Republic of Sudan
Federal Ministry of Health

National Strategy Document
For Scaling-up Midwifery in
the Republic of the Sudan
2009
Preface

Letter signed by the officials FMOH(??), government??
Acknowledgements

The development of this document was a collaborative effort with the contribution of many organizations and individuals who volunteered their valuable time. Their knowledge and insights were essential and contributed towards developing a clear vision for the future of midwifery in the Sudan.

We would like to thank the participants of the Consultation and Consensus Workshop for their active participation as it was during this meeting that the National Midwifery Strategy was conceived and took shape.

We also thank the Focal Point for Nursing and Midwifery at the Federal Ministry of Health – Human Resources Department for their contribution which greatly helped to align the strategy to existing initiatives.

We greatly appreciate the work carried out by the staff of the Reproductive Health Programme. Their technical contributions were invaluable and the administrative logistical assistance provided helped enormously.

We would also like to thank the UNFPA Country Office in the Sudan for the financial and technical support for this initiative.

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Executive Summary

Background
The Republic of the Sudan has a high maternal mortality ratio, more than 1,100 per 100,000 live births and is not on track to achieving Millennium Goal 5 which entails the reduction of maternal mortality by 75% before 2015. In recent years a number of policies and strategies have been developed that address this gap within a broader context; reproductive health, achieving MDGs maternal mortality reduction and education reform in nursing and midwifery. The Roadmap for Reducing Maternal and Child Mortality in Sudan published in 2008 specifically identifies midwifery as the corner stone of Maternal and Child Health.

The need for an improved midwifery service provision (both in quality as well as quantity) has been recognized and in the past few years quite a number of initiatives have been developed addressing this with special emphasis on care provision in the community setting. These initiatives have usually addressed single issues and the process of implementing change has been slow and fragmented. If this continues Sudan will remain behind in achieving MDGs 4 and 5.

It appears at this time, that there is a growing realization that scaling up the midwifery workforce can only be effectively addressed when there is a cohesive unified vision strategy that guides the areas of change needed to be implemented. A national strategy on scaling up midwifery that is aligned with existing strategies provides the framework for action(s), and guides organizations and donors in the planning of programmes and projects. It also provides answers to the following questions. What measures are needed:
- to create and maintain production of a competent midwifery workforce
- to ensure the enabling work environment needed for skilled attendance
- to guarantee the quality of midwifery services provision
- to increase utilization of midwifery services

This strategy is a consensus document developed by an independent consultant supported by the UNFPA in close collaboration with the Federal Ministry of Health-Reproductive Health Programme and in consultation with all the important stakeholders. It incorporates the results from a two day consultation workshop held in Khartoum on 29-30 April 2009. It is in line with current policies and strategies and is based on the on-going collaborative work being carried out in the country. The strategy provides a long-term vision for quality midwifery service provision by competent and qualified midwives who fit the internationally agreed to definitions of midwife and skilled birth attendant and who is an essential part of the health services especially at the community level. It also provides a framework for the most crucial changes, actions and strategies that can be incorporated into a short and medium term transitional strategy for implementation

Current Situation
Based on a recent situational analysis of midwifery in the Sudan, number of strengths and weaknesses were identified. They can be classified in the following categories:
- **Human resources and coverage of care**
Strengths: Midwifery service provision is part of the cultural history in the country and is a known entity in Sudan. There is a large workforce of midwifery-related service provision and working especially at the community level, the Village Midwives. Recruitment for Village Midwife Schools strives to find candidates from communities in need of midwifery services. There is a promising new initiative that is bringing Village Midwife Schools physically to the locations that are most in need of midwifery services in order to train those who would otherwise not be able to leave the area to attend the existing schools usually in larger towns.

Weaknesses: There are too many cadres of providers of midwifery related services in all settings with varying competencies and not providing the full range of midwifery care. Besides the so called Sister Nurse-Midwives (the last one being graduated in 1992) Sudan has no midwifery cadre that qualifies as a skilled birth attendant especially in the setting where this is needed the most, in the community. Facility based nurse-midwives are concentrated in Khartoum State and the capacity for training is severely limited due to closure of 2 of the 3 existing schools. Human Resources for Health planning for midwifery services is complicated by lack of good data on attrition, utilization and the variation in training capacity.

Education and training
Strengths: The development of a new 2 year midwifery technician curriculum to replace the current 1 year Village Midwife programme is a promising initiative.

Weaknesses: The minimum educational entrance requirement for midwifery training often cannot be realized resulting in a large portion of village midwives who are illiterate or with limited literacy. There is a great variation in the basic educational level of certified nurse-midwives which makes it difficult to speak about a standard of quality in care provision in facilities. All the midwifery schools (village midwife as well as the only functioning certificate nurse-midwife school) are in dire need of rehabilitation and need appropriate supplies and teaching materials. The current group of midwifery teachers/tutors cannot be considered as qualified teachers and are lacking in both clinical skills and teaching methodology. There is not enough coordination between midwifery schools and clinical skills training sites. All the village midwifery schools are donor dependent for their existence.

Enabling environment
Weaknesses: Almost all the areas considered to be part of an enabling environment are not present for community based midwifery services; village midwives are not employed in the health system and have no job or salary security, there is poor supervision and mentoring, there is no career pathway and limited chances for continued education, there is no/poor access to supplies and medications and poor links with referral services. Except for the job employment and salary security areas, facility based midwives also face the same limiting factors in the enabling environment.

Image and attractiveness of midwifery
Weaknesses: There is a worsening of the image of midwifery which could be a contributing factor to less utilization of village midwives (and the continued use of Traditional Birth Attendants)

Policies, legal and regulatory frameworks and political will
Strengths: There have been some policies and strategies developed that include scaling up midwifery and midwifery education reform

Weaknesses: There is not enough investment in midwifery education and service provision making it almost totally donor dependent. There is not enough political engagement to support better implementation of existing policies and strategies. There is currently no legal or regulatory
framework for midwifery services and thus compromising the guarantee of quality of service provision to the public

**Recommendations from the Consultation Workshop**

Using an adaptation of the framework (figure 1) for scaling up midwifery developed during the First International Forum on Scaling up Midwifery held in Hammamet, Tunisia in 2006 and organized by the UNFPA, the International Confederation of Midwives (ICM) and WHO, the key results and recommendations from the Consultation Workshop are as follows:

![Figure 1: framework for scaling-up midwifery services](image)

**Policy, legal and regulatory frameworks**
- Advocacy is needed to ensure political will and involvement, financial support and policy development and implementation
- A regulatory framework for midwifery must be initiated to ensure quality and should include comprehensive job descriptions with corresponding scopes of practice, a registration system, certification or licensing procedures and accreditation processes for educational and training institutes

**Equity in access to services**
- Continuation of human resource planning for midwifery services based on population until more data is available and more understanding is acquired about the factors that determine how women decide which caregiver to seek
- Continuation of policy to recruit midwifery students from villages where the need is greatest and where they will most likely return home to work
- Break the spiral of negative image of village midwives by providing more supportive supervision, community awareness about the competency of village midwives and involving persons of influence in the community (including TBAs) when recruiting new midwife trainees.

**Training and Education**
- Prepare qualified teachers for all levels of midwifery education
- Continue refreshment courses for all levels of current midwifery workforce including life saving skills (EmOC)
- Standardize midwifery curricula
- Ensure that training and teaching sites are up to standard physically as well as having sufficient and up to date teaching materials and supplies

**Supervision and support**
- Provide systematic supportive supervision especially at the community level with qualified and capable supervisors

**Enabling environment**
- Incorporate village midwives into the health system as employees by providing salaries and/or incentives (either monetary or other motivations)
- Ensure that village midwives have access to sufficient supplies and medications
- Look into providing village midwives with better communication means as cell phones
- Provide better links from community to referral facilities with EmOC
- Consider bringing EmOC facilities closer to the community (Health Center level)

**Monitoring and Evaluation**
- Implement routine data collection involving midwives and the maternity workforce at the community level so that midwives and the community can use the data
- Implement rigorous evaluation for all new programmes involving scaling up midwifery so that lessons learned will not be lost

**Stewardship and Resource Mobilization**
- Advocate for government to provide sufficient expenditures for maternal health and midwifery service provision to avoid total donor dependence and to guarantee sustainability of the services

**Image and attractiveness of midwifery**
- Initiate a public campaign to raise the image of midwifery in the Sudan
- Capacity build leadership in the midwifery community
- Support the revitalization of the Sudanese Midwifery Association
- Strive to have midwifery representation at the policy and planning level
- Stimulate collaboration between all members of the maternal workforce

**National Strategy for Scaling up Midwifery in the Republic of Sudan**

During the Consultation Workshop the participants developed two strategies. One for the long term vision that would be used to guide the process of change and a transitional strategy that would cover the short to middle term operational and strategic activities that can be implemented. This transitional strategy is based on the current situation in the workforce, the integration of on-going initiatives and a prioritization of the most pressing issues. It does not include the specific decision making needed to operationalise the strategy but is intended to guide the work plans to be developed for implementation.

**Long term vision strategy**

This strategy is the vision to aspire to. Although it is acknowledged that it will take a long time to achieve it should be regarded as the end result to which all the phases of implementation will lead to. This long-term vision is based on creating a professional and competent midwifery workforce in the Sudan.

- Midwifery education/training is based on the internationally accepted ICM core competencies (including additional competencies as EmOC when possible) ensuring that midwives are by definition skilled birth attendants
• Midwifery education/training will be primarily provided by competent midwife teachers in collaboration with other specializations.

• There will be two educational paths to midwifery:
  - a three year programme leading to a diploma
  - a four year programme leading to a degree (BSc)

• Both levels require the same minimum educational background, a secondary school certificate but the degree programme will demand a higher proficiency level and possibly a better demonstrated motivation during the application interview.

• Graduates of both programmes will be called midwife.
• Both levels will have sufficient clinical training to produce competent practicing midwives.
• Both levels can work in any setting from community to tertiary hospital.
• Graduates in the degree programme will generally become the midwifery teachers, supervisors, and managers or will go into other specialty areas as research etc.
• Both levels will have a career paths
  - Degree to post graduate levels
  - Diploma to degree and post graduate level
• Diploma midwives will be recruited from the communities (as much as possible).
• Phasing out of existing cadres will take place gradually and allow for upgrading when possible. Certificate nurse-midwives and health visitors will be able to upgrade to diploma midwife within the guidelines determined in the Sudan Declaration for nursing and midwifery education.
• Diploma midwives will generally be health centre based with outreach to the community and most likely will work in teams with any other providers of maternal health services and especially with those based in the community.
• Investments made at the health centre level will ensure that they are clean, well equipped and can provide at least the basic EmONC functions.
• Midwives will be instrumental in providing Family Planning promotion and services at all levels.
• Quality of service provision will be assured by a legal and or regulatory framework including:
  - Registration and certification or licensing
  - Standardization of curricula and accreditation of midwifery education and trainings institutes
• Midwives will work according to evidence based standards of practice and practice reflective practice aided by supportive supervision.
• Midwives will be an integral part of the health system and be employed and duly salaried.
• Midwives will have a strong sense of identity and value and will partner with women, their families and their communities to ensure that pregnancy and childbirth is made safer.
• Midwives will be part of policy making.

