time and in different settings if needed.

3. The core elements of an investment plan for midwifery education (global, regional, national)

4. Suggestions on how to improve advocacy for quality education.

Background documents

The ICM 7 Essential Competencies for Basic Midwifery Practice (updated 2013)


Group 2: What would improvements in research to support quality midwifery education look like over the next 15 years, and how will we achieve this?

**Background:** Research on midwifery education has been carried out in countries such as India, demonstrating that few graduates have confidence in their ability to provide the basic midwifery competencies due to poor education (Sharma 2014). A paper co-authored by a multi-agency group of educators and researchers has called for action on midwifery education, along with the closely related issues of regulation and association (Bharj et al 2016). The Lancet Series on Midwifery (2014) summarised the evidence on midwifery available to date; it defined midwifery and its scope of practice, and demonstrated the impact of midwifery if it were to be consistently implemented. It also identified significant knowledge gaps in areas essential for high quality midwifery. Improving education requires knowledge to inform the content (what) of midwifery education as well as the educational process (how), so that women and babies are cared for by midwifery staff who can provide evidence-informed, up to date care.

The SDGs provide a significant opportunity for increasing high quality research to improve knowledge of ways of meeting the needs of women, babies and families, and to increase access to quality midwifery education. Research and innovation for quality midwifery education using an interdisciplinary approach is critical to the achievement of the “Survive, thrive and transform” agenda, and research is one of the 9 pillars of the “Global Strategy for Women, Children and Adolescents 2016–30”. Midwifery is critical to the implementation of the “Workforce 2030” strategy.

1. Where are we now?

**Quality midwifery education and how it relates to research and quality of care improvements. Opportunities and challenges**

- Investment in research on midwifery care using interdisciplinary approach has been increasing in quality and quantity, evidenced by the breadth of research included in The Lancet Series on Midwifery 2014.

- A fundamental problem is the inconsistent implementation of midwifery care, and of midwifery education, globally. Expectations of scope of practice and of educational needs (length and content) vary widely according to the perceived needs of different settings. A mixed workforce includes a range of professional and non-professional groups who contribute to the provision of midwifery care in varied ways at different levels in the health care system adding to the diversity of scope of practice and education provision (see Appendix). Despite the existence of international standards of competencies for midwives, many education programmes for midwives are not compliant with these standards. Many providers of midwifery care are educated to provide only a limited scope of practice as defined by the Lancet Series QMNC framework, such as essential interventions.
The Lancet Series on Midwifery demonstrated significant knowledge gaps in providing high quality care for women and babies, especially in areas that fall within the scope of midwifery. Most research to date has been on interventions to treat problems, rather than on preventive and supportive care. A follow-on paper from the series (submitted for publication) has developed a new research agenda based upon gaps identified in the original four series papers, intended to help to fill these gaps.

The capacity and skills of midwives to engage in and to lead relevant interdisciplinary research remain weak, as recognised by the investments in capacity building for research through the Lugina African Midwives Research network (LAMRN). Even in countries where research by midwives is recognised as important, resources to support early career development in research are limited. This limits not only the quality and quantity of research conducted, but also the type of research questions that are asked, and the projects that are funded – and as a result, the knowledge available to inform the care of mothers, babies, and families is compromised.

Research into the process of midwifery education is limited and small scale.

Questions

i. **Do we have an agreed plan for the research needed to inform midwifery education?**

Four things are needed:

1. Clarity on what education is needed and by who and how to get there – and then evidence to inform its provision (See Lancet Series QMNC framework and Appendix)
2. A strategy for increased funding for research on the preventive and supportive care needed by all women, babies and families to ensure a sound knowledge base for practice and policy
3. Development of research intended to inform midwifery education provision
4. A programme of capacity and capability building for research by midwives to enable them to engage in, and to lead, interdisciplinary research relevant to education

2. **Where do we want to go? Optimising opportunities and meeting challenges over the next 15 years**

Questions

*Research into the content of education programmes*

1. What would a “gold standard” of research on midwifery look like in the future, taking on board issues such as changing epidemiology (obesity, diabetes, low breastfeeding rates), increasing humanitarian needs, gender discrimination, respectful maternity care and human rights, and emerging diseases?

2. How do we ensure that research findings relevant to midwifery education, including critical issues such as leadership, respectful care, obstetric violence, increasing medicalisation, the economic benefits of midwifery versus other models of care etc. are included in education and training? Could education and training be based on what women and newborns need as described in the quality framework from the Lancet Series on Midwifery, for example, rather than a narrow focus on clinical interventions?

