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Contents

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* During the work, this contributor's institutional affiliation changed from UNFPA initially to the Burnet Institute

Wording used in this document

In this implementation guidance, when referring to pregnancy, childbirth and the postnatal period, the term “women” is also intended to include adolescent girls. The terms “women” and “mothers” are intended to be inclusive of all those who self-identify as women and/or who give birth. While the majority of people who are pregnant or can give birth are cisgender women (who were born and identify as female), this guidance is also inclusive of the experiences of transgender men and other gender-diverse individuals who have the reproductive capacity to give birth.

The terminology of health professions is aligned with the current (2008) edition of the International Standard Classification of Occupations (ISCO-08), a publication of the International Labour Organization[1]. In this document, “midwives” refers to both midwives and nurse-midwives, provided that the nature of the work performed by nurse-midwives aligns with the midwifery tasks specified and listed in ISCO-08. Midwives can be of any gender.

A newborn is weighed by a midwife during a home visit in the postnatal period in Pakistan. © ICM

01

Introduction

Enjoying the highest attainable standards of health is a fundamental human right. Despite progress in recent decades, maternal and neonatal mortality, morbidity and stillbirths remain high globally *(1–5)*. Many women and newborns experience mistreatment and overmedicalization throughout antenatal, intrapartum and postnatal care, which can severely affect their health and well-being and hinder progress towards achieving universal health coverage *(6,7)*.

← GO BACK TO TABLE OF CONTENTS

To improve maternal and newborn health and well-being outcomes and achieve universal health coverage, the World Health Organization (WHO) supports the transition to midwifery models of care; a way to optimize service delivery to better meet the needs of women and newborns before, during and after pregnancy and childbirth *(8)*. In these models, quality care is coordinated by midwives who make autonomous decisions across their full scope of practice, as part of interdisciplinary teams. When complications arise, midwives collaborate seamlessly with obstetricians, paediatricians and other specialists, through effective consultation and timely referral systems, jointly ensuring continuous, personalized care to women and newborns.

A single health system can accommodate multiple models for maternal and newborn care, each adapted to different needs and contexts. Expanding service delivery through midwifery models of care represents a cost-effective, evidence-based and human rights-driven strategy that saves lives and enhances the health and well-being of women and newborns worldwide. This approach ensures the provision of quality maternal and newborn care before, during and after pregnancy, while addressing critical maternal and newborn health and equity challenges (8). The best results are achieved when care is provided by the same midwife or team of midwives during pregnancy, birth and the postnatal period (continuity of midwife care).

In 2024, WHO published a global position paper presenting the definition, guiding principles and case for transitioning to midwifery models of care *(8)*. Figure 1 summarizes the key information from this position paper.

Midwifery models of care

Why choose midwifery models of care?

- To save lives
- To increase vaginal birth rates
- To reduce assisted vaginal births and caesarean section rates
- To improve women's experience of care
- To reduce health inequities and reach universal health coverage
- To improve cost-effectiveness

← GO BACK TO TABLE OF CONTENTS

Fig 1. Key concepts related to midwifery models of care. Source: WHO, 2024 *(8)*

Midwifery models of care provide women and newborns with care from an autonomous midwife, working as part of a team, throughout pregnancy, childbirth and the postnatal period.

- Woman- and newborn-centred care
- Provided by autonomous midwives within teams

- A trusting woman-midwife relationship and partnership
- Supporting healthy and physiological processes

- Quality and holistic care, based on evidence
- Provided before and during pregnancy, childbirth and the postnatal period

1.1 What is the purpose of the implementation guidance?

This document provides strategic and practical guidance to countries transitioning to midwifery models of care.

Aligned with global health priorities and the Sustainable Development Goals (SDGs), this document provides strategic and practical guidance to countries transitioning to midwifery models of care. It equips policymakers and health care leaders with evidence-based practices and a transition framework assessment tool to optimize services and resource use. By emphasizing interdisciplinary collaboration and coordination, the guidance outlines actionable steps for integrating and strengthening midwifery care within national and subnational health systems.

Recognizing that countries are at different stages of transition, this flexible guidance is designed to adapt to each country's specific needs—whether are newly committed to adopting midwifery models of care or are already scaling up established midwifery services.

← GO BACK TO TABLE OF CONTENTS

1.2 Who are the expected users?

This guidance is designed to support government officials within the Ministry of Health—particularly those involved in maternal and newborn health, human resources for health, primary health care and broader health systems. The successful transition and sustainability of midwifery models of care depend on strong leadership and ownership from the Ministry of Health *(9–11)*.

Under the Ministry of Health's leadership, a broad range of stakeholders should be involved in transitioning to these models, and they too can benefit from this guidance. These stakeholders include:

- End-users and women's and community groups
- Health care policymakers and government leaders in maternal and newborn health, human resources for health, and health systems
- Representatives from other relevant ministries (e.g., Finance, Education, Planning, and Women's Affairs)
- Implementing partners, international health organizations and nongovernmental organizations
- Health care administrators, managers, midwives and other health workers
- Professional associations, regulatory authorities, educational and training institutions
- Researchers, academics, advocacy groups and media and communication professionals

1.3 Exploring midwifery models of care

There is no single, standardized description of midwifery models of care, as each country tailors its approach to meet its unique needs. This customization results in a diverse range of models worldwide *(12)*.

Designing a model of care involves defining key service delivery elements *(13)*. For a model to be considered a midwifery model of care, it is essential that professional midwives serve as the main care providers for women and newborns across the continuum of maternal and newborn health services. These services include pre-pregnancy, antenatal, intrapartum and postnatal care *(8)*. Midwives provide care autonomously within their scope of practice while collaborating within interdisciplinary teams. This collaboration is supported by established referral systems and mechanisms for interprofessional collaboration across health workers and service delivery platforms to ensure continuity of care in the event of complications *(8)*. The midwifery approach to care is grounded in the core philosophy and principles of the profession, providing person-centred, respectful and evidence-based care, and encouraging a strong partnership and relationship between the midwife and the woman *(8)*.

Table 1 presents the core service delivery elements of midwifery models of care. While these are foundational, they can be expanded to suit the unique needs and context of each country. For example, the service package might be expanded within midwives' scope to include sexual and reproductive health services, extending the continuum of care beyond the postnatal period and potentially broadening the target population to include adolescent girls and boys.

Countries also have the flexibility to select service delivery platforms that best meet local needs.
These platforms can be:

- Community-based settings
- Hospital-based settings
- Public and private sectors, including public–private partnerships
- Facilities in resource-limited environments, or humanitarian and crisis settings *(8)*

← GO BACK TO TABLE OF CONTENTS

Table 1. Core service delivery elements of each midwifery model of care

Care recipients	Women and newborns
Package of midwifery services	Reproductive, maternal and newborn care services
Continuum of care	Pre-pregnancy, pregnancy, labour and childbirth and/or the postnatal period
Main care providers	Midwives providing and coordinating care Making their own decisions within their scope of practice
Approach to care	Based on the midwifery philosophy of care *(14)* - Person-centered - Relationship and partnership between midwives and women - Optimization of physiological, biological, psychological, social and cultural processes - Use of interventions only when indicated.

Midwifery models of care are flexible and can be integrated or merged to suit varying contexts. For instance, a midwife might provide continuity of care within a community-based birth centre during a humanitarian crisis. As each country has specific needs, midwifery models of care should be tailored accordingly. In decentralized systems, this approach can also be applied at the subnational level.

To assist countries in designing their tailored models, this document provides examples of adaptable configurations, including:

1 **Continuity of midwife care models**

2 **Birth centres**

3 **Community-based models**

4 **Private practice models**

5 **Models for humanitarian and crisis settings**

These examples are not meant to represent definitive best practices but to serve as adaptable options to inspire context-specific solutions.

← GO BACK TO TABLE OF CONTENTS

A pregnant woman and her husband are shown exercises to facilitate birth by a midwife in Portugal. © WHO/Carlo Bruno Santos

1.3.1 Continuity of midwife care models

Continuity of midwife care models are defined as approaches in which a known and trusted midwife—or a small team of midwives—acts as the primary caregiver for women and their babies throughout the entire continuum of care, from the antenatal period through labour and childbirth to the postnatal phase (8).

This model provides consistent care and emotional support during pregnancy, labour, childbirth and the weeks that follow. It fosters ongoing personal connections, effective care management and seamless information sharing, resulting in more personalized and integrated care (8). WHO recommends these models in settings with well-functioning midwifery programmes (15–17). Box 1 provides an example of continuity of midwife care in New Zealand.

← GO BACK TO TABLE OF CONTENTS

BOX 1

Continuity of midwife care in New Zealand

In New Zealand, pregnant women choose a Lead Maternity Carer, often a midwife, who coordinates all aspects of their maternity care, including antenatal, intrapartum and postnatal care for up to six weeks. This model centres on women, supporting informed decision-making about their care.

Lead Maternity Carer midwives are available 24/7, often working in small group practices to provide continuous care. A fully publicly funded network of midwife-led facilities provides intrapartum and postnatal care services at all levels of care. This approach addresses clinical and sociocultural needs and improves access for priority groups such as Māori, Pasifika, socially disadvantaged women and women with disabilities.

Lead Maternity Carer midwives have access agreements with hospitals and collaborate with hospital staff to ensure person-centred, integrated and seamless care, including access to specialized care through referral and consultation. National referral guidelines and electronic records support and facilitate interdisciplinary collaboration. The success of this system highlights the importance of strong partnerships, comprehensive training and effective collaboration among health care providers.

1.3.2 Community-based midwifery models of care

Community-based midwifery models of care provide essential services directly to local communities, ensuring that quality, culturally sensitive and personalized care is accessible where people live. As a core component of primary health care, this approach is essential for achieving universal health coverage by adapting services to local needs and preferences (13). It is particularly beneficial in rural, remote and underserved areas where access to health care facilities is limited. These models use various service delivery platforms—such as mobile health units and community health centres—to bring midwifery care closer to the population effectively. Box 2 provides an example of a community-based midwifery model of care in Senegal.

← GO BACK TO TABLE OF CONTENTS

BOX 2

Itinerant midwives strategy in Senegal: a community-based midwifery model of care

In Senegal, the itinerant midwife (sage-femme itinérante in French) conducts regular visits to health posts, community sites and local gathering places to ensure comprehensive, integrated, community-based maternal, newborn, child and adolescent health services. This care spans from antenatal care, intrapartum care, and essential newborn care; to immunization, integrated management of childhood illnesses, nutrition counselling, family planning and health education. The itinerant midwife also manages medication and supplies, oversees data collection and use, and trains and supervises community health workers. Women and communities are central to the success of the itinerant midwife strategy. They actively participate in planning and evaluating itinerant services, support itinerant midwife mobility and help secure suitable housing when needed. Communities also engage in outreach and promotion to raise awareness and encourage the use of itinerant midwife services.

Through close collaboration with local actors, the intinerant midwife strengthens community health systems, expands access to quality care and creates an environment that supports positive maternal and child health outcomes.