First phase transitional strategy
This strategy is intended to guide the first phase implementation of the long term vision strategy. It builds upon a so-called ‘and/and strategy’ which means that it calls for short term operational changes which are relatively easy to implement and show quick visible results while at the same time integrating the corresponding longer term strategic and attitude changes that are harder to implement but are necessary to ensure sustainability.
• Continue refresher courses for village midwives currently working
• Provide for continuing education for midwifery teachers currently working to include skills training as well as teaching methodology
• Continue the one year village midwifery training but provide more supervision
• Implement the new two year midwife technician curriculum as soon as possible provided the following are in place:
  - Qualified midwifery teachers ¹
  - Rehabilitation of schools including skills labs and teaching materials
• Implement a zonal training initiative
• Start a bridging course for nurses who want to become midwives and work at the community level as a temporary measure for a quick scaling-up of a better quality of midwifery services at the community level.
• Establish a regulatory body (Council) and start registration of all cadres of midwives working in the country
• Start developing evidence based standards for midwifery practice
• Advocate for the employment of midwives in community service
• Start work on a strategy of midwifery led health centers with outreach to the community including supervision over existing cadres working in the community (village midwives or community health workers) and collaboration with TBAs to ensure that harmful practices are stopped and that TBAs can be utilized to lower the number delays due to women not seeking care

¹ There was much discussion as to how to ensure that there were sufficient numbers of competent and qualified midwifery teachers in time as not to delay the start of the new curriculum. Some solutions were: recruitment from the existing workforce of sister midwives who immediately could fill the gap but there may not be enough available; immediately start a supplementary teaching course along with skills course for other professions (obstetricians and nurses with MCH master) who could step in and temporarily fill the gap; reinstate the 1 year midwifery diploma programme to BSc nurses to create a critical mass of midwives who could also teach but this would delay implementation of the new curriculum by more than a year; temporarily bring in midwifery teachers from other Arabic speaking countries. The final solution will involve a combination of the options and decisions will need to be taken by the National Midwifery Committee
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Introduction

The death of women as a result of complications during pregnancy and/or childbirth is a tragedy for her family and community and it is estimated that more than 500,000 women suffer this fate each year and that at least 10 times as many women will suffer severe health problems after pregnancy and childbirth. Newborn death which often directly linked to maternal health and birth is estimated world-wide at 7 million cases. In the past 20 years, a number of interventions and strategies have proven to be effective in reducing maternal death and disabilities, yet MDG 5, the reduction of maternal mortality, is still the MDG that has shown the least progression. It has become increasingly evident that the reduction of maternal mortality needs more than singular and vertical approach. Reducing maternal (and newborn) mortality and morbidity requires a comprehensive vision for skilled and adequate service provision, sound management and governance of health systems, political commitment and civil society engagement. There is sufficient evidence that shows that midwifery service provision is a strategy that can greatly contribute to the reduction of maternal mortality and to the advancement of women’s health.

The Republic of the Sudan has a high maternal mortality ratio, more than 1,100 per 100,000 live births and large variations between states. The country is not on track to achieving Millennium Goal 5 which entails the reduction of maternal mortality by 75% before 2015. The Sudan Roadmap for Reducing maternal and Child Mortality (2008) identified the main determinants of maternal (and child) health as:
- Weakness of the Public Health Care System
- Lack of community awareness
- Lack of active political commitment towards maternal and child health, translated into channeling of resources towards much needed interventions

The fight against maternal mortality and morbidity requires a multi sided approach that involves health system strengthening (including human resource and quality of care issues), social mobilization and political will.

In recent years a number of policies and strategies have been developed that address the lack of progress of achieving MDGs 4 & 5 within the broader contexts of reproductive health, achievement of all the MDGs, including maternal mortality reduction and education reform in nursing and midwifery. These include the following:
- Health Sector Strategy: Investing in Health and Achieving the MDGs 2007-2011
- The National Strategy for Reproductive Health 2006-2010

Moreover, these documents echo the growing international consensus on midwifery care and emphasize the importance of a qualified midwifery workforce as a means of reducing maternal and newborn mortality and morbidity. The Roadmap for Reducing Maternal and Child Mortality in Sudan specifically identifies midwifery as the corner stone of Maternal and Child Health and can be seen as an intervention that will make a difference in the numbers of lost lives in mothers and newborn.

The need for improved midwifery service provision (both in quality as well as quantity) has become a priority area of work in the Sudan and in the past few years quite a number of initiatives have been developed addressing this with special emphasis on care provision in the community setting. These initiatives have usually addressed single issues and the process of implementing change has been slow and fragmented. Emerging from civil war and instability, Sudan has depended on donors and
development organizations for much of the investments made in midwifery training and midwifery service provision without leading the work as part of a unified and cohesive strategy and there is too little government support for midwifery. Because of this, Sudan could remain behind in achieving MDGs 4 and 5.

It appears that in the past few years, a growing momentum for support to midwifery in the Sudan has taken place that has been accompanied by a burst of activities in the areas of midwifery education and service provision. This has been strongly led by the Ministry of Health-RH programme and supported by donors and agencies. Very recently, a national technical committee on Midwifery was installed in Khartoum which is charged with overseeing a national strategy and taking on the coordination of the implementation of the recommendations and actions of this strategy. This group can provide the oversight and leadership to carry the momentum further. It is during this exciting time that the National Strategy for scaling up Midwifery was conceived and it should be able to guide the further development of midwifery in the Sudan.

This midwifery strategy is a consensus document developed by an independent consultant supported by the UNFPA in close collaboration with the Federal Ministry of Health-Reproductive Health Programme and in consultation with all the important stakeholders. It incorporates the results from a previously carried out situation analysis and the results from two day consultation and consensus workshop held in Khartoum on 29-30 April 2009. It is in line with current policies and strategies and is based on the ongoing collaborative work being carried out in the country. The strategy provides a long-term vision for quality midwifery service provision by competent and qualified midwives who fit the internationally agreed to definitions of midwife and skilled birth attendant and who is an essential part of the health services especially at the community level. It also provides an implementation work plan and monitoring and evaluation framework for changes, actions and strategies prioritized in the first phase short and medium term transitional strategy.

**Rationale and Aims**

In general, a clear national strategy can provide unified vision for change, can provide a framework for programmes and other initiatives, can outline the relationship between areas of change and helps avoid fragmentation in implementation and it can provide the basis for avoiding duplication of effort and demonstrate areas for collaboration.

There is a growing realization that scaling up the midwifery workforce can only be effectively addressed when there is a cohesive unified vision strategy that guides the areas of change needed to be implemented. A national strategy on scaling up midwifery that is aligned with existing strategies provides the framework for action(s), and guides government, organizations and donors in the planning of programmes and projects. It also provides answers to the following questions.

What measures are needed:
- to create and maintain a competent and motivated workforce of skilled birth attendants
- to ensure an enabling work environment needed for skilled attendance
- to guarantee an adequate numbers of providers and the quality of services provided
- to increase utilization of services
Guiding Principles
The principles guiding the development of this document are as follows:
- It builds upon existing work and programmes in the area of maternal newborn mortality reduction
- It is owned by the Sudan and supported by government, community, donors and other stakeholders
- It is relevant to priority health needs and community needs and is to be carried out in partnership and collaboration
- It’s implementation is phased, action oriented and results based

Methodology
There were two major inputs for the development of the National Midwifery Strategy for the Sudan. These were; 1) the results of a recent situational analysis of midwifery in the Sudan and 2) the results from a Consensus and Consultation Workshop held on 29-30 May 2009 in Khartoum. The methodology used to achieve these results is outlined below. The results themselves follow in the next section. Besides the two above mentioned, the knowledge, expertise and on-going insights from a few strategic key informants was crucial to the development of the strategy.

Situational Analysis
In December 2008 and in April, an international maternal health specialist contracted by UNFPA carried out a situational analysis of midwifery in the Sudan. This was achieved using the following methods:

**Literature review:**
The literature review consisted of international midwifery specific documents, policies and reports and Sudan specific documents, strategies, policies and reports.

**Interviews**
Interviews were conducted with midwifery teachers, expert midwives and obstetricians, Reproductive Health Coordinators, representatives from donor organizations, Federal and State government officials and other stakeholders.

**Site visits**
Visits were carried out in three states to midwifery schools, to universities, and to health facilities.

**Key informants**
Throughout the entire process a number of key informants provided background information to the consultant linked to the historical context of midwifery in the Sudan and also provided the consultant with current up-to-date information.

The information from the above mentioned sources was collected was collated, analyzed and reported in relation to the following key areas: human resources and coverage of care, education and training, enabling environment, image and attractiveness of midwifery, and policies, legal and regulatory frameworks and political will. A strengths and weaknesses analysis was also carried out and there are descriptive reports of some examples of best practices found in the country.
Consultation and Consensus Workshop
A two-day consultation and consensus workshop was held on 29-30 May 2009. The Federal Ministry of Health-RH Programme was responsible for the workshop organisation and a Maternal Health International Consultant supported by the UNFPA-Sudan in collaboration with the Federal Ministry of Health-RH Programme was responsible for the content. Invited participants were the representatives from the newly formed ‘National Midwifery committee’, representatives from other directorates in the Federal Ministry of Health including the focal point for Nursing and Midwifery, experts in maternal health, representatives from universities and training institutes, representatives from the midwifery (and midwifery related) cadres representatives from the Obstetrics profession and representatives from UN agencies and donor agencies. The list of workshop participants can be found in Annex 1. (Can FMoH provide this?)

Workshop Goals
- To achieve consensus on the elements and areas of planning and implementation to achieve an effective and efficient scale-up of midwifery services in the Sudan
- To achieve consensus on the framework and content of a national strategy for scaling up midwifery services in the Sudan

Workshop Design
A participatory approach was taken during the two days in which plenary presentations and group work was scheduled. The plenary sessions presented the results of a recent situational analysis on midwifery in the Sudan, current data and statistics, best practice examples of midwifery scale up strategies in other countries (Afghanistan, Bangladesh and Indonesia) and theoretical background information on prioritization for implementation. This information set the stage for the interactive group work which involved the following:
- Determining strategies and actions needed for scaling up midwifery at the community level
- Determining strategies and actions needed for scaling up midwifery at the facility level
- Determining strategies and actions needed for ensuring quality in midwifery service provision
- Preliminary prioritization of elements and actions for implementation

Key results and recommendations

Results Situational analysis
The key results from the situational analysis are as follows:

Cadres of care currently providing midwifery related services
There are currently 5 cadres of trained midwifery or midwifery related providers:
- Graduate Nurse-Midwives (the sister midwife): 4 year diploma programme that ended in 1992, small numbers still working and mostly in higher positions or at Teaching hospitals
- Certificate Nurse-Midwives: 1 year midwifery training after a 3 year nursing certificate, working mostly at facilities providing hands on care
- Village Midwives: 1 year certificate programme, community and health unit based, providing hands on care
- Health Visitors: 2 year programme after Nurse-Midwife certification, working as teachers and supervisors and providing primarily antenatal care and family planning at facility level
- Assistant Health Visitors: 1 year programme for certificate nurse midwives developed as stop gap solution to the shortage of health visitors

At present, only graduate nurse-midwives fit internationally accepted definitions of midwife and Skilled Birth Attendant. It is probably that some of the nurse-midwives singularly fit the criteria but not that the cadre as a whole can be recognized as SBAs. There is great diversity in competency levels of all cadres (except the Graduate Nurse-Midwife) due to the variation in the years of primary education prior to training. Although upgrading is possible, each individual would need to be separately assessed (according to standard criteria) in order to determine if this is possible.