*Research into the process of education*

1. How can we ensure that education policy and practice is evidence based? What is the evidence for a 3 year direct entry training, an 18 month post nursing course, shorter
course, in-service trainings etc.? Do we need to develop a step-wise approach, with clearly defined stages towards full-scope practice?

2. What research is needed to support quality midwifery education over the next 15 years?

3. How can the need for research into midwifery education, and the process for achieving this, be clearly described to a Minister of Health who is uncertain about investing in midwifery over the next 15 years? How can this be set out regionally, and how could research needs be described in an investment plan (at varying levels)?

**Capacity and capability building for midwives in conducting research**

4. How could or should countries with relatively strong research capacity among midwives assist those countries which do not yet have that capacity and capability, to ensure that midwives are enable to fully participate in, and lead, interdisciplinary research relevant to midwifery education?

**Expected outcomes:**

5. A clear and measurable plan for strengthening the research needed to inform midwifery education over the next 15 years

6. Guidance for countries for introducing (or strengthening) research on midwifery and to develop capacity and capability of midwives in research, over time and in different settings

7. The core elements of an investment plan for research needed for midwifery education (global, regional, national)

**Background documents**


x. Bharati S et al. Do the pre-service education programmes for midwives in India prepare confident ‘registered midwives’? A survey from India. Global Health Action, [S.l.], v. 8, dec. 2015. ISSN 1654-9880.
Towards a classification of what education is needed by who

<table>
<thead>
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<th>WHO?</th>
<th>SCOPE OF MIDWIFERY</th>
<th>WHAT DO THEY NEED?</th>
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**Group 3: What is needed to ensure that quality midwifery education supports the implementation of the “Global Strategy for Women, Children and Adolescents’ 2016–2030” and “Workforce 2030”, and how will we achieve this?**

**Background:** The “Global Strategy for Women, Children and Adolescents’ 2016-2030” (GS2) sets out 9 Action Areas through which to end preventable maternal, newborn, child, and adolescent deaths and stillbirths and which could yield a 10 fold return on investments. Such a “grand convergence” in health could give all women, children and adolescents an equal chance to survive and thrive. Quality midwifery education is critical to the achievement of the 9 Action Areas, see Flyer.

The “**Global Strategy on HRH: Workforce 2030**” has 4 objectives: (see report)

1. Optimise performance, quality and impact of the (MIDWIFERY EDUCATION) workforce through evidence-informed policies
2. Align investment in the (MIDWIFERY EDUCATION) workforce with current and future needs of the population, taking account of ... education policies ...
3. Build capacity of institutions at subnational, national and global levels for effective (MIDWIFERY EDUCATION ) public policy, stewardship, leadership and governance
4. Strengthen data for monitoring and accountability of ... (MIDWIFERY EDUCATION )
A. Where are we now? Opportunities and challenges

Questions

1. Do we know enough about current midwifery education in various settings and the extent to which it:
   — already responds to the 9 action areas for GS2 i.e. for women and newborns in fragile and humanitarian settings, for legal rights of the midwife and the woman and her family, for research and community engagement etc.?
   — meets the 4 objectives of Workforce 2030?

2. What is the current state of midwifery faculty and leadership in terms of supporting implementation of the two Global Strategies?

3. Do we have a clear analysis of midwifery education policy, and whether or not policies support implementation of the 2 Strategies?

B. Where do we want to go? Optimising opportunities and meeting challenges.

4. What steps need to be taken to ensure midwifery education, in various settings, supports and is integrated into:
   — the 9 action areas for GS2 i.e. for women and newborns in fragile and humanitarian settings, for legal rights of the midwife and the woman and her family, for research and community engagement etc.?
   — the 4 objectives of Workforce 2030?

5. How can the case for the positioning of midwifery education within the two Global Strategies be best explained to a Minister of Health who is uncertain about investing in midwifery over the next 15 years? How can this be set out regionally and globally?

6. What advocacy is needed to demonstrate the centrality of midwifery education to the implementation, and M&E of the 2 global strategies to ensure increased investment over the next 15 years?

Expected outcomes

7. Clear and measurable actions to ensure midwifery education supports the implementation of the two Global Strategies.

8. Options for countries for introducing (or strengthening) updated midwifery education, over time and in different settings if needed, to support the two Global Strategies.

9. The core elements of an investment plan for midwifery education (global, regional, national) based on the two global strategies ensuring gender, equity and rights for women, newborns and their families as well as for those who provide midwifery care.

10. Suggestions on how to move forward on advocacy for midwifery education in the context of the two Global Strategies.

Background documents

2. Global Strategy on HRH: Workforce 2030
3. WHO Midwifery Educator Core Competencies