1.3.3 **Birth centres**

Birth centres[2] are dedicated spaces where women and newborns at low risk of complications receive quality care provided and coordinated by midwives (18–22). While these centres always provide intrapartum care, they sometimes offer additional services, such as antenatal, postnatal and sexual and reproductive health services, provided through a continuity of midiwife care model (19,22).

Birth centres are part of the health system and can either be:

- Freestanding birth centres – located outside of the hospital setting with the option to refer women and newborns to a higher-level facility in case of complications *(18–20,22,23)*.
- Alongside birth centres – located within a hospital setting, physically connected to the hospital for easy access to additional resources in case of complications *(18–20,22,23)*.

The successful implementation of birth centres depends on delivering quality midwifery care that is recognized and valued by the community. This is supported by strong referral systems and seamless coordination between health care providers and facilities *(19,22,24)*. When more complex care or specialized interventions are needed, midwives consult with and refer women and newborns to specialist practitioners—such as obstetricians, paediatricians or other experts—ensuring that interdisciplinary teams work collaboratively to provide the best possible care. Box 3 provides information on a policy brief released by ICM on birth centres.

← GO BACK TO TABLE OF CONTENTS

BOX 3

Implementation of midwife-led birth centres: a policy brief by ICM *(22)*

The ICM released a policy brief on implementing birth centres, presenting the Pathway to Change—which outlines the processes and mechanisms required to scale up birth centres—and detailing a series of actions to ensure their successful implementation. This policy brief was based on evidence from a descriptive case study of four birth centres in Bangladesh, Pakistan, South Africa and Uganda, providing valuable insights into these service delivery platforms (9).

1.3.4 Private midwifery models of care

Midwifery care can also be provided by a privately practising midwife, either individually or as part of a private health care organization. To ensure that all women and newborns receive quality, equitable and financially sustainable care, these private models should be fully integrated into national and subnational health systems through a robust policy and regulatory framework, including financing mechanisms preventing financial hardships. Box 4 provides an example of a private midwifery model of care in Uganda.

← GO BACK TO TABLE OF CONTENTS

BOX 4

Private maternity homes in Uganda: continuity of maternal and newborn care provided by private midwives

In Uganda, private maternity homes provide continuity and person-centred antenatal, intrapartum and postnatal care to women and newborns, often delivered by the same one or two midwives. Women enter the model with an antenatal visit and continue with monthly visits, aiming for eight throughout pregnancy. They receive intrapartum care during labour and childbirth, followed by a structured postnatal care system based on the “4–6 model,” which includes follow-ups at six hours, six days, six weeks and six months postpartum, along with immediate access to family planning services.

In private maternity homes, midwives work closely with other health workers, including doctors and nurses, ensuring a collaborative approach to care, particularly for referrals or managing complications. Financing for private maternity services varies by location, with urban centres generally more expensive than rural ones. To ease financial burdens, many centres offer flexible payment options, allowing women to pay in instalments throughout pregnancy.

1.3.5 Midwifery models of care in humanitarian and crisis settings

Midwifery models of care can be adapted to resource-constrained environments, providing essential maternal and newborn interventions in humanitarian and crisis settings. These settings include refugee or internally displaced persons camps, armed conflict and natural disasters (8). Box 5 provides an example of a midwifery model of care in Pakistan during floods.

← GO BACK TO TABLE OF CONTENTS

BOX 5

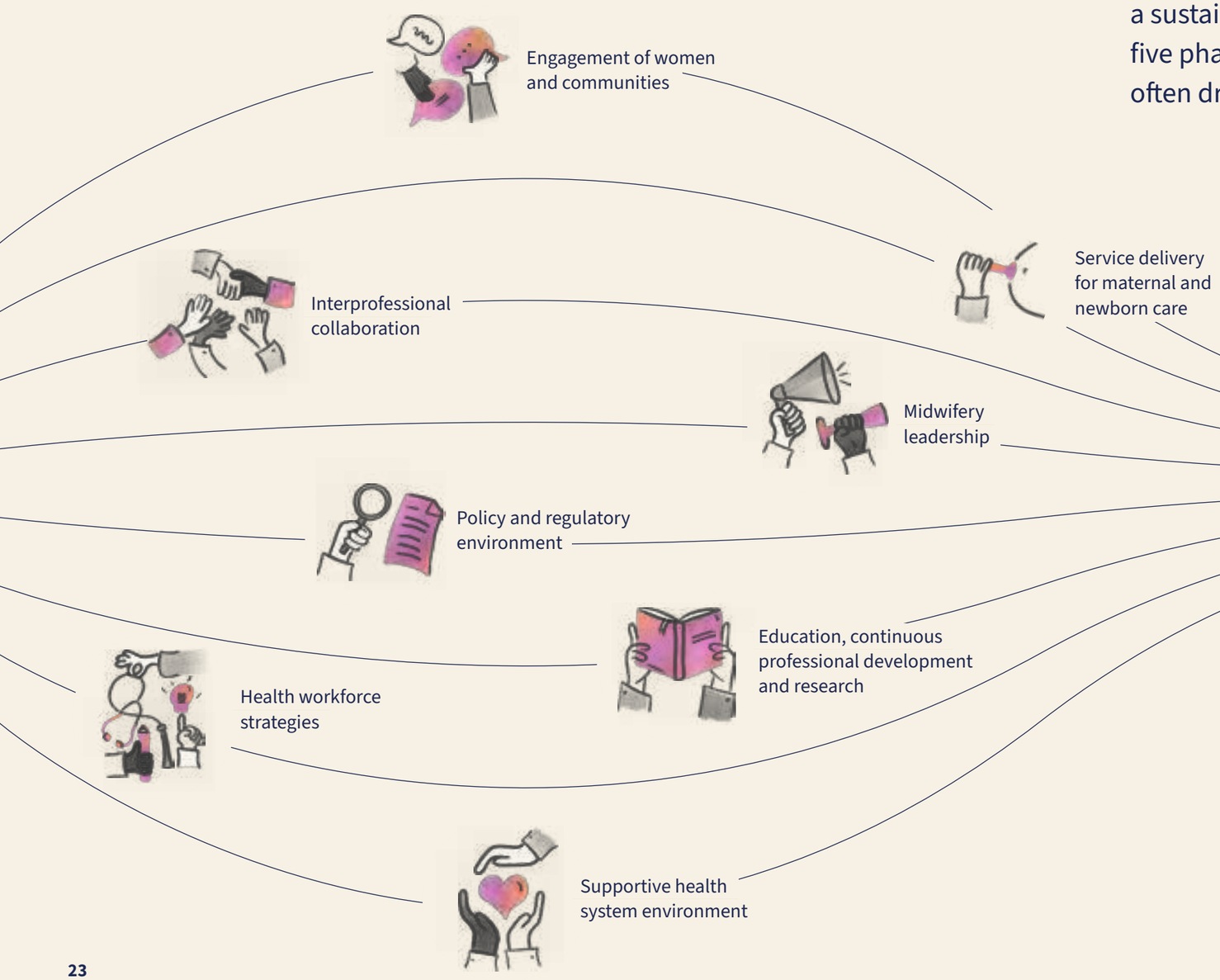
Mobile midwifery model of care during floods in Pakistan

In June 2022, devastating floods in Pakistan displaced over 33 million people, severely disrupting health services and leaving pregnant women highly vulnerable with limited access to essential health services, compounded by unsafe shelters lacking privacy, hygiene and basic resources.

In response, a mobile midwifery model was implemented to provide timely, life-saving support to women and newborns despite the challenging terrain and disrupted infrastructure. The model ensured an early response to the health care needs of pregnant women and newborns in flood-affected districts. Equipped with essential supplies and trained in emergency obstetric and neonatal care, mobile teams of midwives traveled by boat, vehicle or on foot to reach affected areas, providing antenatal visits, quality labour and childbirth care, and postnatal care, with referrals for more complex emergencies.

This model prioritized flexibility, cultural sensitivity and strong collaboration with local authorities, community leaders and other humanitarian actors. By integrating health education and counselling on topics such as breastfeeding, newborn care and early detection of complications, the mobile midwifery teams supported women and families to make informed health decisions during the crisis, strengthening community trust, resilience and capacity, ultimately contributing to more equitable and sustainable maternal and newborn health services even after the emergency had subsided.

1.4 A flexible approach for transitioning to midwifery models of care



← GO BACK TO TABLE OF CONTENTS

Transitioning to midwifery models of care is a dynamic, non-linear and context-specific process that requires a structured yet adaptable approach.

This guidance outlines eight areas that must be addressed to achieve a sustainable transition to midwifery models of care. Each area is divided into five phases of transition. All transition areas are essential, and progress in one often drives—or depends on—progress in others.

The transition process proposed in this guidance involves initiating and sustaining change through essential pillars, as outlined in Chapter 2. It is anchored in the development of strategic and operational plans, structured into a four-step process to support priority setting, described in Chapter 3. To guide this process, a transition framework assessment tool is provided to help countries estimate their current phase of transition in each area. Recommended actions for advancing each transition area—such as women and community engagement or interprofessional collaboration—are presented in Chapter 4 and can be incorporated into countries' operational plans, based on evolving needs.

Tailored solutions aligned with each country's unique health system, policies and cultural context are essential. Progress may not be linear; a country may shift between different transition phases in response to evolving needs and external factors, such as political instability or changes in national and subnational priorities (10). Rather than prescribing a rigid process, this document offers a flexible, adaptable approach that can respond to changing circumstances and emerging challenges.

Annex I presents the development process of this implementation guidance. The essential pillars and transition areas presented in this guidance were identified through a literature review and further refined through expert consultations. While they provide a strong foundation, further research is needed—particularly on the transition to continuity of midwifery care models to determine optimal service delivery designs and strategies for sustainable national scale-up. This includes economic analyses of relative costs and benefits. The economic analysis of relative costs and benefits is particularly important to build a compelling investment case for midwifery models of care, including improved maternal and neonatal health outcomes, social and economic advantages and efficient use of healthcare resources.

← GO BACK TO TABLE OF CONTENTS

Women receive counselling from a midwife about breastfeeding, nutrition and handwashing at the Noor-e-Khuda Clinic in Mazar-e-Sharif, Afghanistan. © UNICEF Afghanistan

02

Essential pillars for the transition to midwifery models of care

This chapter presents the essential pillars for initiating and sustaining the transition to midwifery models of care. These pillars are not intended to be followed in a strict sequence; rather, they are typically pursued concurrently. Sustained, adaptive efforts are essential to maintain these pillars, achieve lasting impact, strengthen health system resilience and improve maternal and newborn health outcomes.

← GO BACK TO TABLE OF CONTENTS

A woman receives antenatal care from a midwife at the Pala Island village health post, in South Sulawesi, Indonesia. © WHO / Harrison Thane

2.1 Foster and secure political commitment and funding

Political commitment is essential for creating an enabling environment for change and mobilizing the necessary resources for a successful transition to midwifery models of care *(10,25–27)*.