Enabling environment
The limiting factors for community based village midwives cover a whole range of areas. As they are not integrated into the health system and thus not employed (either publically or privately), they have no job security and no guarantee of income. There are very limited opportunities for continuing education and most often none or too little supervision which keeps the midwives isolated and not able to evolve within their work field. In general, they have no or poor access to supplies and medications; either they cannot afford to buy them or they cannot access these items as there is no functioning system for replenishment of supplies and medicines that is available to the midwives. They are often severely limited in their ability to consult and or refer cases due to lack of communication equipment and transport and thus cannot adequately carry out the single most important intervention that community midwives have, timely referral of complications.

Although Nurse-Midwives are often employed at facilities, they experience limiting factors as well. These are mostly related to the poor physical condition of the facilities and the lack of supplies and equipment.

Access to services
Good human resource planning in health requires a thorough analysis of various factors: clear vision and consensus on the type of provider or competencies needed in a defined area of work, agreement on numbers needed in general and specific numbers that are demographic related, education/training capacity, level of attrition of trained care providers and related to this the degree of utilization of the services.

The major bottleneck in the Sudan in relation to midwifery human resource planning is the lack of data. Current planning is based on general population based ratios and there is no consideration to geographical based planning which is most likely necessary in many areas in the Sudan as the country is large with large variations in population densities. At present, the planning is based on the output of the midwifery schools but as almost all of these schools are donor dependant there is no guarantee of continuity making this a risk factor in the planning. There is not enough known about the number of Village Midwives currently working and their case loads. The recent Household Survey shows that a significant percentage of births are being conducted by TBAs and not by trained midwives and there is too little understanding of the so-called demand side factors which determine user utilization of midwifery services.
Midwifery training and education

The current one year Village Midwife Training does not produce according to a ‘fitness for purpose’ principle and need to be better aligned with the actual work field that that the midwives encounter. There are currently gaps in skills and too little of a knowledge base. The poor physical condition of the schools and the lack of supplies and teaching materials are a large contributing factor to the poor status of midwifery education. There is often too little coordination between schools and clinical skills sites; either there is too little opportunity to utilize clinical sites or the site preceptors do not work according to the school prescribed methods. This is crucial as clinical, hands on experience that is aligned to the knowledge base learned during basic training is essential to producing qualified midwives especially in the community setting.

The single most identified limited factor in midwifery education in the Sudan is the lack of competent midwifery teacher. There are serious competency gaps in both clinical skills as well as in teaching methodology. Although promising, there are various initiatives being developed and implemented but without coordination and monitoring of these efforts at a central level they could result wasted investment. An example of this is the implementation of the new 2 year midwifery technician training (with a class of secondary school or higher graduates) without paying significant attention to the changes required in competencies and attitudes by teachers and staff to accommodate the students and where some problems have been reported in the initial phase.

At present, there are a number of singular initiatives being carried out relating to the development of new 2 year midwifery curriculum as well as diploma and degree midwifery programmes. It would greatly help these initiatives if there were a national consensus and policy on midwifery service provision and the prerequisites for midwifery education/training so that all future curricula could be based on ‘fitness for purpose’. It would then be possible to agree on standardized curricula which would be a good step toward quality assurance in midwifery education.

Political will, policies, and legal-regulatory framework

Although there are quite a few national and state strategy documents that address midwifery care provision within a broader scope, there are no national policy documents to guide the development of midwifery as a profession in the Sudan. There is currently no legal or regulatory framework for midwifery. The establishment of a Midwifery Council would be a first and very important step towards regulating the profession.

There is a serious lack of political engagement and possibly knowledge about the added value of midwifery service provision as demonstrated by the lack of federal budgeting and spending on maternal health and midwifery services.

During the analysis two promising and innovative initiatives were identified and written up as best practice case studies. Although neither of the initiatives have been rigorously tested, there is enough anecdotal evidence that demonstrates their value and validates looking into them further. Here follows a short summary of each study:

**Case study local midwifery training initiative**

Many of the states in the Sudan recruit village midwife candidates from the communities where there is the greatest need for their services and this is a good strategy aimed towards increasing midwifery coverage and possibly also utilization (although there is no hard evidence that utilization of services increases when local midwifery personnel have been recruited). One of the problems encountered has
been recruiting girls from conservative areas especially in Eastern Sudan as they do not get permission to leave the area to stay at the midwifery school during the training period. This was also the case in Wager a locality in Kassala State and located about 120 km from the midwifery school in Kassala. The solution was found to set up a local midwifery school in Wager, situated in houses in the community and to staff it with local personnel (as much as possible). Being closer to home and thus avoiding the problem of traveling, a class of students from Wager and the surrounding area were recruited and started the training in 2008. By doing this, the school (and its management) became a trusted part of the community. When after 7-8 months of training it became evident that the trainees needed more clinical experience there was little resistance to moving them to Kassala to finish the training. The initial mistrust by their fathers and husbands had disappeared and every trainee received permission to finish the programme in Kassala.

This appears to be a culturally sensitive strategy aimed at training the critical mass of village midwives needed in rural areas and could possibly be scaled up to other areas in the Sudan.

**Case study Midwifery School Clinics**

The midwifery school in Omdurman has a small birth clinic and antenatal clinic attached to it which women in the community can access. The teachers of the school reported that the clinic, being in the community, has a low threshold for access and especially because it was staffed 24 hours a day with teachers and student midwives. The concept of midwifery schools running their own ‘in house’ clinic is promising for the following reasons:

- It positions them in the community and provides the opportunity to partner with women (the basic universal midwifery principle).
- By lowing the threshold to care, it could help increase utilization and midwifery coverage in the community.
- It provides the student midwives with its own clinical site where trainees and their own school preceptors have access to real cases.
- It simulates the real life situation that midwives face in the community and for which they are trained for when midwives need to make important decisions about timely referrals or pre-referral treatment as opposed to making these decisions in the setting where the referral would go to and where most likely the necessary expertise and skills are available.
- It would stimulate the continuum of midwifery care as it would provide antenatal, intrapartum and postnatal care.

This concept needs to be worked out further but it is imaginable that it could be designed as an income generating project for the school.

The results of the situational analysis were synthesized into a strengths and weaknesses format which provided the logistical starting point for the development of the National Midwifery Strategy and are summarized below:

- **Human resources and coverage of care**
  - Strengths: Midwifery service provision is part of the cultural history in the country and is a known entity in Sudan. There is a large workforce of midwifery-related service provision and working especially at the community level, the Village Midwives. Recruitment for Village Midwife Schools strives to find candidates from communities in need of midwifery services. There is a promising new initiative that is bringing Village Midwife Schools physically to the locations that are most in
need of midwifery services in order to train those who would otherwise not be able to leave the area to attend the existing schools usually in larger towns.

- **Weaknesses:** There are too many cadres of providers of midwifery related services in all settings with varying competencies and not providing the full range of midwifery care. Besides the so-called Sister Nurse-Midwives (the last one being graduated in 1992) Sudan has no midwifery cadre that qualifies as a skilled birth attendant (according to the international definition) especially in the setting where this is needed the most, in the community. Facility based nurse-midwives are concentrated in Khartoum State and the capacity for training is severely limited due to closure of 2 of the 3 existing schools. Human Resources for Health planning for midwifery services is complicated by lack of good data on attrition, utilization and the variation in training capacity.

- **Education and training**
  - **Strengths:** The development of a new 2 year midwifery technician curriculum to replace the current 1 year Village Midwife programme is a promising initiative.
  - **Weaknesses:** The minimum educational entrance requirement for midwifery training often cannot be realized resulting in a large portion of village midwives who are illiterate or with limited literacy. There is a great variation in the basic educational level of certified nurse-midwives which makes it difficult to speak about a standard of quality in care provision in facilities. All the midwifery schools (village midwife as well as the only functioning certificate nurse-midwife school) are in dire need of rehabilitation and need appropriate supplies and teaching materials. The current group of midwifery teachers/tutors cannot be considered as qualified teachers and are lacking in both clinical skills and teaching methodology. There is not enough coordination between midwifery schools and clinical skills training sites. All the village midwifery schools are donor dependant for their existence.

- **Enabling environment**
  - **Weaknesses:** Almost all the areas considered to be part of an enabling environment are not present for community based midwifery services; village midwives are not employed in the health system and have no job or salary security, there is poor supervision and mentoring, there is no career pathway and limited chances for continued education, there is no/poor access to supplies and medications and poor links with referral services. Except for the job employment and salary security areas, facility based midwives also face the same limiting factors in the enabling environment.

- **Image and attractiveness of midwifery**
  - **Weaknesses:** There is a worsening of the image of midwifery which could be a contributing factor to less utilization of village midwives (and the continued use of Traditional Birth Attendants)

- **Policies, legal and regulatory frameworks and political will**
  - **Strengths:** There have been some policies and strategies developed that include scaling up midwifery and midwifery education reform
  - **Weaknesses:** There is not enough investment in midwifery education and service provision making it almost totally donor dependant. There is not enough political engagement to support better implementation of existing policies and strategies. There is currently no legal or regulatory framework for midwifery services and thus compromising the guarantee of quality of service provision to the public
Recommendations from the Consultation and Consensus Workshop

An adaptation of the framework for scaling up midwifery developed for the First International Forum on Scaling up Midwifery held in Hammamet, Tunisia in 2006 and organized by the UNFPA, the International Confederation of Midwives (ICM) and WHO, was used to guide the group discussions and to divide the results into issue areas. This framework is illustrated in annex 2.

The full list of the resulting recommendations is as follows:

Policy, legal and regulatory frameworks
- Advocacy is needed to ensure political will and involvement, financial support and policy development and implementation
- A regulatory framework for midwifery must be initiated to ensure quality and should include comprehensive job descriptions with corresponding scopes of practice, a registration system, certification or licensing procedures and accreditation processes for educational and training institutes

Equity in access to services
- Continuation of human resource planning for midwifery services based on population until more data is available and more understanding is acquired about the factors that determine how women decide which caregiver to seek
- Continuation of policy to recruit midwifery students from villages where the need is greatest and where they will most likely return home to work
- Break the spiral of negative image of village midwives by providing more supportive supervision, community awareness about the competency of village midwives and involving persons of influence in the community (including TBAs) when recruiting new midwife trainees.

Training and Education
- Prepare qualified teachers for all levels of midwifery education
- Continue refreshment courses for all levels of current midwifery workforce including EmOC
- Standardize midwifery curricula
- Ensure that training and teaching sites are up to standard physically as well as having sufficient and up to date teaching materials and supplies

Supervision and support
- Provide systematic supportive supervision especially at the community level with qualified and capable supervisors

Enabling environment
- Incorporate village midwives into the health system as employees by providing salaries and/or incentives (either monetary or other motivations)
- Ensure that village midwives have access to sufficient supplies and medications
- Look into providing village midwives with better communication means as cell phones
- Provide better links from community to referral facilities with EmOC
- Consider bringing EmOC facilities closer to the community (Health Center level)

Monitoring and Evaluation
- Implement routine data collection involving midwives and the maternity workforce at the community level so that midwives and the community can use the data
- Implement rigorous evaluation for all new programmes involving scaling up midwifery so that lessons learned will not be lost
**Stewardship and Resource Mobilization**
- Advocate for government to provide sufficient expenditures for maternal health and midwifery service provision to avoid total donor dependence and to guarantee sustainability of the services
- **Image and attractiveness of midwifery**
  - Initiate a public campaign to raise the image of midwifery in the Sudan
  - Capacity build leadership in the midwifery community
  - Support the revitalization of the Sudanese Midwifery Association
  - Strive to have midwifery representation at the policy and planning level
  - Stimulate collaboration between all members of the maternal workforce
National Strategy for Scaling-up Midwifery in the Republic of the Sudan

Introduction

During the Consultation and Consensus Workshop the participants discussed strategies and actions needed for scaling up midwifery services at both the community as well as the facility level. They also spent time discussing the concept of quality in service provision and what is needed to achieve this. This resulted in the development of two strategies. One for the long term vision that would be used to guide the process of change and an initial transitional strategy that would cover the prioritized short to middle term operational and strategic activities for implementation.

Long-term vision strategy

The long-term vision strategy is one to aspire to and reflects the creation and maintenance of a professional and competent midwifery workforce in the Sudan as an integral part of the health system. It is backed by sufficient evidence that the provision of quality midwifery services is a key strategy and cost effective intervention that can make significant progress towards improving the health of women while reducing maternal and neonatal death and disability.

It is acknowledged that the achievement of this long-term strategy will take many years and will require a phased implementation. Crucial to this success is the commitment and support from government and other stakeholders. It should be regarded as the end result to which all the phases of implementation will lead to.

The Midwife and her Scope of Work

The midwife in the Sudan will be by definition a skilled birth attendant. There will be various educational pathways for midwifery but each will produce autonomous, competent and qualified health care providers for childbearing women and their newborns who will be called ‘midwife’. The midwife in the Sudan will have a strong sense of identity and values and will partner with women, their families and their communities to ensure that pregnancy and childbirth is made safer. The midwife believes that every woman has the right to timely, appropriate and culturally sensitive care. The midwife will be a specialist in her own right able to provide a continuum of care during pregnancy, during childbirth, and in the first period following birth. The midwife will also be instrumental in providing family planning promotion and services at all levels as well as having a strong background in health, nutrition and hygiene promotion. The midwife can practice at all levels of health care provision ranging from the community to teaching hospitals. Midwives will be represented at all levels of national and state policy and decision making.

The cadre known as village midwife will play an important role in the provision of care at the community level providing antenatal care, care during childbirth, post natal care, family planning promotion and health promotion. The village midwife is not necessarily per definition a skilled birth attendant. The
village midwife will be regarded a member of the team providing midwifery (obstetric) care and will receive support and supervision from a midwife (when possible).

**Midwifery education**
Midwifery education and training is based on the internationally accepted basic competencies for midwifery practice as defined by the International Confederation of Midwives including the additional competencies for as Emergency Obstetrics (when appropriate and possible). Both programmes will teach the knowledge, skills and attitudes/behavior that are necessary to practice midwifery and both programmes will provide sufficient clinical training to produce competent practicing midwives. There will be two educational pathways: 1) a three year diploma programme and a 2) four year BSc programme. Midwifery education/training (including village midwife training) will be primarily provided by competent midwife teachers in collaboration with other specializations. For entry into both programmes the same minimum primary education level will be required, a secondary school certificate, but the degree programme will demand a higher proficiency level and possibly a better demonstrated motivation during the application interview. Diploma midwifery students will be recruited from the communities (as much as possible) so that they can serve their communities after graduation. Graduates from the degree programme will generally become midwife teacher, supervisors and managers or will go into other specialty areas as research etc. Educational advancement will exist from degree level to post graduate level and from diploma level to degree and higher level.

**Midwifery as part of a functioning health system**
Midwives will be an integral part of the health system and be employed and duly salaried. Diploma midwives will generally be health centre based with outreach to the community and ideally will work in teams with any other cadres of caregivers providing maternal and newborn health services (including village midwives) and especially with those based in the community. Investments made at the health centre level will ensure that they are midwifery led, clean, and well equipped and can provide at least the basic Emergency Obstetric and Neonatal Care functions.

**Quality Midwifery Care**
The quality of midwifery service provision will be assured by a legal and or regulatory framework including registration and certification or licensing and standardization of curricula and accreditation of midwifery education and trainings institutes. Midwives will work according to evidence based standards of practice and practice reflective practice aided by supportive supervision.

**First phase transitional strategy**
This strategy is intended to guide the first phase implementation of the long term vision strategy. It builds upon a so-called ‘and/and strategy’ which means that it calls for a number of short term operational changes which are relatively easy to implement when sufficient funding is available and show quick visible results while at the same time integrating the corresponding longer term strategic and attitude changes that are harder to implement but are necessary to ensure sustainability. It was recognized that the aims, actions and elements described in this transitional strategy are generally on a
macro planning level and based on a prioritization from the overall strategy recommendations and based on urgency and chance of success.

The prioritized elements of the first phase transitional strategy can best be grouped in categories corresponding to the agreed to aims of a national midwifery strategy document and are as follows:

**Create and maintain production of a competent midwifery workforce**

- Continuation of in-service midwifery training and upgrading of current midwifery workforce in interventions aimed at reducing maternal mortality and morbidity
- Quick scale-up of competent midwifery services at the community level
- Continuation of current one year curriculum midwifery training programme with concentration of improving quality of teachers
- Phased or zonal implementation of new village midwife training programme
- Training and deployment of diploma and degree level midwives

In this two pronged aim, there is equal emphasis on the creation as well as the maintaining of a competent midwifery workforce. Maintaining the current workforce, especially of the village midwives is essential for midwifery coverage and actions are needed to increase the quantity and quality of the current workforce through rehabilitating and supplying midwifery schools and providing in-service upgrading and refreshment courses to midwives and midwifery teachers where possible and aligned with existing initiatives from donors. At the same time, a start can be made on initiating the actions needed to create in the long-term a competent and qualified midwifery workforce as envisioned in the long-term strategy. Continued collaboration and dialogue with the educational and training institutes who are developing new curricula is important.

**Ensure the enabling work environment needed for skilled attendance**

- Creating political consensus for support to and financing of midwifery services
- Advocate for the employment of midwives in community service and/or performance incentives
- Provide supportive supervision to village midwives

The first building block of an enabling environment for midwifery services is political support and willingness to help finance the services. This will involve knowledge sharing and advocacy efforts aimed towards policy and decision makers. This is necessary to ensure the sustainability of the services and the achievement of the long term vision.

An enabling work environment involves many factors and there is sufficient evidence showing a positive correlation between positive practice environments and good performance. The elements chosen for the transitional strategy in this aim are general and aimed towards the incorporation of village midwives into the health system which is recognized as the single most inhibiting factor to quality midwifery service provision in the Sudan. This can be achieved through offering paid employment to midwives or through incentives (monetary or motivational) and the provision of supportive supervision, especially at the community level with qualified and capable supervisors. Both actions will contribute to a more motivated workforce which is synonymous with quality care.

Although recognized that a functioning referral system is an essential enabling element for skilled attendance, this was not prioritized at the time as it involves changes in the health system which is
broader than the scope of the National Midwifery Strategy. It is however, strongly recommended to incorporate midwifery into any Emergency Obstetrics (EmOC) strategies being developed or implemented and is further discussed in the section ‘Specific Topic Areas for Further Discussion’ of this document.

**Guarantee the quality of the provision of midwifery services**

- Midwifery regulation
- Evidence based midwifery
- Midwifery Leadership

Regulation is the foundation on which quality is based and often not addressed in midwifery service provision as is the case in the Sudan. Moreover, regulation ensures protection of the public by setting the standards and criteria for appropriate and quality service provision. This element is timely as it can immediately be incorporated into an existing initiative being supported by the WHO and driven by the Nursing-Midwifery Focal point at the Federal Ministry of Health-Human Resource Planning Directorate which is aimed at the establishment of a Nursing-Midwifery Council. A regulatory framework for midwifery will help to ensure quality and should include comprehensive job descriptions with corresponding scopes of practice, a registration system, certification or licensing procedures and accreditation processes for educational and trainings institutes.

An evidence base to service provision (including midwifery services) is crucial to the guarantee of quality and moreover ensures that harmful and non-beneficial interventions are replaced by beneficial and cost-effective interventions. Evidence based standards and guidelines also ensure that care is culturally sensitive and appropriate and thus helps increase utilization of services. The collection of data and monitoring and evaluation is also part of an evidence base and it is identified as a priority area in the transitional strategy so that a start can be made on a sustainable health information system that can be used to map services as well as evaluating new initiatives so that lessons learned will not be lost.

The transition to a professional midwifery workforce in the Sudan will need to be midwifery led, and in collaboration with other disciplines. To this end, there is a great need for building midwifery leadership capacity to ensure that there are strong and visionary leaders who are role models and who can represent midwifery at the policy and planning level. Support to the revitalization of the Sudanese Midwifery Association is a short term action that will contribute to this goal and aligns with the current work that UNFPA is carrying out in the Sudan in collaboration with the International Confederation of Midwives.

**Increase utilization of midwifery services**

- raise the image of midwifery and midwifery empowerment
- better communication with childbearing women and their families
- dialogue collaboration with TBAs

It appears that the image of the village midwife has declined. Although the exact reasons for this are not know, it is speculated that this may be primarily caused by a lack of understanding and knowledge of the capabilities of the trained midwife as opposed to the TBA. Social, cultural and financial reasons could also contribute to this. It is recognized that this lack of positive image contributes to a spiral that affects the village midwife in her work and attitude that is ultimately is self-fulfilling and needs to be broken.
More research is needed to better understand the factors that play a role in this. A public information campaign (national, state) highlighting the capabilities and work of (village) midwives in the Sudan could help break this spiral but is not sufficient without investing in community mobilization and awareness activities on the ground and especially with the users of the services. The negative image spiral can also be broken with systematic celebratory days for midwives as the International Day of the Midwife as these days provide midwives with the opportunity to be amongst peers and those who support them and can boost their image while at the same time midwifery is profiled positively in the environment. On the side of the midwives themselves it has been recognized that they would greatly benefit from pre-service communication training and community placements as these actions would place the midwives in the future work situation and help profile and position them in the communities. Continuing dialogue with TBAs could provide the environment for collaboration between the traditional providers and the village midwives. It may also be necessary to introduce incensement schemes or other innovative initiatives which will require further discussion and planning. A short term action which can be carried out is when recruiting new midwife trainees, to include persons of influence (including TBAs) in the process of identifying candidates as this could potentially position them better in the community when they return from the training to practice.
Strategic Implementation and Monitoring

Implementation and Monitoring Framework

The choice of elements and actions in the transitional strategy is based on the current situation in the workforce, the possible integration of these actions into ongoing initiatives and a prioritization of the most pressing issues. It should be regarded as a planning and monitoring instrument and describes the prioritized key actions to be taken in the short to middle term (approximately 3-5 years). It should not be regarded as a work plan as these require more details. The framework sets out the key data or information needed for the monitoring and evaluation of the actions prioritized for this strategy.

It is envisioned that this framework will be a valuable help when leveraging funding for the implementation of elements of this strategy. It is also expected that it will help guide the specific work plans and log frames that will be developed with government and individual donors. It is also envisioned that depending on funding sources, a number of detailed work plans will be developed at a later date to accommodate parts of the transitional strategy.

The actions described in the transitional implementation and monitoring framework should be initiated within a period of 1-5 years but will remain ongoing and be continued into the next phases of midwifery scale-up. A detailed timeline will need to be developed once there is a good idea of the magnitude of support and capacity for midwifery scale-up in the country.