When policymakers prioritize midwifery models of care, they drive systemic reforms, secure funding for workforce development and implement supportive policies that improve both maternal and neonatal health outcomes. This commitment not only legitimizes these models but also fosters the collaboration needed for sustainable, long-term improvements in maternity services. Engaging decision-makers by demonstrating how the transition aligns with subnational, national and global health goals helps secure political support. The return of investment from midwifery models of care can serve as a strong advocacy tool. Ongoing advocacy and leadership across all levels are critical for sustaining political momentum and ensuring that midwifery models of care remain a priority at both national and subnational levels *(10,26,28)*

While transitioning to midwifery models of care requires initial investments, their medium- and long-term cost-effectiveness optimizes subnational and national resource use, resulting in significant cost savings and reduced health expenditures *(8)*. To ensure the transition is both effective and sustainable, securing dedicated funding from diverse sources—through earmarked budgets and the integration of midwifery financing into broader health strategies, like universal health coverage—is essential to cover operational costs *(10,25,26)*

← GO BACK TO TABLE OF CONTENTS

2.2 Establish or strengthen governance

Establishing or strengthening governance fosters political commitment and national and/or subnational consensus, ensures strategic alignment and efficient use of resources for the transition to midwifery models of care, and facilitates stakeholders' engagement in the process *(10,11,29,30)*. This involves creating or reinforcing two key structures:

- National Technical and Strategic Advisory Midwifery Working Group: this group guides strategic direction and oversight of the transition to midwifery models of care.
- Project management team: this team supports the operationalization of the strategic plan.

Additionally, countries may opt to establish a temporary national midwifery task force to address specific, time-sensitive issues, such as policy development or urgent midwifery challenges. Depending on the country context, strengthening or creating regional midwifery working groups can also provide valuable support.

In some settings, the midwifery working group may function as a subgroup within national technical advisory groups on maternal and newborn health, human resources for health or primary health care. If the national midwifery working group operates independently, strong communication and collaboration with these technical advisory groups—where they exist—are highly recommended.

These structures can also be established or strengthened at the subnational level.

← GO BACK TO TABLE OF CONTENTS

2.3 **Build partnerships**

Interest groups play a significant role in the integration of midwifery models of care within health systems, either supporting or opposing the transition to these models *(11)*.

To foster acceptance and improve coordination across sectors, it is essential to build strategic partnerships and engage key stakeholders—such as women, community members, obstetricians, paediatricians, nurses, midwives and policymakers—early in the process *(10,11,27,30)*. Their continued involvement is crucial for a successful and sustainable transition, with professional associations also playing an important role.

Misunderstandings about midwifery models of care, even among midwives, often hinder implementation *(10,26,27)*. Continuous advocacy is essential to improving understanding of midwifery models of care and the role of midwives through clear, evidence-based communication, cross-sector discussions, joint workshops and learning events *(10,26,28)*. Additionally, influential leaders acting as advocacy champions, along with a strong media strategy—including press releases, journalist engagement and social media coverage—can further bolster these efforts. Box 6 presents an example of successful advocacy for midwifery professional recognition in Morocco.

USEFUL RESOURCES

- Transitioning to midwifery models of care: global position paper. Geneva: World Health Organization. WHO, 2024 [8]

BOX 6

Leading advocacy for midwifery professional recognition and safe practice in Morocco

The Association Marocaine des sages-femmes (Moroccan Association of Midwives) led a successful advocacy campaign to establish midwives' professional identity, scope of practice and competencies, culminating in the passage of Law No. 44-13 in 2016—a significant milestone for the profession. The Association Marocaine des sages-femmes developed policy briefs and awareness campaigns, with support from many stakeholders, including the Association Nationale des Sages-Femmes au Maroc (National association of midwives in Morocco), leveraging scientific evidence to highlight the critical role of midwives in reducing maternal mortality in Morocco over the past 30 years. Their efforts resulted in the 2016 law, which, for the first time, formally defined the identity and scope of midwifery practice in the country. This structured approach involved extensive advocacy and stakeholder engagement—including with parliamentarians, ambassadors, media, United Nations agencies, feminist associations and health authorities—and demonstrated the power of an evidence-based approach, persistence, collaboration and solidarity. It also underscored the importance of building midwives' capacity for effective advocacy.

← GO BACK TO TABLE OF CONTENTS

2.4 Ensure sustainability of the transition to midwifery models of care

Sustainability is crucial for realizing the full potential of midwifery models of care. With strong political, financial and operational support, countries can establish midwifery models of care that consistently provide quality, accessible care to women and newborns *(10,11,26,27)*.

To preserve and enhance these benefits in the long term, and to achieve lasting impact, a comprehensive strategy is needed. This strategy should maintain political commitment, sustain ongoing advocacy and leadership, integrate midwifery models into national and/or subnational health systems, secure long-term funding and remain adaptable to evolving needs *(10,25,26)*.

A woman receives antenatal care at Nonsavang Healthcare Center, Champasak, Lao People's Democratic Republic (2023). © WHO/Enric Catala

03

Strategic planning process

The transition to midwifery models of care requires a structured strategic planning process that includes:

- **Situation analysis**
  Assessing current conditions
- **Strategic plan**
  Identifying national and/or subnational priorities
- **Operational plan and monitoring and evaluation framework**
  Outlining actionable steps
- **Financial planning and resource allocation**

USEFUL RESOURCES

- Strategizing national health in the 21st century: a handbook. Geneva: World Health Organization. WHO, 2016 (31)
- Guide for conducting national and subnational programme reviews for maternal, newborn, child and adolescent health. WHO, 2024 (32)
- Facilitators' guide for conducting national and subnational programme reviews for maternal, newborn, child and adolescent health WHO, 2024 (33)

← GO BACK TO TABLE OF CONTENTS

A midwife in Australia demonstrates how a baby enters the pelvis during labour using a model of a baby and pelvic bones. © ICM

← GO BACK TO TABLE OF CONTENTS

STEP 1

Conduct a situation analysis

A thorough situation analysis provides a clear understanding of the current landscape and identifies specific areas requiring improvement. The following list of suggested areas for situation analysis can be adapted depending on the needs of your country.

- Assess the current state of maternal and newborn health, key quality indicators and service coverage.
- Evaluate governance structures, political commitment and midwifery leadership.
- Conduct a strengths, weaknesses, opportunities and threats analysis to identify barriers and enablers for the transition.
- Perform stakeholder analysis and community mapping.
- Identify women's and communities' values, needs and preferences for maternal and newborn care.
- Review the policy, regulatory and financial environment supporting or hindering the transition.
- Examine existing service delivery and models of maternal and newborn care.
- Assess interprofessional collaboration among health workers in maternal and newborn care.
- Conduct workforce planning and forecasting for midwifery models of care.
- Review midwifery education programmes, including opportunities for continuous professional development.
- Assess health system infrastructure and capacity for transitioning to midwifery care.

← GO BACK TO TABLE OF CONTENTS

STEP 2

Design a strategic plan

- **Identify priorities:** determine the key national and/or subnational priorities for transitioning to midwifery models of care and develop a comprehensive strategic plan for their effective implementation *(27)*. Chapter 5 introduces a transition framework assessment tool to assist countries in estimating their current phase of transition across various areas and in identifying areas of progress.

- **Ensure alignment:** integrate these national and/or subnational priorities and objectives with the needs of the target users, ensuring alignment with existing subnational, national and international programmes, policies and strategies.

STEP 3

Develop an operational plan with a monitoring and evaluation framework

- **Develop a tailored operational plan** that aligns with the local context and available resources. Chapter 4 of this document outlines specific actions for each transition area that can be incorporated into the plan. Include a dedicated section that details how women, communities and stakeholders will be engaged specifying points of contact, communication methods, transition areas, channels and frequency.

- **Incorporate a robust monitoring and evaluation framework** to assess the effectiveness of the implemented strategies *(27)*.

- **Develop a regular review cycle** to track progress, ensure accountability, address challenges and adapt to changing needs *(27)*.

STEP 4

Develop a financial plan and allocate resources

- **Secure financial support** including identifying and securing the necessary financial resources from government budgets, international donors and private sector partnerships. Explore various funding mechanisms, including grants, loans and public–private partnerships.

- **Conduct budgeting and cost analysis** including estimating the costs associated with workforce training, recruitment, infrastructure development or adaptation, service delivery platforms and other operational needs *(27)*. Develop a comprehensive, costed national and/or subnational implementation plan for midwifery models of care, ensuring that budgets cover ongoing operational costs and contingencies.

USEFUL RESOURCES

- OneHealth tool: a resource for supporting countries in setting priorities based on impact and cost-effectiveness considerations in low- and middle-income countries. WHO, 2025 (34)

← GO BACK TO TABLE OF CONTENTS

Three women and their newborns receive postnatal education at the National Centre for Maternal and Child Health, in Bayangol District, Ulaanbaatar, Mongolia, during the COVID-19 pandemic in 2021. © WHO/Khasar

04

Transition areas for midwifery models of care

4.1 **Women and community engagement**

← GO BACK TO TABLE OF CONTENTS

A fundamental principle of midwifery models of care is the trusting relationship and partnership between midwives and women *(8)*. By empowering and involving women and their communities in the transition to midwifery models of care — and fostering demand for quality midwifery care — the transition can be successful, even in humanitarian and fragile settings *(10,35–37)*.

This approach ensures that the models are responsive to the diverse needs, beliefs and practices of women and communities, ultimately improving health outcomes, strengthening primary health care, increasing community acceptance of midwifery models of care, enhancing midwives' job satisfaction and retention and reducing costs *(9,10,35,38–40)*.

It is important to include representatives from vulnerable communities and marginalized groups to ensure their perspectives are fully integrated into the process and that no one is left behind. Box 7 provides an example of women and community engagement for midwifery models of care in La Florida, Chile.

BOX 7

Enhancing community engagement for midwifery models of care at Dra. Eloísa Díaz Hospital, La Florida, Chile

Dra. Eloísa Díaz Hospital in La Florida, Chile, handles approximately 2500 births annually. The hospital-based midwifery model emphasizes respectful, person-centred care, supporting women and their families to actively participate in the childbirth process. Since 2023, the hospital is has adopted the “Open Hospital” strategy, aimed at fostering community engagement by encouraging citizen participation in decision-making and providing clear, accessible information about services, resources and policies to women, their partners, families and the broader community.

The open hospital strategy includes a public information access representative and committees focused on public information and innovation, promoting community co-creation and enhancing health care access for all. Strong community connections are cultivated through guided maternity ward tours with midwives and the collaborative development of birth plans, allowing women and their families to share their preferences and expectations for childbirth. Direct communication between the health care team and the community is further enhanced through an Instagram account managed by midwives, which has gained nearly 10 000 followers.

The model has achieved the highest rate of normal births in Chile's national public health network and is nationally recognized for its positive community impact. It has significantly improved birth experiences, fostered evidence-based practices and received outstanding feedback from the community.

← GO BACK TO TABLE OF CONTENTS

Recommended actions

Improving community awareness about midwifery models of care

- Develop tailored communication materials about midwifery models of care addressing literacy levels and cultural contexts, based on evidence.
- Promote positive stories by using storytelling to share the experiences of women and newborns receiving care during pregnancy, childbirth and the postnatal period in a midwifery model of care.
- Organize awareness-raising activities, such as community forums, media campaigns or outreach sessions. Engage women and community leaders, advocates and influencers to amplify messaging.
- Empower communities to advocate for midwifery models of care at local, subnational and national levels.

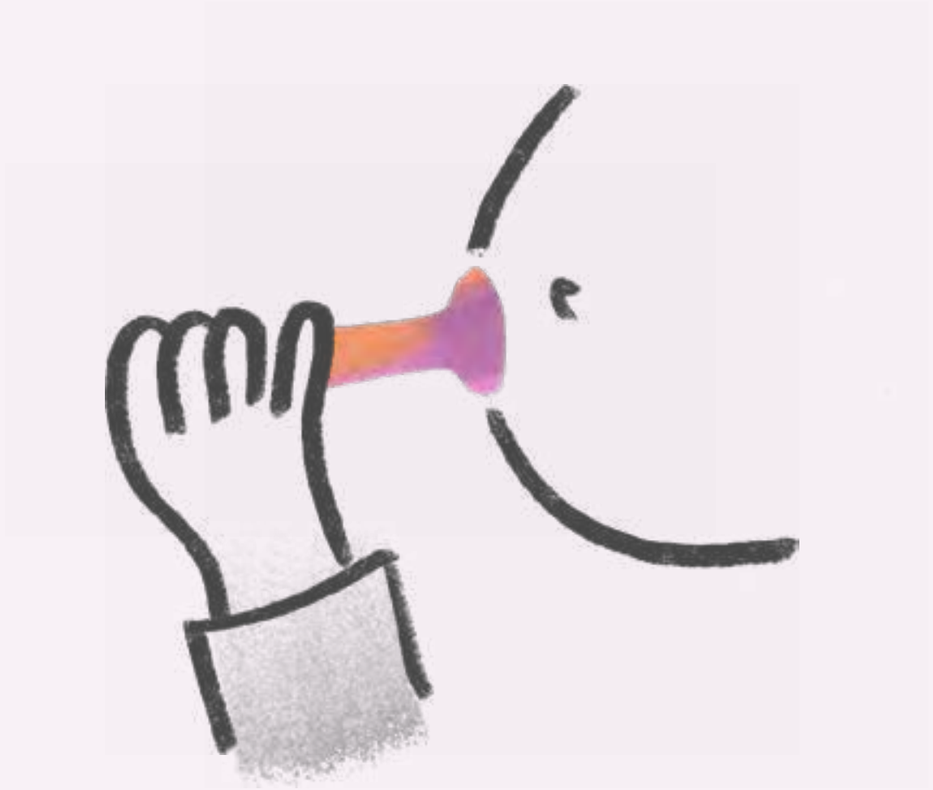
Fostering engagement with women and communities

- Define and implement participatory approaches to actively engage women and community members, including monitoring and evaluation mechanisms.
- Integrate participatory practices within the health system to ensure sustainable participation of women and communities in the transition process.
  Integrate women and communities into governance structures.
- Establish social accountability and feedback mechanisms, enabling continuous feedback on midwifery models of care.
- Collaborate on projects and mobilization initiatives to support the transition to midwifery models of care.

USEFUL RESOURCES

- Community engagement: a health promotion guide for universal health coverage in the hands of the people. WHO, 2020 (41)
- Transitioning to midwifery models of care: global position paper. Geneva: World Health Organization. WHO, 2024 (8)
- A mapping and synthesis of tools for stakeholder and community engagement in quality improvement initiatives for reproductive, maternal, newborn, child and adolescent health. Spencer et al, 2021 (42)
- Integrating stakeholder and community engagement in quality of care initiatives for maternal, newborn and child health. WHO, 2020 (43)

4.2 **Service delivery for maternal and newborn care**



← GO BACK TO TABLE OF CONTENTS

A sustainable transition to midwifery models of care requires comprehensive organizational changes and ongoing adaptation across the health system, including a thorough service delivery design and implementation approach of the model *(11,24,27,28)*.

Effective models of care are dynamic, continuously evolving through performance monitoring and responding to changing population needs, health priorities and local contexts. This approach ensures that every individual receives timely and appropriate care delivered by the right team in the right setting *(12)*.

Recommended actions

Preparing for the design phase

- Gather evidence from global and local best practices.
- Arrange for interdisciplinary visits to pilot sites or locations where midwifery models of care been successfully implemented.

Designing tailored models

- Agree on the approach, care recipients, service package, delivery platforms, care providers, care pathways – including referral systems, interprofessional collaboration mechanisms and financing mechanisms. Table 2 provides important considerations for each of these elements.

Implementing the new or updated midwifery models of care

- Pilot in selected facilities and or regions, including capacity building for health workers on the model and approach to care.
- Assess, document and share lessons learned.
- Refine the model and prepare for scale-up.

← GO BACK TO TABLE OF CONTENTS

A pregnant woman undergoes an ultrasound scan performed by a midwife using portable ultrasound technology at Ntimaru Sub-County Level 4 Hospital in Kehancha, Migori County, Kenya. © UNFPA Kenya

Table 2. Important considerations when designing a midwifery model of care

DESIGN ELEMENT	IMPORTANT CONSIDERATIONS	RESOURCES
Approach to care Define the model's guiding principles and core values to ensure the provision of quality care.	• Ensure that the approach integrates the key elements of quality health care: people-centred, effective, safe, timely, equitable, integrated and efficient (40). • Align the approach with the midwifery philosophy of care. • Whenever possible, prioritize continuity of midwife care provided by the same midwife or small team of midwives throughout the continuum of care. • Ensure that these values, along with a common vision and shared goals, are understood and embraced by key stakeholders.	• Delivering quality health services: a global imperative for universal health coverage. WHO, 2018 (40) • Standards for improving quality of maternal and newborn care in health facilities. WHO, 2016 (44) • Transitioning to midwifery models of care: global position paper. WHO, 2024 (8) Continuity and coordination of care: a practice brief to support implementation of the WHO • Framework on integrated people-centred health services. WHO, 2018 (45)
Care recipients Identify the target populations and intended beneficiaries of the model.	• Aim to achieve universal health coverage and equity for all women and newborns, regardless of geographic location, ethnicity, religion, education level, employment status, income level, disability, sexual orientation, age or cultural background. • Ensure that the model prioritizes underserved and high-risk populations and actively works to reduce disparities.	• Innov8 approach for reviewing national health programmes to leave no one behind: technical handbook. WHO, 2016 (46) • WHO AccessMod 5 tool. Supporting Universal Health Coverage by modelling physical accessibility to health care. WHO, 2023 (47)
Midwifery service package Determine the range of health services to be provided by midwives within the model.	• Develop a comprehensive midwifery service package that spans pre-pregnancy, antenatal, intrapartum and postnatal care. • Ensure the package aligns with midwives' scope of practice and includes all key service categories—such as promotion of self-care, prevention, health education and counselling for women and newborns, diagnostics and treatment. • Emphasize continuity of health service delivery across the entire continuum of care.	• WHO universal health coverage Service Planning, Delivery & Implementation (SPDI) Platform. WHO (48)

Table 2. Important considerations when designing a midwifery model of care

DESIGN ELEMENT	IMPORTANT CONSIDERATIONS	RESOURCES
Service delivery platforms Define the appropriate settings for care provision, such as community-based services, hospitals or birth centres.	• Ensure that services are available closer to where women and communities live. • Adapt service delivery platforms to accommodate resource-limited or crisis settings, as needed. • Strengthen linkages between traditional birth attendants, community-level health workers and facility-based providers to support seamless care transitions across the continuum.	• WHO AccessMod 5 tool. Supporting Universal Health Coverage by modelling physical accessibility to health care. WHO, 2023 (47)
Care pathways and providers Establish clear pathways that promote continuity of care across health providers and levels of the health system, including in cases of complications.	• Identify the entry point to the model of care for women and newborns. • For models based on continuity of midwife care model, define a manageable caseload per midwife or small group of midwives (i.e. the number of women per year for whom each midwife will serve as the main care provider). Develop a care pathway for complications that includes clear referral and escalation protocols, and fosters interprofessional collaboration across health care providers and service platforms. This approach should support continuity of care, while maintaining the relationship between women, newborns and their midwives. This includes developing referral, escalation and communication protocols. • Define the roles and responsibilities of all health workers involved in the model, ensuring these are reflected in official job descriptions to support effective collaboration.	• Networks of care for maternal and newborn health: implementation guidance. WHO, 2024 (49)
Financing mechanisms Secure sustainable financing mechanisms, including financial protection and payment systems, to promote equity in care.	• Ensure health financing for universal access to essential midwifery services by exploring public funding, insurance schemes and cost reduction strategies.	• WHO Health Financing Progress Matrix. WHO (50)

4.3 Interprofessional collaboration

← GO BACK TO TABLE OF CONTENTS

In midwifery models of care, midwives work autonomously within their scope of practice while collaborating with obstetricians, paediatricians, nurses and other health professionals. Trust-based, respectful and non-hierarchical interprofessional collaboration is essential for a successful transition to midwifery models of care and for ensuring quality care *(26,27,35,39,51–54)*.

Recommended actions

Building relationships and enhancing collaboration

- Foster and leverage positive relationships among midwives, doctors, nurses and other health workers, promoting collaboration based on equality, trust and mutual respect.
- Establish shared values, as well as a common vision and goals, across professional groups.
- Enhance health workers' understanding of midwives' roles, responsibilities and the principles and benefits of midwifery models of care.
- Reduce hierarchical structures and promote shared decision-making. This enables midwives to fully exercise their autonomy within their scope of practice, and supports equitable, collaborative care.
- Foster psychological safety by challenging and addressing cultures of blame and shame.
- Build and strengthen alliances between professional associations of midwives, obstetricians, paediatricians, nurses and other health workers through jointly organized initiatives and events.
- Ensure the inclusion of midwives in interprofessional committees and working groups, such as maternal and perinatal death surveillance and response committees.

Fostering interdisciplinary communication

- Develop and strengthen communication and coordination mechanisms among health workers, including in emergency settings.
- Promote regular interdisciplinary meetings to review cases, address challenges and reinforce teamwork.
- Establish and maintain networks of care that connect facilities and health workers across all levels of the health system.
- Implement effective systems for conflict resolution among health workers to support collaboration and professional respect.

Enhancing joint education and orientation

- Engage midwives, obstetricians, paediatricians, nurses and other relevant health workers in joint education and orientation, both pre-service and in-service.