The implementation work plan and monitoring and evaluation framework can be found in annex 2. It contains the 14 goals prioritized in the first phase transitional strategy with the corresponding inputs, actions, output indicators and outcome/impact indicators. The goals are diverse in nature and cover capacity building, quality improvement, advocacy and partnerships. This framework is adapted from ‘A Guide to Monitoring and Evaluation of Capacity Building Interventions in the Health Sector in Developing Countries’ from the MEASURE Evaluation Manual Series published in 2003.

In this context the following definitions are used:

- Inputs: set of resources, including financial resources, space policy and orientation that are the raw materials that contribute to capacity or change at each level
- Actions (also called processes): set of activities, practices or functions by which the resources are used in pursuit of the expected results
- Output indicators: Set of products anticipated through execution of practices, activities or functions
- Outcome indicators: set of results that represent capacity (an ability to carry out stated objectives) often expected to change as a direct result of capacity building intervention
- Impact indicators: Long-term results achieved through improved performance of the sustainable and improved health system

This model was especially chosen as it highlights the inputs needed to realize this transitional strategy. The inputs are considered one of the risk areas in the current situation in the Sudan as these inputs are generally related to political will and the availability of resources.

As this framework actually represents the first phase prioritized actions for short- and medium term implementation, the outcome and impact indicators have been grouped together. When applicable, there are outcome or impact indicators that relate to the overall goal. In some cases there are more specific indicators suggested which are related to the specific actions.
Transitioning the midwifery and midwifery related cadres

The long term midwifery vision strategy calls specifically for a professional midwife in the Sudan and the recommendations regarding education and scope and place of practice are aligned with the new vision. However, since Sudan currently has 5 cadres of trained midwives or other providers of maternal care there must be planned for a transitioning from the current situation to the vision goal. During the Consultation and Consensus Workshop, some work was carried out to clarify the transitions that need to take place.

The long term vision strategy for midwifery in the Sudan provides for 2 educational pathways to becoming a certified midwife. These midwives will essentially replace the current cadres (except for the village midwife) and work in clinical practice (including health promotion) at all levels (from community to teaching hospital). In addition, the degree level midwives will also take up positions as managers, supervisors and teachers.

The current village midwives will gradually be phased out and be replaced by the new community midwife cadre who in principle is a midwife auxiliary fully trained in the basic core competencies for midwifery practice. They will be the backbone of midwifery service provision in the communities and will work in teams with (if possible) being supervised by a midwife (or other with midwifery skills) who is based either in the community or at a basic health unit/health center.

An overview of the results of this discussion is as follows:

- Village midwife (old curriculum) phased out and replaced by Community midwife
- Nurse midwife phased out and replaced by Midwife (both levels)
- Graduate nurse midwife initiation of similar level Midwife (degree level)
- Assistant health visitor phased out and not replaced Midwife (both levels)
- Health Visitor phased out and replaced by Midwife (both levels)

Annex 3 depicts the full transitioning strategy for midwifery related cadres. (still needs to be made)

The establishment of the new diploma and degree level educational programmes for midwives is taken up in the first phase transitional strategy for midwifery in the Sudan as well as the implementation of the new midwifery community curriculum. As it will take respectively 2-5 years before the first new graduates from these programmes are available for employment, it will be necessary to develop a comprehensive work plan for the transitioning of midwifery cadres. This will involve a long period of time and be strongly influenced by the institutional capacity of the midwifery school and availability of sustainable funding to finance the schools.

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2 A decision on the exact nomenclature for this cadre will need to be made. Some suggestions are community midwife, village midwife, and midwife auxiliary. The term midwife technician is not considered appropriate
3 The Sudan Declaration on Nursing and Midwifery Education (2000) states clear criteria for the bridging from nurse midwife to diploma level midwife until 2015
4 Since this programme was stopped in 1992, there will be no transitioning but initiation of a similar level of education
5 Since a health visitor is also a nurse midwife, some of this cadre will also be able to bridge to a diploma level midwife under the criteria set in the Sudan Declaration
Related to this issue is the position of TBAs in the new strategy. The TBA cadre has not been incorporated into the transitioning midwifery related cadres strategy as they are not trained providers. They have however been included into the first phase implementation strategy as a means of increasing access to midwifery services and improving community relations. This is discussed further in the next section of this report (Specific Topic Areas for Further Consideration).

**Next steps for implementation**

Advocacy efforts aimed toward the Sudan National and State governments are part and parcel of the implementation plan for the new midwifery strategy, but given the current economic crisis and the lack of broad based government commitment, it will be necessary to solicit support, funds and resources in order to operationalise the midwifery strategy implementation framework. In other words, sufficient attention should be spent on the inputs in the M&E framework, as without these, the further actions will not be able to take place. This will require an analysis of resource availability and a pragmatic implementation strategy or aligning and collaborating with on-going or planned projects and initiatives that are broader scoped. Is it very probably that the transitional strategy as a whole will not be able to be implemented but it is also very possible that some of the actions in this strategy can be implemented within existing or emerging initiatives by donors and organizations in the Sudan. In this respect resources could be pooled and not be entirely dependent on one source. It could also speed up implementation as often within existing initiatives, management and logistics can be shared.

As the areas of work in this framework are based on need and opportunity, it will require periodic review. It is recommended that this be carried out by the National Midwifery Committee annually. It can be expected that the need will not change but that the opportunities for the implementation of midwifery scale-up activities may change over time.

It is also recommended that a new consultation workshop will be organized three years after the launch of this strategy. At this time, the progress to date can be reviewed and the stakeholders, experts and interested parties can help develop the next short to middle term implementation plan.

**Specific topic areas for further consideration**

Most of the recommendations from the Consultation and Consensus Workshop reached consensus could be easily fit into the various proposed actions as described in the implementation strategy. However a few topics remained that were more complex and where discussions were carried out in depth. Some of these topics involve innovative initiatives that need piloting, others are important issues that need further consideration in the next phase(es) of implementation and some are general topics that need further thought and consideration.
The position of Traditional Birth Attendants (TBAs) in the midwifery strategy

This subject was discussed in depth during the Consultation and Consensus Workshop and although consensus could not be reached on all recommendations, it was decided to take on the majority opinion in these cases.

A review of the facts shows that TBAs are often the birth attendant of choice for many women in the Sudan. There is anecdotal evidence that in some areas TBAs and village midwives compete for the provision services to some women and that in general there is poor communication between TBAs and village midwives (or other healthcare providers for that matter). Although there is no compelling evidence demonstrating the added value made by TBAs globally to safe motherhood, there is also very little evidence of proven harm. There is also a growing international consensus that TBAs can contribute to the achievement of MDG 5 as an accepted part of a community team providing care to childbearing women. TBAs can often identify problems or complications and because of her status in the community, she can be influential in convincing the women and/or her family to seek help. It is a huge step from recognizing the potential of collaboration with TBAs to incorporating them into the health system and this is step was not taken in the current strategy. It is recognized however that a better understanding of what TBAs do well as well as also knowing which practices by TBAs actually are harmful is important. Establishing a continuous dialogue with TBAs (either in formal or informal relationships) could lead to more trust and respect and eventually to the stopping of existing harmful practices. Collaborating with TBAs is taken up in one of the recommendations from the Consultation and Consensus Workshop which states: When recruiting new midwife trainees form the community, involving TBAs could result better collaboration between the midwife and the TBA once the midwife returns to the community or local health unit to work.

Although the subject of TBAs may be more contentious than any of the others and because of the huge potential of increasing access to midwifery services by utilizing TBAs (especially given the current situation in the Sudan), improving dialogue and relationships with TBAs has been incorporated as one of goals in the first phase implementation strategy and should be seen as a middle term pilot strategy that needs to be evaluated. The suggested action is to implement an incentive scheme to motivate TBAs to work with midwives in communities but this will need further discussion before it can be planned and implemented.

Clarifying the role and status of village midwives

The consensus reached about the future of midwifery in the Sudan states clearly that it should evolve into a true autonomous profession and in this respect the roles and responsibilities of the ‘midwives’ of the future are clear. There was unanimous agreement that the current village midwife is not a skilled birth attendant and there was disagreement as to the role, scope of practice and the position of the village midwife in the future. It was questioned whether this cadre-even when upgraded into a cadre with a 2 year training- will ever be considered as skilled birth attendants according to the internationally agreed to definition. It was even suggested during the Consultation and Consensus Workshop that this cadre could be phased out and replaced by diploma midwives.

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Currently there is no global consensus about the prerequisites for basic midwifery education that is not part of a university or institute of higher education but experiences in other countries suggest strongly that a full secondary school education (or at least 10 years) is needed to develop midwives who can function as autonomous skilled birth attendants. While at the same this, it is recognized that in most resource poor countries it will be very difficult finding a critical mass (enough to provide midwifery coverage in the rural areas) of candidates to be found for recruitment who fulfill this criteria. This problem can only be solved with long term education and literacy programmes.

However, there are some very strong arguments for retaining a midwifery related cadre at the community level in the Sudan:
- Village midwives are part of the history and culture of the Sudan and there has been significant investment in this cadre resulting in a large number having received training and working in the communities and health units.
- It is not probable that the diploma midwives (in the future) will be motivated to work at the community level and in the long-term strategy, it is envisioned that it would be more efficient to have the diploma (or degree) midwife fulfill a pivotal role in the continuum of midwifery care model from the community to the facility, by leading the maternal health care team and operating from the health unit/health centre level.
- A community based midwifery (related) cadre is essential to achieving full maternal health coverage in the Sudan otherwise there is a strong possibility that maternal health care will remain in (or revert back to) the hands of untrained Traditional Birth Attendants.

Another important issue that requires immediate attention is the status and positioning of the village midwife. There is still need for clarity on the following issues:
- Distinction between the village midwife with one year training and the village midwife ‘new style’ completing the new 2 year programme. In the first batch of midwives trained with the new curriculum, it appears that this was an issue as they requested different midwifery kits than the standard one to distinguish them as being a different type of midwife than the previous ones. This could be addressed also in the nomenclature of this new cadre. A new title could offer this distinction and could be formally implemented into the new midwifery regulations.
- Clarity as to the difference between the village midwife ‘new style’ and the diploma midwife of the future. It will be necessary to clarify the role and responsibilities of this cadre as soon as possible with a clear description of her role in the maternal health continuum and the level of her autonomy. This will also make clearer which level of supervision she will require and this is important to know when designing supervision systems.

The following issues need to be considered and agreed upon:
- Within the long term midwifery strategy, the midwife of the future has completed either a diploma or degree programme
- To ensure full midwifery (related) coverage in the Sudan a midwifery related cadre is needed, which is provided under the new 2 year midwifery curriculum
- The person completing the new 2 year midwifery curriculum should be distinguishable from the village midwife
- The title of midwife technician does not cover the entire (and holistic) scope of midwifery related practice and should not be used. The use of the word midwife in the position description of this cadre could cause confusion within the legal or regulatory mechanisms of the future. The term
midwifery auxiliary should be considered as it conveys that the care provider is very much aligned with the work of the midwife but is not recognized as an autonomous midwife.
- The midwifery auxiliary will need separate regulation under the Midwifery Council
- The midwifery auxiliary will require supervision. The level of supervision required will vary from person to person based on their level of primary education and life experience. This could be determined by an exit evaluation after finishing the programme and further determined by periodic evaluation in the field.
- There should be a bridging possibility for qualified midwifery auxiliaries to diploma level. This can help increase the image of the cadre and attract girls with full primary school education who are not in the position to follow the diploma programme as it opens the door to career advancement.
- The person completing the new 2 year midwifery curriculum should be considered of a higher level than those completing the one year programme.