USEFUL RESOURCES

Networks of care for maternal and newborn health: implementation guidance. WHO, 2024 (49)

← GO BACK TO TABLE OF CONTENTS

A surgical mobile interdisciplinary team pictured after a successful caesarean section performed during a hospital power outage in Montepuez District, Cabo Delgado, Mozambique. © UNFPA Mozambique/Mbuto Machili

4.4 Midwifery leadership and research

← GO BACK TO TABLE OF CONTENTS

Strong midwifery leadership at every level—educational, regulatory, political, research, clinical and operational as well as robust research, is critical to support the transition to midwifery models of care and to ensure that the needs of women and newborns are effectively represented and addressed *(10,11,28,55,56)*.

This approach not only elevates the quality of care but also accelerates the adoption of evidence-based practices *(10, 28, 57)*. Strong midwifery associations must be actively engaged in policy dialogue and decision-making.

← GO BACK TO TABLE OF CONTENTS

Recommended actions

Ensuring midwifery representation in decision-making

- Establish and strengthen senior leadership positions to support the governance and management of midwives, ensuring their active contribution to health policy, as outlined in the WHO Global Strategic Direction for Nursing and Midwifery (SDNM) 2021–2025 policy priority (55). Depending on the national context, subnational positions may also be required.
- Engage midwives in policy decisions, midwifery models of care planning, implementation and monitoring and evaluation at all levels—subnational, national, regional and global.

Strengthening leadership capacities of midwives

- Invest in strengthening midwives' leadership capacity, as outlined in the WHO SDNM policy priority (55).
- Strengthen the capacity for midwives to lead and advocate, ensuring involvement in health policy decision-making and planning (56).
- Identify and support midwifery champions within communities and health systems.
- Encourage midwifery leaders to join health committees, advisory groups, or task forces.
- Develop awards and recognition mechanisms to highlight midwifery leaders' contributions, providing role models for early-career midwives.
- Create leadership programmes for young midwives to prepare them for roles in subnational, national and global health dialogues.

Building strong professional associations

- Strengthen midwifery professional associations to engage effectively with allied associations in delivering quality, respectful care.
- Ensure that associations in fragile contexts are equipped to represent midwives during crises.

Fostering research

- Encourage and promote research coordinated or led by midwives.
- Establish partnerships with research institutions to support and advance evidence-based practices.

USEFUL RESOURCES

- Global strategic directions for nursing and midwifery 2021–2025. WHO, 2021 (55)
- Roles and responsibilities of government chief nursing and midwifery officers: a capacity-building manual. WHO, 2015 (58)

4.5 Policy and regulatory environment

← GO BACK TO TABLE OF CONTENTS

Creating a supportive policy and regulatory environment is crucial for providing quality care to women and newborns *(11,24,26,27,37,56,59)*. This entails recognizing midwives as autonomous practitioners and enabling them to operate within their full scope of practice *(10,11,26,27)*.

Recommended actions

Establishing and strengthening a supportive policy environment

- Ensure that subnational and national policies, strategies, plans and budgets support the sustainable implementation of midwifery models of care.
- Develop laws and policies to recognize midwives as autonomous health practitioners, allowing them to fully exercise their scope of practice.
- Design and implement midwifery policies that contribute to progress toward Every Woman Every Newborn Everywhere targets, universal health coverage and Sustainable Development Goals, particularly in maternal, newborn and reproductive health, gender equality and equitable quality education.

Establishing and strengthening a supportive regulatory environment

The specific actions to strengthen midwifery regulation depend on the context and the risks to patient safety. Where applicable, consider an umbrella law for all health practitioners and a multi-practitioner regulatory agency to ensure consistency while addressing specific risk profiles.
Licensing schemes include:

- Tailored entry-to-practice requirements with minimum standards for midwifery education and practice.
- Mechanisms to assess and assure continuing competence.
- Accreditation of midwifery education institutions and licensing of graduates based on clear standards.
- Recognition of international midwifery qualifications based on competence and comparability.
- A code of conduct and ethics for professional practice.
- Protocols for addressing professional misconduct and resolving grievances
- Regulated scope of practice determined by education, skills and competence, supported by governance and clinical oversight *(59)*.

USEFUL RESOURCES

- Health practitioner regulation: design, reform and implementation guidance. WHO, 2024 (59)
- Global strategic directions for nursing and midwifery 2021–2025. Geneva: World Health Organization. WHO, 2021 (55)

← GO BACK TO TABLE OF CONTENTS

A woman is supported during labour by her companions of choice and a midwife at Casa Angela birth centre, São Paulo, Brazil, in 2023. © ICM

← GO BACK TO TABLE OF CONTENTS

4.6 **Education and continuous professional development**

Adequate midwifery education and sustained investment in continuing professional development support the delivery of quality care.

This, in turn, strengthens midwives' professional identity, competence and confidence, while enhancing their autonomy across their scope of practice *(10,11,26,27,37,48,51,55,56)*. As outlined in the WHO SDNM 2021–2025, midwife graduates should meet or exceed health system needs and possess the needed knowledge, competencies and attitudes to address national health priorities *(50)*. Box 8 provides information on the WHO, UNICEF, UNFPA and ICM seven-step action plan to strengthen the quality of midwifery education.

← GO BACK TO TABLE OF CONTENTS

Recommended actions

Developing and strengthening standards and curricula

- Align midwifery education with optimized roles within health and academic systems as outlined in the WHO SDNM policy priority *(50)*.
- Create and implement competency-based education programmes that incorporate effective learning design, adhere to quality standards and meet population health needs, as outlined in the WHO SDNM policy priority *(50)*.
- Develop and implement flexible and validated national education and continuous professional development programmes to keep midwives updated with evolving evidence-based practices.

Strengthening faculty and educating students

- Ensure faculty are competent in effective pedagogical methods and technologies and possess clinical expertise, as outlined in the WHO SDNM policy priority *(50)*.
- Prepare and strengthen educational institutions, practice settings and clinical mentors.
- Utilize innovative learning methods alongside traditional theory and clinical practice.
- Enhance student well-being and retention with financial support, scholarships, mentorship programmes, peer support groups and well-being services.

USEFUL RESOURCES

- Regional competency assessment tool for midwifery educators and midwives. WHO, 2021 (62)
- Global strategic directions for nursing and midwifery 2021–2025. WHO, 2021 (55)
- Strengthening quality midwifery education for universal health coverage 2030. WHO, 2019 (61)
- Three-year regional prototype competency-based pre-service midwifery curriculum. WHO, 2016 (63)
- Midwifery educator core competencies. WHO, 2014 (64)

BOX 8

Seven-step action plan to strengthen quality midwifery education

WHO, UNFPA, UNICEF and ICM developed a seven-step action plan to strengthen quality midwifery education. This action plan provides a framework to develop and strengthen midwifery education through intersectoral collaboration and engagement from multiple stakeholders and the community *(61)*.

USEFUL RESOURCES

- The State of the World's Midwifery 2021: building a health workforce to meet the needs of women, newborns and adolescents everywhere. WHO, 2019 (56)

← GO BACK TO TABLE OF CONTENTS

4.7 **Health workforce strategies**

Adequate workforce planning, improved working conditions and targeted retention strategies are essential to ensure equitable and accessible midwifery models of care for all women and newborns *(10,11,24,26,27,37,55,56)*.

These measures help build a resilient and responsive health workforce capable of addressing the diverse needs of maternal and newborn care. The WHO SDNM 2021–2025 recommends that countries increase the availability of midwives by sustainably creating midwifery positions, recruiting and retaining midwives, and ethically managing international mobility and migration *(55)*.

← GO BACK TO TABLE OF CONTENTS

Recommended actions

Conducting workforce planning

- Conduct midwifery workforce planning and forecasting using a health labour market lens, as outlined in the WHO SDNM policy priority *(55)*, determined by the midwifery models of care the country will adopt.
- Attract, recruit and retain midwives in the locations with greatest needs, as outlined in the WHO SDNM policy priority *(55)*.
- Explore how the transition to midwifery models of care can impact access, quality, recruitment and retention.
- Map health care facility needs to identify service gaps and determine staffing requirements for midwifery models of care implementation.
- Develop or update workforce strategic and investment plans using insights from data and analysis.
- Maintain a national registry of qualified midwives to support workforce planning, deployment and ongoing professional development.

Developing recruitment and deployment strategies

- Optimize the domestic production of midwives to meet or surpass health system demand, as outlined in the WHO SDNM policy priority *(55)*.
- Sufficient job opportunities to support health service delivery for maternal and newborn health care, as outlined in the WHO SDNM policy priority *(55)*.
- Implement the WHO Global Code of Practice on the International Recruitment of Health Personnel (the “Code”), as outlined in the WHO SDNM policy priority *(55)*.
- Increase and secure job opportunities to ensure unemployed midwives are employed in the health sector, addressing critical gaps in supply and distribution.

Developing attraction and retention strategies

- Evaluate national pay scales in relation to living wages and commit to establishing a fair, gender-neutral remuneration system for all midwives, including those in the private sector, adequate to the levels of responsibility
- Consider incentives and supportive social policies to attract individuals to the midwifery workforce.
- Establish benefits for midwives working in emergency and humanitarian settings, such as overtime and hazard pay where needed, benefit from comprehensive occupational health and safety measures, specific training in emergency preparedness and response, diagnosis and mental health support and services.
- Establish clear career pathways and continuous professional development programmes for midwives to encourage professional growth and advancement, including management, leadership, education and research. Acknowledge the educational advancements of midwives by aligning their roles and responsibilities with appropriate remuneration.
- Implement policies and establish practices that promote work–life balance by ensuring manageable workloads and adequate staffing levels.
- Develop mentoring and management, including support for early career midwives.

USEFUL RESOURCES

- Health labour market analysis support tool (beta version 3.0) user manual. WHO, 2024 (65)
- Global strategic directions for nursing and midwifery 2021–2025. WHO, 2021 (55)
- Health labour market analysis guidebook. WHO, 2021 (66)
- WHO guideline on health workforce development, attraction, recruitment and retention in rural and remote areas. WHO, 2021 (67)
- National health workforce accounts: implementation guide. WHO, 2018 (68)
  National health workforce accounts: a handbook. WHO,2017 (69)
- Sixty-third World Health Assembly. Agenda item 11.5, 21 May 2010: WHO global code of practice on the international recruitment of health personnel. WHO, 2010 (70)

4.8 Supportive health system environment

← GO BACK TO TABLE OF CONTENTS

A supportive health systems environment is essential for a successful transition to midwifery models of care, ensuring women and newborns receive quality midwifery care *(26,27,37,54–56)*.

This includes ensuring that midwives, doctors, nurses and other health workers have access to safe and supportive gender-responsive working conditions, in an environment with adequate infrastructure and commodities *(24,35,46)*. This also involves midwives being enabled to autonomously provide care within their full scope of practice, free from interference caused by institutional hierarchical structures or unequal power dynamics in management *(10,26,54,71)*. Effective teamwork and interprofessional collaboration are addressed in the relevant section.

Recommended actions

Fostering adaptive workplace practices and policies

- Enable midwives to fully contribute to service delivery as outlined in the WHO SDNM policy priority, including enforcing policies that protect their autonomy within their defined scope of practice *(55)*.
- Create a gender-responsive environment free from discrimination, violence and harassment.
- Enforce zero tolerance for verbal, physical, and sexual harassment and promote workplace violence prevention through conflict management training.

Developing or improving infrastructure and facilities

- Establish workplace policies that provide essential resources such as water, sanitation, electricity, supplies, commodities and safe infrastructure, including accommodation and transport.
- Ensure that appropriate health care facilities are available, including referral systems and transportation, and evaluate the need for new or tailored facilities.
- Identify the essential medical supplies and equipment needed.
- Ensure a supply allocation and distribution plan is determined for each scenario or location.

Promoting the use of innovation and technology

- Expand workers' access to innovation, tools, and technology to enable them to maximize their performance, well-being, motivation and job satisfaction, including in the context of performance management, service delivery and advanced practice.
- Assess the need for electronic health records, data management systems and other digital tools to support maternal and neonatal outcomes monitoring and evaluation.

USEFUL RESOURCES

- Global strategic directions for nursing and midwifery 2021–2025. Geneva: World Health Organization. WHO, 2021 (55)

← GO BACK TO TABLE OF CONTENTS

A mother being supported by a midwife on how to breastfeed her newborn baby at Raja Isteri Pengiran Anak Saleha Hospital, Bandar Seri Begawan, Brunei Darussalam, in 2016. © WHO Yoshi Shimizu

05

Transition framework assessment tool

A transition framework assessment tool, presented in Table 3, was developed to help countries estimate their current phase of transition across transition areas such as women and community engagement, service delivery and interprofessional collaboration. By identifying their phase, countries can better understand their progress, identify national and/or subnational priorities and determine necessary actions for strengthening health systems and midwifery models of care.

This framework was developed through a literature review and expert consultation. While it has not yet been pilot tested in any country, this implementation guidance presents it as a flexible and adaptable tool that can be tailored to fit different national contexts and specific needs. Further research is recommended to enhance its effectiveness and refine its application.

← GO BACK TO TABLE OF CONTENTS

For each transition area, it is recommended to follow these steps:

- **Review.** Examine the findings from the situation analysis using the transition areas outlined in the Transition Framework Assessment Tool.
- **Compare.** Assess the country's situation by comparing it to the descriptions provided for each phase in the tool.
- **Select.** Identify the phase that best reflects the country's situation for each transition area and circle the corresponding box. Since each box covers multiple elements, the country may be at different levels for different aspects. In such cases, it is recommended to select the lowest applicable phase.
- **Summarize.** Provide a summary of the results. A summary table could be used to describe the identified phase and its associated colour for each transition area.

Example: In country X, for the transition area "women and community engagement", there is clear understanding of midwifery models of care (phase IV). However, there is no formal women and community representation in advocacy, governance or decision-making processes (phase II). Phase II will be circled as the final assessment, and the summary table will be completed accordingly, reflecting this phase and its corresponding colour.

Transition area	Women and community engagement
Phase	Phase II - Initial transition
Associated colour	

Table 3. Transition framework assessment tool

Women and community engagement

PHASE I	PHASE II	PHASE III	PHASE IV	PHASE V
There is little to no awareness of midwifery models of care.	There is limited but growing awareness of midwifery models of care.	There is growing awareness and understanding of midwifery models of care.	There is a clear understanding of midwifery models of care.	A comprehensive and widespread understanding of midwifery models of care is established.
Women and communities have limited or no involvement in the transition to midwifery models of care.	Initial efforts are underway to involve women and communities in the transition to midwifery models of care.	Structured engagement and formal participatory approaches involving women and communities are underway in the transition to midwifery models of care; however, accountability and feedback mechanisms remain limited.	Formal engagement mechanisms have been established to ensure structured participation of women and communities in the transition of midwifery models of care, with feedback systems in place.	Ongoing and inclusive engagement with women and community representatives – including those from vulnerable settings – is fully integrated into the transition process.
Women and communities are minimally represented in advocacy, governance and decision-making process related to this transition.	Women and communities are not yet formally represented of women and communities in advocacy, governance or decision-making processes related to this transition.	Representation of women and communities in advocacy, governance or decision-making processes is emerging, but vulnerable communities and marginalized groups are not systematically involved.	Advocacy, governance, decision-making and continuous improvement processes include voices from vulnerable communities and marginalized groups.	Participatory approaches are established, ensuring active involvement in advocacy, governance, decision-making and continuous improvement processes.

Table 3. Transition framework assessment tool

Service delivery

PHASE I	PHASE II	PHASE III	PHASE IV	PHASE V
There are no midwifery models of care in place.	Discussions are emerging on the design of a context-specific midwifery model of care, including the definition of the midwifery service package and care pathways, to establish a strong conceptual foundation.	The design of the midwifery model of care has been finalized, incorporating a comprehensive package of services provided by midwives and clearly defined care pathways to ensure continuity of care across health platforms.	The midwifery model of care has been scaled up nationally, ensuring access to quality midwifery care for all women and newborns.	The midwifery model of care has been fully integrated into the national health system, ensuring quality and equitable continuity of midwife care for all women and newborns.
	Initial preparations for pilot implementation are under way.	Pilot implementation has been launched in select regions and/or facilities, with initial monitoring and evaluation frameworks being established.	Discussions are emerging on adapting the model to a continuity of midwifery care model where it does not exist yet.	Monitoring and evaluation frameworks, along with continuous quality improvement mechanisms, are in place.
		Discussions are emerging on the development of a strategy scale up.		

Table 3. Transition framework assessment tool

Interprofessional collaboration

PHASE I	PHASE II	PHASE III	PHASE IV	PHASE V
Collaboration among midwives, obstetricians, paediatricians, nurses and other health workers remains limited or minimal.	Early collaboration and relationship-building efforts are taking place through informal joint initiatives among midwives, doctors, nurses and other health workers.	Collaboration has been strengthened through structured interdisciplinary initiatives.	Midwives demonstrate autonomy in decision-making within their scope of practice, while maintaining interprofessional collaboration.	Collaboration is fully embedded across the health system, characterized by equal partnerships, continuous interprofessional education, formal networks of care and effective conflict resolution mechanisms.
Decision-making remains hierarchical, with midwives operating under the supervision of medical doctors, including obstetricians.	Initial steps are being taken towards more equitable decision-making. However, midwives largely continue to operate under the supervision of medical doctors including obstetricians, who often retain authority over clinical decisions, including those within the midwifery scope of practice.	Shared decision-making is increasing; however, the process remains largely hierarchical, with midwives continuing to work under the supervision of medical doctors, including obstetricians.	They maintain clear, respectful and consistent communication with other health professionals to ensure coordinated care and positive health outcomes.	A culture of trust and shared leadership is maintained, underpinned by an ongoing commitment to continuous quality improvement.

Table 3. Transition framework assessment tool

Midwifery leadership and research

PHASE I	PHASE II	PHASE III	PHASE IV	PHASE V
Midwifery leadership is absent or minimal.	Informal leadership among midwives is beginning to emerge.	Midwifery leadership positions are increasing.	Senior midwifery leadership positions are fully integrated within health and education governance structures.	Midwifery leadership drives continuous improvement across policy, education, research and practice.
There is no organizational structure for midwifery within the Ministry of Health.	Initial steps are under way to establish midwifery representation within the Ministry of Health.	There is expanded midwifery representation in formal governance and decision-making processes, although midwives' contributions are not always fully considered.	A Chief Midwife or equivalent position exists within the Ministry of Health.	Midwifery representation in governance and decision-making processes within the Ministry of Health is strong and formalized, with midwives' voices actively considered.
Midwifery representation in governance and decision-making processes is lacking or minimal.	Midwives are starting to participate in governance and decision-making processes.	A professional midwifery association has been established, with a basic governance framework and clearly defined objectives.	Midwives are represented in governance and decision-making processes, and their contributions are actively considered.	Supported by a sustainable funding model, the professional midwifery association plays a pivotal role in advocacy and contributes to national decision-making processes.
No professional midwifery association exists.	Discussions on establishing a professional midwifery association are emerging, although efforts remain unstructured.	An increasing number of midwives are engaging in research activities; however, they continue to lack leadership roles in research, and there are no formal midwifery research initiatives or dedicated funding.	The professional midwifery association functions as a formal and established entity, advocating for and representing midwives in national decision-making processes.	Midwives are leading and coordinating research activities, supported by dedicated funding and institutional mechanisms.
Midwives are not engaged in research activities.	Some midwives are beginning to engage in research activities, but they are not leading research, and institutional support for midwifery-led research initiatives is limited or absent.		Midwives are leading and coordinating research activities, although funding for midwifery remains limited.	

Table 3. Transition framework assessment tool

Policy and regulatory environment

PHASE I	PHASE II	PHASE III	PHASE IV	PHASE V
Formal strategies or policies that acknowledge midwives and midwifery care as absent or minimal.	Discussions on incorporating midwifery models of care into national health strategies are under way, with initial drafts of legal frameworks in development.	Draft policies and strategies specific to midwifery care define the roles and responsibilities of midwives.	Enacted policies enable midwives to practise as autonomous professionals, with authority to make decisions within their defined scope of practice.	Comprehensive and well-established national strategies and policies fully acknowledge and support midwifery models of care.
No regulatory system or licensing scheme for midwifery is in place.	Emerging licensing schemes include documented minimum education and practice standards, although these are inconsistently applied.	The midwifery regulatory system has expanded to include a defined scope of practice, accreditation mechanisms for midwifery education programmes, and a formal code of conduct and ethics, officially endorsed by a regulatory authority.	Regulatory processes are implemented at the national level, with documented evidence of regular review and standardized practices in official guidelines.	A robust midwifery regulatory system and licensing scheme are fully integrated into the national health system, with established monitoring and evaluation processes in place.
Workplace policies and institutional constraints limit midwives from practising to the full extent of their nationally recognized qualifications and education.	Preliminary efforts are being made to revise workplace policies and reduce institutional constraints.	Workplace policies have been revised to enable midwives to practise to the full extent of their qualifications and education.	Midwifery models of care are included in national health strategies.	Workplace policies and institutional frameworks fully support midwives to practise to the full extent of their nationally recognized qualifications and education.

Table 3. Transition framework assessment tool

Education and continuous professional development

PHASE I	PHASE II	PHASE III	PHASE IV	PHASE V
Formal midwifery education programmes are either absent or severely limited.	A competency-based midwifery curriculum of at least three years is being piloted in select educational institutions, with feedback mechanisms in place to support curriculum refinement.	The midwifery curriculum has been revised based on pilot feedback and formally adopted by educational institutions nationwide to align with evolving population needs.	Competency-based midwifery education and continuing professional development programmes are standardized and implemented nationwide.	Competency-based midwifery education and continuing professional development programmes are fully aligned with national health strategies and legal frameworks, supported by dedicated budget allocations and robust monitoring and evaluation systems.
Discussions are emerging on the development of a competency-based midwifery curriculum with a minimum duration of three years.	Preliminary frameworks for continuing professional development programmes have been developed, focusing on essential skills, attitudes and knowledge updates for practising midwives.	Continuing professional development programmes have been expanded and standardized to ensure the consistent delivery of quality professional development opportunities for midwives.	Comprehensive continuing professional development opportunities enable midwives to continuously update and enhance their competencies.	Ongoing evaluation and continuous improvement processes are established for both the midwifery education curriculum and continuing professional development programmes.
Continuing professional development programmes are not in place.				