**Strengthening midwifery services and basic EmOC at Health Unit Level**

There was a strong consensus agreement (and supported by sufficient evidence) that maternal mortality and morbidity can be combated when women are able to access emergency care and this has traditionally been operationalised by investing in facility based care often at the rural hospital level. This approach will not be sufficient in the Sudan as all too often as it appears that women do not and sometimes cannot access these hospitals. There are a number of reasons for this including, no availability of transportation, hospital inaccessibility resulting from poor road conditions especially in the rainy season and social and/or cultural restraints. The participants in the Consultation and Consensus Workshop strongly recommended supporting health systems where Basic Health Units and/or Health Centers are strengthened to become focal points for maternity services and basic EmOC services. This will entail ensuring sufficient technical capacity in EmOC at this level and will require investing in midwives (the future diploma or degree level) or medical officers to work at this level and sufficient investment in the physical capacity of these units and centers. Another area for improvement is the referral system which will need strengthening in terms of: communication between providers, availability of affordable transport and data collecting and monitoring. Increasing the quality and availability of EmOC requires a concerted effort at all levels.

It was also envisioned that strengthening of the Basic Health Unit/Health Center for maternity services and being staffed by competent and capable midwives would lower the threshold to access for women from the communities and thus increasing facility based births. At the same time, the midwife at this level can be an effective and sympathetic supervisor of the village midwives within her catchment area and could theoretically provide outreach consultancies to the communities when required. The Basic Health Units/Health Centers can also become an important link in the supply chain to communities (especially for supplies, equipment and medications required for quality midwifery services) and can be instrumental in data collection (Health Information Systems) that can feed into national data for monitoring and evaluation.
General Recommendations

1. This strategy needs to go hand in hand with advocacy efforts in order to persuade leadership to commit to and support midwifery services in the Sudan.
2. The National Technical Midwifery Committee should be supported in order to ensure strong and consistent leadership for further planning and implementation of the midwifery strategy.
3. The National Technical Midwifery Committee should liaise with donors and NGOs in order to be ensure that existing and planned initiatives in midwifery and midwifery related services are aligned with the national strategy.
4. Expanding midwifery coverage in the communities and underserviced areas should become a priority issue for policy and decision makers.
5. Increasing midwifery coverage should not take place at the cost of maintaining the quality of midwifery services.
6. Support is needed to create and maintain strong midwifery leadership in the Sudan.
7. Public awareness campaigns and social mobilization techniques are needed to increase the utilization of midwifery services in communities in the Sudan.
8. Health system strengthening is required to ensure appropriate and timely maternal and newborn health care provision.
9. The progress of the phased implementation of the midwifery strategy should be closely monitored and evaluated by the National Technical Midwifery Committee.

Looking forward

The preliminary announcement and explanation of this strategy took place during the celebratory meeting on the International Day of the Midwife held in Khartoum on 5 May 2009. The Minister of Health, Mrs Boutrous (full name please) called it a timely document that would greatly help shape policy and contribute towards the achievement of the Millennium Development Goal 5, the reduction of maternal mortality.

This strategy document has been approved by the Federal Government (does this make sense?) and should be considered the foundation to the creation and maintenance of a competent and qualified midwifery and midwifery related workforce in the Republic of the Sudan. It should be made available to all organizations, educational institutes and individuals who are involved with the provision of maternal health in the Sudan at Federal, State and Locality levels.
Annex 1: list of participants Consultation and Consensus Workshop
Annex 2: Framework for Scaling-up Midwifery Services

Adapted from the one used at the First International Forum on Scaling up Midwifery held in Hammamet, Tunisia in 2006 and organized by the UNFPA, the International Confederation of Midwives (ICM) and WHO.
### Annex 3: Implementation work plan with M&E framework first phase midwifery strategy

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<thead>
<tr>
<th>Goals</th>
<th>Inputs</th>
<th>Actions</th>
<th>Output indicators</th>
<th>Outcome/Impact indicators</th>
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<tbody>
<tr>
<td>1. Create and maintain production of a competent midwifery workforce</td>
<td>Financial and technical support for finalization, printing and distribution of the BOC (basic obstetric care) training curriculum</td>
<td>BOC refresher courses for midwives</td>
<td>Trainers of trainers teams trained Number of refresher courses completed</td>
<td>Increase in midwife to village/population ratio Increase in utilization of midwifery services</td>
</tr>
<tr>
<td>1.1. Continuation of in-service midwifery training and upgrading of current midwifery workforce in interventions aimed at reducing maternal mortality and morbidity</td>
<td>Trainers of trainers of BOC BOC refresher courses for midwives</td>
<td>Trainers of trainers teams trained Number of refresher courses completed</td>
<td>Increase in knowledge and experience of village midwives in life saving skills Women receiving appropriate pre-referral management</td>
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<tr>
<td>1.2. Quick scale-up of competent midwifery services at the community level</td>
<td>Support to bridging programmes</td>
<td>Develop bridging course for nurses to become midwives working at the community or health unit level Fast track training of nurses to become midwives</td>
<td>Number of bridging courses</td>
<td>Increase of fast tracked nurse midwives to community and health unit level</td>
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<td>1.3. Continuation of current one year curriculum midwifery training programme with concentration of improving quality of teachers</td>
<td>Financial and physical resources for pre-service midwifery training/education including teacher training Trainers of trainers</td>
<td>Rehabilitation of midwifery schools including clinical skills and teaching equipment Refresher courses for midwifery teachers in knowledge areas MM reduction and in teaching methods</td>
<td>Number of refurbished schools Number of teachers upgraded</td>
<td>Improved knowledge and skills of midwifery teachers and graduating midwives</td>
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<td>Goals</td>
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<tr>
<td>1.4. Phased/Zonal implementation of new village midwife training programme</td>
<td>2 year village midwife curriculum  Development of standardized prerequisites of midwifery school for conduction of Midwives training  Competent midwifery teachers for schools implementing new curriculum  Financial resources for midwifery schools implementing new curriculum</td>
<td>Finalization and approval (accreditation) of new 2 year curriculum  Develop and implement strategies for identifying and recruiting competent midwifery teachers and/or fast tracking other competent health care providers/teachers to midwifery teachers  Rehabilitation (including clinical skills and teaching equipment) of midwifery schools implementing new curriculum</td>
<td>Launch of new curriculum  Number of competent midwifery teachers teaching new curriculum  Number and coverage of schools implementing new curriculum</td>
<td>Number of graduates from programmes with new curriculum  Improved quality of midwifery care at community and health unit levels</td>
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<tr>
<td>1.5 Training and deployment of diploma and degree level midwives</td>
<td>Formulation of National Technical Committee (National Midwifery Committee and Ministry of Higher Education) to develop midwifery diploma and degree curricula and standard list of needs  Financial support for new midwifery education programmes including educational materials and skills training</td>
<td>Finalization and approval (accreditation ) of degree and diploma midwifery curricula  Development and standardization the content of the midwifery bridging course  Development of a standardized assessment tool for certified nurses, nurse midwives and HVs for bridging to Midwifery Diploma</td>
<td>Number of operational degree and diploma midwifery programmes  Number of operational bridging courses for midwifery diploma  Number of midwifery degree/ diploma and bridging (to diploma) programmes started</td>
<td>Number of midwives graduated and working at community or health unit levels  Improved quality of services (qualitative and quantitative)</td>
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<td>Goals</td>
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<td>2. Ensure the enabling work environment needed for skilled attendance in midwifery services</td>
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<tr>
<td>2.1 Creating political consensus for support to and financing of midwifery services</td>
<td>Advocacy for increased financing and political support for midwifery services</td>
<td>Conduct advocacy sessions for the decision makers (ministers, parliamentarians and state Wally’s) to support midwifery services</td>
<td>Number of developed advocacy materials</td>
<td>Sustainable support and financing of midwifery services has been ensured</td>
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<tr>
<td></td>
<td></td>
<td>Production of advocacy materials</td>
<td>Increase in Gov funding for midwifery services</td>
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<td>Goals</td>
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<tr>
<td>2.2 Advocate for the employment of midwives in community service and/or performance incentives</td>
<td>Financial support from Federal and state level to employ midwives</td>
<td>Conduct consensus workshops for midwifery incorporation into the health system including all key partners at national and state levels</td>
<td>Number of workshops conducted</td>
<td>Number of employed midwives</td>
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<td></td>
<td>Financial and technical support for performance based incentive schemes</td>
<td>Development (performance based) incentive schemes</td>
<td>Number of employed midwives</td>
<td>Number of midwives receiving incentives</td>
</tr>
<tr>
<td>2.3 Improving midwives’ access to supplies and equipment (especially in rural areas)</td>
<td>Advocacy targeting governmental and non-governmental to support the provision of supplies to midwives in rural areas</td>
<td>Midwifery supplies and renewable materials periodically distributed to in-service midwives</td>
<td>Number and frequency of midwives receiving supplies</td>
<td>Number of midwives working with recommended and standardized equipment</td>
</tr>
<tr>
<td>2.4 Provide supportive supervision to village midwives</td>
<td>Financial and technical support for supervision training and employment of midwife supervisors</td>
<td>Financial and technical support for implementation of state coordinated supervision system</td>
<td>Number of midwife supervisors trained</td>
<td>Number of midwife supervisors employed</td>
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<td></td>
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<td>Number of midwife supervisors employed</td>
<td>Number of midwives receiving supervision</td>
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<tr>
<td>3 Guarantee the quality of the provision of midwifery services</td>
<td>Federal and state policies and legislation on (nursing) midwifery regulation</td>
<td>Development of Midwifery Law and Code of Conduct</td>
<td>Formulation of Technical Committee for development of Midwifery Law and Code of Conduct</td>
<td>Approved law of code of conduct available</td>
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<td></td>
<td>Financial and technical support for National and State (Nursing) Midwifery regulatory bodies and registration and certification systems</td>
<td>Establishment of the Nursing Midwifery Council (NMC)</td>
<td>Launch of Midwifery Council</td>
<td>Functioning midwifery registration/licensing mechanism</td>
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<td></td>
<td>Partnerships with other regulatory bodies</td>
<td>Development of state coordinated registration and certification licensing mechanisms</td>
<td>Number of midwives (re)registered and or (re)certified</td>
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<td>Development of criteria for (re)certification</td>
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<td>Update the registration of the in-service VMWs</td>
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<td>3.1 Midwifery regulation</td>
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<tr>
<td>3.2 Evidence based midwifery</td>
<td>Collaborations with research and educational institutes</td>
<td>Development of standards and practice guideline for midwifery practice</td>
<td>Number of guidelines or standards in place</td>
<td></td>
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<td></td>
<td>Support for guideline and standards development</td>
<td>Training for care providers in data collection</td>
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<td>Technical and financial support for data collection (training and mechanism) and analysis</td>
<td>Incentive schemes to stimulate data collection at the community level</td>
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<td>Implementation of (Medical Information Systems)</td>
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<td>Improvement of quantity and quality of data collected</td>
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<td>3.3 Midwifery leadership</td>
<td>Support for the formulation of the Sudanese Midwifery Association</td>
<td>Training of the SMA Executive Committee on management</td>
<td>Registration of the Sudanese Midwifery Association</td>
<td>Strong, viable and well-functioning SMA</td>
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<td></td>
<td>Financial support for the establishment of Sudanese Midwifery Association (SMA) office</td>
<td>Support SMA action plan development</td>
<td>Conduction of the 1st meeting of the SMA general assembly with election of the Executive Committee</td>
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<td>Technical and financial support for capacity building SMA</td>
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<tr>
<td>4 Increase utilization of midwifery services</td>
<td>Support for public campaign/awareness raising</td>
<td>National and State public campaigns</td>
<td>Number of campaigns carried out</td>
<td>Number of women receiving midwifery care</td>
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<td></td>
<td>Financial and technical support for research relating to the empowerment of midwives</td>
<td>Conduct KAP survey to determine priority areas for empowering midwives</td>
<td>Number locations where IDM is celebrated per year</td>
<td></td>
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<tr>
<td>4.1 Raise the image of midwifery and empowering midwives</td>
<td></td>
<td>Annual celebration International Day of the Midwife (IDM)</td>
<td>Number communities reached</td>
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<td>Goals</td>
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| 4.2 Better communication with childbearing women and their families  | Financial and technical support for in-service refresher courses on communication for village midwives  
Financial and technical support for pre-service midwifery training to include more time in communities  
Financial and technical support for research to identify what influences women in seeking obstetric care and care provider | Midwifery refresher courses on communication and profiling and positioning in community  
In service training in the communities | Number of midwives completing communication course  
Pre-and-post testing of women’s image of midwives |                                                                          |
| 4.3 Dialogue and collaboration with TBAs                              | Financial support for meetings and information sharing with TBAs  
Financial support for referral incentives schemes for TBAs             | Involving TBAs in the recruiting process of midwifery trainees  
Develop referral incentive schemes for TBAs                              | Number of TBAs referring women to village midwives | Better collaboration between village midwives and TBAs                        |
Annex 4: Framework for transitioning strategy of midwifery and midwifery related cadres