Table 3. Transition framework assessment tool

Health workforce strategies

PHASE I	PHASE II	PHASE III	PHASE IV	PHASE V
Coordinated workforce planning for midwifery models of care is either absent or minimal.	Emerging workforce planning and forecasting efforts include initial mapping of service gaps and facility needs.	The first data-driven workforce plan and forecast have been established, addressing service gaps, facility needs and future workforce requirements.	The comprehensive workforce plan and forecast have been fully implemented, providing a clear roadmap to address service gaps, facility needs and future workforce requirements.	The workforce plan and forecast are continuously updated and refined based on data and feedback to ensure alignment with evolving healthcare needs and priorities.
Data on workforce needs are limited.	Steps have been initiated to gather and compile workforce data from multiple sources, including surveys, institutional records, and national databases.	Preliminary reviews of existing workforce data have been conducted.	Workforce data are thoroughly reviewed using advanced analytics to identify trends, competency gaps and opportunities for optimization.	Workforce data systems are fully integrated across all relevant platforms, enabling real-time data access and more precise workforce management.
There is no national registry of midwives.	Preliminary discussions are under way to establish a national registry of midwives.	Development of a national registry for midwives is under way to ensure accurate tracking and management of midwifery professionals.	The national registry for midwives is operational, offering accurate and up-to-date information on midwifery professionals to support workforce planning and management.	The national registry of midwives is fully operational and continuously updated, including features for professional development, managing certification renewals and generating workforce analytics.
Targeted recruitment and retention initiatives are lacking.	Early discussion are taking place on recruitment and retention strategies.	Strategic discussions on innovative recruitment and retention approaches have been initiated, focusing on competitive compensation, flexible work arrangements, and employee engagement programmes to attract and retain midwives.	Recruitment and retention strategies have been implemented, resulting in improved compensation packages, flexible work arrangements and enhanced employee engagement programmes that effectively attract and retain midwives.	Recruitment and retention programmes are well established and continuously improved, incorporating best practices and feedback to maintain a stable, satisfied and highly skilled midwifery workforce.

Table 3. Transition framework assessment tool

Health system environment

PHASE I	PHASE II	PHASE III	PHASE IV	PHASE V
Foundational health system elements to support midwifery models of care are either absent or minimal.	Efforts have been initiated to establish foundational infrastructure and resources to support midwifery models of care, including the provision of essential supplies and equipment to health facilities.	Infrastructure and resources to support midwifery models of care, including essential utilities such as water and electricity, are being strengthened. An increasing number of facilities are now adequately equipped with essential supplies and equipment.	Key components of a supportive health system have been expanded.	The health system environment is fully supportive of midwifery models of care, with well-equipped, functional infrastructure and universally implemented safe and secure working conditions.
Essential equipment and supplies required to provide midwifery services are lacking.	Initial steps are being taken to improve working environments, with a focus on meeting basic safety, security and hygiene standards. While progress remains limited, these efforts represent the beginning of meaningful improvements.	Safe and secure working conditions are progressively prioritized. This includes: - Workplace safety: enhancements to workplace safety protocols and practices. - Protection Measures: implementation of measures to protect health workers from harassment or violence, promoting a safe and supportive work environment.	Facilities across all levels of care are consistently equipped with essential resources.	Policies and governance mechanisms foster a sustainable and supportive environment for health workers.
Referral systems are either unavailable or inadequate, hindering the effective transfer of women and newborns.			Safe, secure and enabling working conditions are established as standard practice, supported by policies and measures that promote staff well-being and job satisfaction.	
Midwives and other health workers face unsafe and unstable working conditions.				

← GO BACK TO TABLE OF CONTENTS

Once the tool has been applied and the summary table completed with the phase assigned to each transition area, the following steps are recommended to analyze and make strategic use of the results.

- **Identify national priorities.** Review the transition areas at the lowest phase, as these indicate the most delayed components of the transition process. Prioritizing these areas for short- and medium-term interventions can help accelerate progress effectively.

- **Compare across areas.** Look for inconsistencies or gaps between related transition areas. For example, standardized and enforced competency-based midwifery education and continuing professional development may be at Phase IV, while awareness among women and communities about midwifery models of care remains at Phase I. Such discrepancies may indicate bottlenecks or critical areas for improvement.

- **Define strategic actions and integrate them into the operational plan.** Based on the assessment results, define specific actions to advance each transition to the next phase. Include these actions in the operational plan. Detailed suggested actions for each transition area can be found in Chapter 4.

- **Monitor progress over time.** Apply the tool periodically to track progress and support adjustments to strategic planning.

- **Utilize results in broader reporting and advocacy.** The results can inform national reports, operational plans, advocacy initiatives and reporting to international partners.

- **Communicate results effectively.** Develop a concise summary or visual representation using colour coding to share findings with authorities, technical teams and community organizations. This enhances transparency, fosters ownership and promotes multisectoral engagement.

06

Transition stories

This chapter presents transition stories from five different settings and scopes of transition. These stories are not meant to represent definitive best practices but to serve as adaptable options to inspire context-specific solutions.

← GO BACK TO TABLE OF CONTENTS

A pregnant woman receives antenatal care at Barangay Health Station in a fishing village in Malita, Davao Occidental, the Philippines. © WHO / Yoshi Shimizu

Bangladesh

6.1 Transitioning to midwifery models of care in the absence of midwives: a story from Bangladesh

Location
Bangladesh (nationwide)

Scope
National transition

Context

Bangladesh had made significant progress in improving maternal and newborn health outcomes. However, challenges persisted, particularly in rural areas where skilled health personnel remain scarce and home births were still common.

In 2008, to improve maternal and newborn health outcomes, the Government of Bangladesh—supported by UNFPA, WHO, UNICEF and other partners – began transitioning to a midwifery model of care. At that time, there were no professional midwives in the country, making this a groundbreaking initiative.

← GO BACK TO TABLE OF CONTENTS

Transition process

Essential pillars

Strong political commitment from the Government and leadership from the Ministry of Health and Family Welfare, along with close collaboration between government ministries and departments.

Robust partnerships were established with key stakeholders – including UNFPA, WHO, UNICEF, international donors, local NGOs, the Obstetric and Gynaecological Society of Bangladesh, and other professional associations and community leaders – to provide support and advocacy.

Transition process

Process by transition area

Policy and regulatory environment

- **2008** Development of strategic direction to support the introduction of professional midwives, with an interim focus on the effective utilization of nurse-midwives.
- **2014** Publication of the National Strategic Directions for the Midwives in Bangladesh.
- **2016** Upgrade of the Directorate of Nursing Services and the Bangladesh Nursing Council to include midwifery.
- Development of a regulatory framework and licensing scheme, defining midwives' scope of practice.
- **2017** Development of a standard operating procedure for midwifery practice, revised in 2022 to include the administration of essential medicines by midwives.
- Deployment of national guidelines for midwives.
- **2021** Development of a Costed National Action Plan for Midwifery (2021-2025) and Deployment Guidelines for Midwives.

Supportive health system environment

- **2016 - present** Provision of essential supplies and logistics to health facilities to support midwifery services.

Bangladesh

Education and continuing professional development

- **2010-2012** Development of a national midwifery curriculum.
- **2011** Launch of an advanced six-month education programme for nurse-midwives.
- **2013** Introduction of a three-year diploma programme in midwifery.
- Midwifery schools equipped with skills laboratories and necessary infrastructure.
- **2016** Launch of a blended master's programme in sexual and reproductive health and rights for midwifery faculty.
- **2019** Initiation of accreditation processes for midwifery education programmes.
- **2020** Development of a draft continuous professional development programme linked to re-licensing.
- **2022** Introduction of a post-basic bachelor's degree in midwifery.
- **2023** Implementation of a quality assurance programme for midwifery education.
- **2026** Launch of a two-year in-service master's programme in midwifery.

Workforce strategies

- **2014** Creation of 3000 midwifery posts, prioritizing underserved regions.
- **2018** Deployment of 1149 midwives in public health facilities
- **2021** Deployment of an additional 1407 midwives in public health facilities.
- **2022-2024** Creation of 7000 new posts for midwives in the public sector.
- **2025** Development of a structured career pathway for midwives.

← GO BACK TO TABLE OF CONTENTS

Transition process

Process by transition area

Midwifery leadership and research

- **2010** Establishment of the Bangladesh Midwifery Society.
- **since 2017** Capacity-building of the Bangladesh Midwifery Society.
- **2018** Launch of the Young Midwife Leaders development programme to empower midwives through leadership training, coaching and mentorship.
- **2020** Establishment of a dedicated midwifery unit within the Directorate General of Nursing and Midwifery, Ministry of Health.

Service delivery

- **since 2016** Implementation of the midwifery model in public health facilities. Midwives provide a comprehensive range of sexual and reproductive health and rights services—including maternal care, normal deliveries, family planning and gender-based violence response—while coordinating maternal and newborn care within their scope of practice. They also collaborate with other health professionals during emergencies. In facilities where midwives are deployed, they manage approximately 89% of deliveries.
- **2018** Integration of midwifery service data into the District Health Information System.

Bangladesh

Interprofessional collaboration

- **since 2006** Advocacy and support from the Obstetrical and Gynaecological Society of Bangladesh.
- **since 2016** Joint advocacy, orientation and training on midwives' roles and responsibilities for health service managers and other health workers.
- Formal definition of midwives' roles and responsibilities within health facilities.
- **2017** Launch of facility-based mentorship by medical doctors to support midwifery implementation.
- **2018** Continued advocacy and orientation at district level to support implementation of the updated midwives' scope of practice.

Women and community engagement

- National and local awareness-raising campaigns on the benefits of midwifery models of care, conducted through community outreach, mass media and observance of the International Day of the Midwife.
- Ongoing engagement with local communities and leaders to increase demand for midwifery services and promote facility-based childbirth.

Lessons learned

- Transitioning to midwifery models of care is a long-term process that requires sustained political commitment and continuous engagement with communities and stakeholders.
- Adequate recognition and institutional support for midwives are essential to enable them to provide quality care and thrive within the health care system.
- Engagement of the private sector is critical to expanding access to sexual and reproductive health and rights services through midwifery care.
- Job creation should be promptly followed by deployment of midwives into the workforce.
- The deployment of midwives must be accompanied by the creation of a supportive environment for midwifery practice.

Despite limited resources and high workloads, strong teamwork, ongoing mentorship and strategic collaboration can help overcome barriers and enhance the quality of care.