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

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

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

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

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

Supersedes the ICM “Definition of the Midwife” 1972 and its amendments of 1990
INTERNATIONAL CONFEDERATION OF MIDWIVES

ESSENTIAL COMPETENCIES FOR BASIC MIDWIFERY PRACTICE 2002

INTRODUCTION
The International Confederation of Midwives (ICM) is a federation of midwifery associations representing midwives in 72 nations of the world. The ICM works closely with all UN agencies in support of Safe Motherhood, primary health care strategies for the world's families, and the definition and preparation of the midwife. In keeping with the aims of the ICM, the ICM/WHO/FIGO international Definition of the Midwife (1992), the ICM International Code of Ethics for Midwives (1993), the ICM Global Vision for Women and Their Health (1996) and requests from member associations, the ICM has taken the lead in defining these essential competencies for midwives.
Throughout this document, the term "competencies" is used to refer to both the broad statement heading each section as well as the basic knowledge, skills and behaviours required of the midwife for safe practice in any setting. They answer the question: "What does a midwife do?" and are evidence-based. (See Appendix 1)
It is fully understood that these competencies may be considered maximum in some areas of the world, and minimum in other areas. Some knowledge and skills have been separated into a category, "additional". This allows for variation in the preparation and practice of midwives throughout the world, depending on the needs of their local community and/or nation.
Likewise, in recognition that midwives receive their knowledge and skills from several different educational pathways, these competencies are written for generic use by midwives and midwifery associations responsible for the education and practice of midwifery in their country or region. The essential competencies are guidelines for those interested in developing midwifery education, and information for those in government and other policy arenas who need to understand who a midwife is, what a midwife does, and how the midwife learned to be a midwife.
It is expected that the document will undergo continual evaluation as it is used world-wide and as the health care needs of childbearing women and families change.

KEY MIDWIFERY CONCEPTS
The key midwifery concepts that define the unique role of midwives in promoting the health of women and childbearing families include: partnership with women to promote self-care and the health of mothers, infants and families; respect for human dignity and for women as persons with full human rights; advocacy for women so that their voices are heard; cultural sensitivity, including working with women and health care providers to overcome those cultural practices that harm women and babies;
a focus on health promotion and disease prevention which views pregnancy as a normal life event. Midwives recognise that equity of status for women will bring the greatest impact on global maternal-child health by ensuring adequate nutrition, clean water and sanitation; so they are committed to the improvement of basic living conditions as well as providing competent midwifery services.

**SCOPE OF MIDWIFERY PRACTICE**

The scope of midwifery practice used throughout this document is built upon the ICM/WHO/FIGO international *Definition of the Midwife* (1992). Midwifery practice includes the autonomous care of the girl-child, the adolescent and the adult woman prior to, during and following pregnancy. This means that the midwife gives necessary supervision, care and advice for women during pregnancy, labour and the postpartum period. The midwife conducts deliveries on her own responsibility and cares for the newborn infant. This care includes primary health care supervision within the community (preventive measures); health counselling and education for women, the family and the community including preparation for parenthood; the provision of family planning; the detection of abnormal conditions in the mother and child; the procurement of specialised assistance as necessary (consultation or referral); and the execution of primary and secondary emergency measures in the absence of medical help. Midwifery practice is ideally conducted within a community-based health care system that may include traditional birth attendants, traditional healers, other community-based health workers, doctors, nurses and specialists in referral centres.

**THE MIDWIFERY MODEL OF CARE**

The Midwifery Model of Care is based on the premise that pregnancy and birth are normal life events. The Midwifery Model of Care includes: monitoring the physical, psychological, spiritual and social wellbeing of the woman and family throughout the childbearing cycle; providing the woman with individualised education, counselling and antenatal care; continuous attendance during labour, birth and the immediate postpartum period; ongoing support during the postnatal period; minimising technological interventions; and identifying and referring women who require obstetric or other specialist attention. This model of care is woman-centred and therein lies its accountability.

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3

**THE FRAMEWORK FOR DECISION-MAKING IN MIDWIFERY CARE**

Midwives assume responsibility and accountability for their practice, applying up-to-date knowledge and skills in caring for each woman and family. The safety and overall well-being of the woman is of foremost concern to the midwife. The midwife strives to support a woman's informed choices in the context of a safe experience. The midwife's decision-making process utilises a variety of sources of knowledge and is dynamic, responding to the changing health status of each woman. Midwives involve women and their families in all parts of the decision-making process and in developing a plan.
of care for a healthy pregnancy and birth experience.

**STEP 1:** Collect information from the woman, from the woman's and the infant's records, and from any laboratory tests in a systematic way for a complete assessment.

**STEP 2:** Identify actual or potential problems based on the correct interpretation of the information gathered in Step 1.

**STEP 3:** Develop a comprehensive plan of care with the woman and her family based on the woman's or infant's needs and supported by the data collected.

**STEP 4:** Carry out and continually update the plan of care within an appropriate timeframe.

**STEP 5:** Evaluate the effectiveness of care given with the woman and her family, consider alternatives if unsuccessful, returning to STEP 1 to collect more data and/or develop a new plan.

**GUIDING STATEMENT TO MEMBER ASSOCIATIONS**

The essential competencies for basic midwifery practice that follow are based on the values, vision, strategies and actions used by those who attend to the health needs of women and childbearing families. Member associations are encouraged to use this ICM statement of competencies, as needed in their countries, in the education, regulation and development of standards of practice for midwives as well as in policies needed to strengthen midwifery.

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**ESSENTIAL COMPETENCIES FOR BASIC MIDWIFERY PRACTICE**

MAY 2002

**GENERIC KNOWLEDGE, SKILLS AND BEHAVIOURS FROM THE SOCIAL SCIENCES, PUBLIC HEALTH AND THE HEALTH PROFESSIONS**

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

**Basic Knowledge and Skills:**

1. Respect for local culture (customs).
2. Traditional and modern routine health practices (beneficial and harmful).
3. Resources for alarm and transport (emergency care).
4. Direct and indirect causes of maternal and neonatal mortality and morbidity in the local community.
5. Advocacy and empowerment strategies for women.
8. Strategies for advocating with women for a variety of safe birth settings.
9. Knowledge of the community - its state of health including water supply, housing, environmental hazards, food, common threats to health.
10. Indications and procedures for adult and newborn/infant cardiopulmonary resuscitation.
11. Ability to assemble, use and maintain equipment and supplies appropriate to setting of practice.

**Additional Knowledge and Skills**
12. Principles of epidemiology, sanitation, community diagnosis and vital statistics or records.
13. National and local health infrastructures; how to access needed resources for midwifery care.
15. National immunisation programs (provision of same or knowledge of how to assist community members to access to immunisation services).

**Professional Behaviours - The midwife:**
1. Is responsible and accountable for clinical decisions.
2. Maintains knowledge and skills in order to remain current in practice.
3. Uses universal/standard precautions, infection control strategies and clean technique.
4. Uses appropriate consultation and referral during care.
5. Is non-judgmental and culturally respectful.
6. Works in partnership with women and supports them in making informed choices about their health.
7. Uses appropriate communication skills.
8. Works collaboratively with other health workers to improve the delivery of services to women and families.

**PRE-PREGNANCY CARE AND FAMILY PLANNING METHODS**

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

**Basic Knowledge of:**
1. Growth and development related to sexuality, sexual development and sexual activity.
2. Female and male anatomy and physiology related to conception and reproduction.
3. Cultural norms and practices surrounding sexuality, sexual practices and childbearing.
4. Components of a health history, family history and relevant genetic history.
5. Physical examination content and investigative laboratory studies that evaluate potential for a healthy pregnancy.
6. Health education content targeted to reproductive health, sexually transmitted infections (STIs), HIV/AIDS and child survival.
7. Natural methods for child spacing and other locally available and culturally acceptable methods of family planning.
8. Barrier, steroidal, mechanical, chemical and surgical methods of contraception and indications for use.
9. Counselling methods for women needing to make decisions about methods of family planning.
10. Signs and symptoms of urinary tract infection and common sexually transmitted infections in the area.

Additional Knowledge of:
11. Factors involved in decisions relating to unplanned or unwanted pregnancies.
12. Indicators of common acute and chronic disease conditions specific to a geographic area of the world, and referral process for further testing/treatment.
13. Indicators of and methods of counselling/referral for dysfunctional interpersonal relationships including sexual problems, domestic violence, emotional abuse and physical neglect.

Basic Skills:
1. Take a comprehensive history.
2. Perform a physical examination focused on the presenting condition of the woman.
3. Order and/or perform and interpret common laboratory studies such as haematocrit, urinalysis or microscopy.
4. Use health education and basic counselling skills appropriately.
5. Provide locally available and culturally acceptable methods of family planning.
6. Record findings, including what was done and what needs follow-up.

Additional Skills:
7. Use the microscope.
8. Provide all available methods of barrier, steroidal, mechanical, and chemical methods
of contraception.
9. Take or order cervical cytology smear (Pap test)

CARE AND COUNSELLING DURING PREGNANCY

Competency #3: Midwives provide high quality antenatal care to maximise the health during pregnancy and that includes early detection and treatment or referral of selected complications.

Basic Knowledge of:
1. Anatomy and physiology of the human body.
2. Menstrual cycle and process of conception.
4. How to confirm a pregnancy.
5. Diagnosis of an ectopic pregnancy and multiple fetuses.
6. Dating pregnancy by menstrual history, size of uterus and/or fundal growth patterns.
7. Components of a health history.
8. Components of a focused physical examination for antenatal visits.
9. Normal findings [results] of basic screening laboratory studies defined by need of area of the world; eg. iron levels, urine test for sugar, protein, acetone, bacteria.
11. Normal psychological changes in pregnancy and impact of pregnancy on the family.
12. Safe, locally available herbal/non-pharmacological preparations for the relief of common discomforts of pregnancy.
14. Nutritional requirements of the pregnant woman and fetus.
15. Basic fetal growth and development.
16. Education needs regarding normal body changes during pregnancy, relief of common discomforts, hygiene, sexuality, nutrition, work inside and outside the home.
17. Preparation for labour, birth and parenting.
18. Preparation of the home/family for the newborn.
19. Indicators of the onset of labour.
20. How to explain and support breastfeeding.
21. Techniques for increasing relaxation and pain relief measures available for labour.
22. Effects of prescribed medications, street drugs, traditional medicines and over-the-counter drugs on pregnancy and the fetus.
23. Effects of smoking, alcohol use and illicit drug use on the pregnant woman and fetus.
24. Signs and symptoms of conditions that are life-threatening to the pregnant woman; eg. pre-eclampsia, vaginal bleeding, premature labour, severe anaemia.

25. Signs, symptoms and indications for referral of selected complications and conditions of pregnancy: eg. asthma, HIV infection, diabetes, cardiac conditions, post-dates pregnancy.

26. Effects of above named chronic and acute conditions on pregnancy and the fetus.

Basic Skills:
1. Take an initial and ongoing history each antenatal visit.
2. Perform a physical examination and explain findings to woman.
3. Take and assess maternal vital signs including temperature, blood pressure, pulse.
5. Perform a complete abdominal assessment including measuring fundal height, position, lie and descent of fetus.
7. Listen to the fetal heart rate and palpate uterus for fetal activity pattern.
8. Perform a pelvic examination, including sizing the uterus and determining the adequacy of the bony structures.
9. Calculate the estimated date of delivery.
10. Educate women and families about danger signs and when/how to contact the midwife.
11. Teach and/or demonstrate measures to decrease common discomforts of pregnancy.
12. Provide guidance and basic preparation for labour, birth and parenting.
13. Identify variations from normal during the course of the pregnancy and institute appropriate interventions for:
   a. low and/or inadequate maternal nutrition
   b. inadequate fetal growth
   c. elevated blood pressure, proteinuria, presence of significant oedema, severe headaches, visual changes, epigastric pain associated with elevated blood pressure
   d. vaginal bleeding
   e. multiple gestation, abnormal lie at term
   f. intrauterine fetal death
g. rupture of membranes prior to term
14. Perform basic life saving skills competently.
15. Record findings including what was done and what needs follow-up.

Additional Skills:
16. Counsel women about health habits; eg. nutrition, exercise, safety, stopping smoking.
17. Perform clinical pelvimetry [evaluation of bony pelvis].
18. Monitor fetal heart rate with doppler.
19. Identify and refer variations from normal during the course of the pregnancy, such as:
   a. small for dates [light]/large for dates [heavy] fetus
   b. suspected polyhydramnios, diabetes, fetal anomaly (eg. oliguria)

CARE DURING LABOUR AND BIRTH

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

Basic Knowledge of:
1. Physiology of labour.
3. Psychological and cultural aspects of labour and birth.
4. Indicators that labour is beginning.
5. Normal progression of labour and how to use the partograph or similar tool.
7. Measures to assess maternal well-being in labour.
10. Transition of newborn to extra-uterine life.
11. Physical care of the newborn - breathing, warmth, feeding.
12. Promotion of skin-to-skin contact of the newborn with mother when appropriate.
13. Ways to support and promote uninterrupted [exclusive] breastfeeding.
14. Physiological management of the 3rd stage of labour.
15. Indications for emergency measures: eg. retained placenta, shoulder dystocia, atonic uterine bleeding, neonatal asphyxia.
17. Indicators of complications in labour: bleeding, labour arrest, malpresentation, eclampsia, maternal distress, fetal distress, infection, prolapsed cord.
18. Principles of active management of 3rd stage of labour.

**Basic Skills:**
1. Take a specific history and maternal vital signs in labour.
2. Perform a screening physical examination.
3. Do a complete abdominal assessment for fetal position and descent.
4. Time and assess the effectiveness of uterine contractions.
5. Perform a complete and accurate pelvic examination for dilation, descent, presenting part, position, status of membranes, and adequacy of pelvis for baby.
6. Follow progress of labour using the partograph or similar tool for recording.
7. Provide psychological support for woman and family.
8. Provide adequate hydration, nutrition and comfort measures during labour.
10. Promptly identify abnormal labour patterns with appropriate and timely intervention and/or referral.
11. Perform appropriate hand manoeuvres for a vertex delivery.
12. Manage a cord around the baby's neck at delivery.
13. Cut an episiotomy if needed.
14. Repair an episiotomy if needed.
15. Support physiological management of the 3rd stage of labour.
16. Conduct active management of the 3rd stage of labour including:
   a. Administration of uterotonic agents
   b. Controlled cord traction
   c. Uterine massage after delivery of the placenta, as appropriate
17. Guard the uterus from inversion during 3rd stage of labour.
18. Inspect the placenta and membranes for completeness.
20. Inspect the vagina and cervix for lacerations.
22. Manage postpartum haemorrhage.
23. Provide a safe environment for mother and infant to promote attachment.
24. Initiate breastfeeding as soon as possible after birth and support exclusive breastfeeding.
25. Perform a screening physical examination of the newborn.
26. Record findings including what was done and what needs follow-up.

**Additional Skills:**
27. Perform appropriate hand manoeuvres for face and breech deliveries.
28. Inject local anaesthesia.
29. Apply vacuum extraction or forceps.
30. Manage malpresentation, shoulder dystocia, fetal distress initially.
31. Identify and manage a prolapsed cord.
33. Identify and repair cervical lacerations.
34. Perform internal bimanual compression of the uterus to control bleeding.
35. Insert intravenous line, draw bloods, perform haematocrit and haemoglobin testing.
36. Prescribe and/or administer pharmacological methods of pain relief when needed.
37. Administer oxytocics appropriately for labour induction or augmentation and treatment of postpartum bleeding.
38. Transfer woman for additional/emergency care in a timely manner.

**POSTNATAL CARE OF WOMEN**

**Competency #5:** Midwives provide comprehensive, high quality, culturally sensitive postnatal care for women.

**Basic Knowledge of:**
1. Normal process of involution and healing following delivery [including after an abortion].
2. Process of lactation and common variations including engorgement, lack of milk supply, etc.
3. Maternal nutrition, rest, activity and physiological needs (eg. bladder).
4. Infant nutritional needs.
5. Parent-infant bonding and attachment; eg. how to promote positive relationships.
6. Indicators of sub-involution eg. persistent uterine bleeding, infection.
8. Signs and symptoms of life threatening conditions; eg. persistent vaginal bleeding, urinary retention, incontinence of faeces, postpartum pre-eclampsia.

Additional Knowledge of:
9. Indicators of selected complications in the postnatal period: eg. persistent anaemia, haematoma, embolism, mastitis, depression, thrombophlebitis.
10. Care and counselling needs during and after abortion.
11. Signs and symptoms of abortion complications.

Basic Skills:
1. Take a selective history, including details of pregnancy, labour and birth.
2. Perform a focused physical examination of the mother.
3. Assess for uterine involution and healing of lacerations/repairs.
4. Initiate and support uninterrupted [exclusive] breastfeeding.
5. Educate mother on care of self and infant after delivery including rest and nutrition.
6. Identify haematoma and refer for care as appropriate.
7. Identify maternal infection, treat or refer for treatment as appropriate.
8. Record findings including what was done and what needs follow-up.

Additional Skills:
9. Counsel woman/family on sexuality and family planning post delivery.
10. Counsel and support woman who is post-abortion.
11. Evacuate a haematoma.
12. Provide appropriate antibiotic treatment for infection.
13. Refer for selected complications.

NEWBORN CARE (up to 2 months of age)

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

Basic Knowledge of:
1. Newborn adaptation to extra-uterine life.
2. Basic needs of newborn: airway, warmth, nutrition, bonding.
3. Elements of assessment of the immediate condition of newborn; eg. APGAR scoring system for breathing, heart rate, reflexes, muscle tone and colour.
4. Basic newborn appearance and behaviours.
5. Normal newborn and infant growth and development.
6. Selected variations in the normal newborn; eg. caput, moulding, mongolian spots, haemangiomas, hypoglycaemia, hypothermia, dehydration, infection.
7. Elements of health promotion and prevention of disease in newborn and infants.
8. Immunisation needs, risks and benefits for the infant up to 2 months of age.

**Additional Knowledge of:**
9. Selected newborn complications, eg. jaundice, haematoma, adverse moulding of the fetal skull, cerebral irritation, non-accidental injuries, causes of sudden infant death.
10. Normal growth and development of the preterm infant up to 2 months of age.

**Basic Skills:**
1. Clear airway to maintain respirations.
2. Maintain warmth but avoid overheating.
3. Assess the immediate condition of the newborn; eg. APGAR scoring or other assessment method.
4. Perform a screening physical examination of the newborn for conditions incompatible with life.
5. Position the infant for breastfeeding.
6. Educate parents about danger signs and when to bring the infant for care.
7. Begin emergency measures for respiratory distress (newborn resuscitation), hypothermia, hypoglycaemia, cardiac arrest.
8. Transfer newborn to emergency care facility when available.
9. Record findings, including what was done and what needs follow-up.

**Additional Skills:**
10. Perform a gestational age assessment
11. Educate parents about normal growth and development, child care.
12. Assist parents to access community resources available to the family.
15. Support parents with multiple births.

**Appendix 1. Background to the evidence-base of the competencies**
Between 1995 and 1999 a modified Delphi Technique was carried out for seven rounds to establish the Provisional Essential Competencies for Basic Midwifery Practice. As agreed by the International Council (the Confederation’s governing body) in 1999, the competencies were field-tested by 17 ICM member associations throughout 2001. The extensive field testing was undertaken by 1,271
practising midwives, 77 educator groups (total of 312 educators), and 79 senior level midwifery student groups (total of 333 individuals) from 22 countries; and 25 regulators from 20 countries. A total of 214 individual competency statements within six domains were presented for consideration and comment. Almost all of the competencies were supported by a great majority of the persons/groups involved in the testing, with many receiving universal support. In April 2002 the ICM International Council discussed and adopted the Essential Competencies for Basic Midwifery Practice, therewith establishing it as an official ICM document.

Skilled attendance at childbirth can make the difference between life and death.

For many women, giving birth entails risking their own lives. Between 11 and 17 percent of maternal deaths occur during childbirth itself, and between 50 and 71 percent in the postpartum period.\(^1\) The safety of births is largely dependent upon the presence of skilled attendants. The determination of who is counted as a skilled attendant has changed over time. Reporting, while improving, is not always consistent.\(^2\) According to the official WHO definition, the term refers to an accredited health professional (doctor, nurse or midwife) who has been educated and trained to proficiency in the skills needed to manage uncomplicated pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns.\(^3\)\(^4\) Skilled attendants can provide emergency obstetric first aid and facilitate prompt referral to emergency obstetric care services.