← GO BACK TO TABLE OF CONTENTS

A woman holding a newborn with the support of a midwife in Bangladesh. © ICM

Democratic Republic of the Congo

6.2 Continuity of midwife care for survivors of sexual violence: a transition story from the Democratic Republic of the Congo

Location
Bukavu, Democratic Republic of the Congo

Scope
Implementation at Panzi General Referral Hospital

Model of care
Continuity of midwife care throughout pregnancy, childbirth and the postnatal period

Care recipients
Pregnant women and survivors of sexual violence

Context

Recognizing the distinct physical and psychological challenges of survivors of sexual violence, Panzi General Referral Hospital in the Democratic Republic of the Congo developed a holistic and integrated model of care. This approach addressed the full continuum of care—from pregnancy, childbirth and the postnatal period, through to one year in the postnatal period.

← GO BACK TO TABLE OF CONTENTS

Transition process

Essential pillars

Establishment of a project management team, including a designated project lead.

Regular team coordination through structured meetings and collaboration.

External funding support from organizations such as Médecins du Monde, UNFPA and Panzi Foundation USA.

← GO BACK TO TABLE OF CONTENTS

Transition process

Process by transition area

Service delivery: design of the model

- The service delivery model is person-centred, integrated and grounded in continuity of midwifery care. It is supported by a strong interprofessional team approach that empowers pregnant girls and women as active agents in their care journey.
- Each woman is paired with a dedicated midwife who provides antenatal, intrapartum (when feasible), early postnatal care, and, where possible, follow-up home visits for up to one year.
- The midwife is supported by an interdisciplinary team of obstetricians, paediatricians, psychologists and social workers for integrated, holistic care.

Interprofessional collaboration

- Organizing regular interdisciplinary team meetings to ensure coordinated, trauma-sensitive care.
- Providing joint interprofessional training on the care model for all staff.
- Creating safe group reflection spaces for the interprofessional team.

Policy and regulatory environment

- Facility policies and protocols were revised to align with the model's approach.

Democratic Republic of the Congo

Women and community engagement

- A Mentor Mothers network has been established and continues to provide peer support and weekly antenatal classes featuring shared experiences.
- Women were given the opportunity and continue to actively develop their own support plans.

Midwifery leadership and research

- A responsible chief for the labour and maternity ward was assigned.
- A dedicated pool of project-affiliated midwives was appointed.

Supportive health system environment

- An individual birthing room was created to offer a calm and supportive atmosphere.

Education and continuous professional development

- Capacity-building activities were organized and tailored to midwives' needs and perceived challenges.

Lessons learned

This model of care demonstrates that, even in low-income, conflict-affected settings with high rates of sexual violence, pregnancy and childbirth can become empowering and positive experiences for women. Strengthening midwives' professional autonomy, competencies, interprofessional collaboration and working conditions benefits both women and their newborns, while also enhancing midwives’ satisfaction and clinical performance.

← GO BACK TO TABLE OF CONTENTS

A pregnant woman receives holistic support from a midwife during labour at Panzi Referral Hospital in the Democratic Republic of the Congo. © UNFPA Democratic Republic of the Congo/Lisa Thanner

England

6.3 From political commitment to large-scale change: transition to continuity of midwife care in England

Location
England, United Kingdom

Scope
Across England (United Kingdom)

Model of care
Continuity of midwife care throughout pregnancy, childbirth and the postnatal period

Care recipients
All pregnant women

Context

In 2015, England (United Kingdom) initiated a review of maternity services to assess maternity care provision and explore new models of care to better meet the needs of women and newborns. Informed by evidence and a broad consultation process with women and communities, the Better Births Review report (2016) recommended continuity of midwife care to create safer, more personalized and equitable services. This shift required large-scale transformation, driven by key factors outlined below *(73)*.

← GO BACK TO TABLE OF CONTENTS

Transition process

Essential pillars

Political commitment from the Secretary of State for Health and Social Care to reduce neonatal mortality and morbidity.

Governance and leadership through an expert panel, including representatives of women.

Incremental funding allocated to support the transition.

Appointment of the first Chief Midwifery Officer, instrumental in setting the vision and direction for maternity care.

Appointment of regional leads across England (United Kingdom) to support the transition process.

← GO BACK TO TABLE OF CONTENTS

Transition process

Process by transition area

Policy and regulatory environment

2021
- Guidance for planning, implementation and monitoring of continuity of midwifery care was developed and published (69).
- Continuity of midwife care for women from Black, Asian and minority ethnic communities and from the most deprived groups was included as a clinical focus area in the National Healthcare Inequalities Improvement Programme.

2023
- A three-year delivery plan for maternity and neonatal services was developed.

Women and community engagement

- Women and communities are engaged through regional drop-in events, service visits, a maternity review email inbox, focus groups, listening events and an online consultation.
- An annual assessment of women's experience of care is conducted through the Care Quality Commission maternity survey *(75)*.

Interprofessional collaboration

2024
- A training programme on continuity of midwife care was developed by the National Health Service England.

England

Service delivery: model design (2016)

2016
- The service model is defined as person-centred and personalized, based on women's needs and decisions. It is integrated, delivered with continuity and provided close to where women lived.
- Continuity of care entails women receiving antenatal, intrapartum and postnatal care from the same midwife, supported by a team of midwives (typically in groups of eight or fewer), with an annual caseload of approximately 36 women.
- Each team maintains links with an obstetrician to ensure timely referral for specialized care.

Education and continuous professional development

2018
- E-learning modules and a board game on continuity of midwife care were created by the Royal College of Midwives.

2019
- The continuity of midwife care model was incorporated into midwifery education programmes.

Health workforce strategies

2021
- Workforce planning was conducted, and tools were developed to determine the number of midwives required for sustainable service delivery.

← GO BACK TO TABLE OF CONTENTS

Outcomes

Compared with women who received no continuity of care, those receiving continuity of midwifery care reported a better experience of care, with the most significant improvements reported by women receiving continuity throughout the antenatal, intrapartum and postnatal periods *(75)*.

Ethiopia

6.4 Introducing a continuityof midwife care model in Northern Ethiopia

Location
North Shoah Zone, Amhara National Regional State, Ethiopia

Scope
Four primary hospitals

Model of care
Continuity of midwife care through pregnancy, childbirth and the immediate postnatal period

Care recipients
Pregnant women at low risk of complications

Context

Between August 2019 and September 2020, four hospitals in Ethiopia piloted a continuity of midwife care model. Instead of seeing different providers at each visit, pregnant women were supported by the same midwife—or a small team—throughout pregnancy, childbirth and the early days after birth.

← GO BACK TO TABLE OF CONTENTS

Transition process

Strong leadership from the Ministry of Health and the Ethiopian Midwives Association was crucial.

Sustained advocacy and partnerships were established through policy dialogues involving the Ministry of Health, regional health bureaus, facility leaders, project team members and the Ethiopian Midwives Association. These efforts guided the model design and implementation planning. Following these discussions, midwives were organized into teams of four to eight and trained on the care model and its philosophy. Each midwife provided comprehensive care across the continuum to a caseload of 37 women. If the primary midwife was not available, another midwife from the team stepped in. In cases of complications, obstetricians and other health workers provided support.

Outcomes

- In the continuity of midwifery care model, 97% of women already knew the midwife supporting them during intrapartum care *(76)*.
- Women reported higher satisfaction with antenatal, intrapartum and postnatal care. Utilization of health services improved, with an increase in antenatal care and postnatal care coverage *(76,77)*.
- Vaginal deliveries and breastfeeding within one hour of birth significantly increased *(76)*.
- Unnecessary interventions were reduced, including a 51% decrease in emergency caesarean sections, a 57% decrease in vacuum births, a 73% decrease in episiotomy rates and a 47% decrease in induction of labour *(76)*.
- Neonatal outcomes improved, with a 61% reduction in preterm birth rates, a 59% reduction in low 5-minute Apgar scores (<7) and a 50% reduction in neonatal intensive care admissions *(76)*.
- Midwives working in the continuity model reported higher job satisfaction.

← GO BACK TO TABLE OF CONTENTS

Next steps

Based on these outcomes, the Ethiopian Ministry of Health, with support from the Ethiopian Midwives Association, developed implementation guidance for the national rollout of the model. Plans to scale up the pilot implementation in 24 woredas (districts) are under consideration.

West Bank

6.5 Transitioning to continuity of midwife care in a conflict-affected setting: story from the West Bank

Location
West Bank, occupied Palestinian territory (oPt)

Scope
Across the West Bank (oPt)

Model of care
Continuity of midwife care throughout pregnancy and the postnatal period

Care recipients
Underserved women in a resource-constrained, conflict-affected setting

Context

The model was introduced through a pilot collaboration between the Palestine Committee of Norway, the Palestinian Red Crescent Society and the Palestinian Ministry of Health. It aimed to address challenges faced by pregnant women in rural areas of the West Bank, particularly restricted access to hospitals. Implementation began in 2013 in two areas and, by 2016, had expanded to six public regional hospitals and 37 rural villages, in collaboration with the Norwegian Aid Committee *(78)*.

← GO BACK TO TABLE OF CONTENTS

Transition process

Essential pillars

A working group and project management team were established to adapt the continuity of midwifery care model to the local context and oversee its implementation.

Stakeholders, including the Ministry of Health, Palestinian Red Crescent Society, community representatives, hospital representatives. and donors were engaged in planning, budgeting and operational processes.

Initial funding was provided by Norway, followed by financial support from the Ministry of Health.

Transition process

Process by transition area

Service delivery: model design

- Midwives managed caseloads in village clinics to build continuous, trusted relationships, with flexible adaptations to respond to local needs.
- Weekly visits by midwives from nearby public hospitals ensured comprehensive antenatal, postnatal and follow-up care. Specialist referrals were made as needed while maintaining continuity of midwife care.

Women and community engagement

- Women and community representatives were engaged in planning, budgeting and implementation processes.

Interprofessional collaboration

- Smartphones were used to facilitate communication and coordination between the community and interprofessional teams.
- Monthly team seminars were held to address challenges and update clinical practices.
- Capacity-building efforts included a two-day seminar to train midwives, nurses and doctors on the principles and practice of continuity of midwifery care.

West Bank

Health workforce strategies

- Bachelor-level midwives replaced less formally trained auxiliary midwives, supported by scholarships for professional licensing as autonomous practitioners.
- Hospital midwife staffing levels were increased.

Supportive health system environment

- Midwives received driving lessons and licenses, and designated, marked cars were provided to ensure their safe transportation to rural clinics and homes.

Midwifery leadership and research

- Regional midwives coordinated services and supervised head midwives and nurse supervisors, adapting schedules to meet local needs.

Outcomes

- A 20% reduction in unplanned caesarean section rates, a 21% reduction in preterm birth rates and a 28% reduction in postnatal anaemia rates were observed *(79)*.

- A significant increase in exclusive breastfeeding rates within six months after birth was reported *(80)*.

- Women reported high satisfaction with care throughout the continuum *(80)*.

- Utilization of health services improved *(81)*.

Activities were temporarily halted in April 2020 due to COVID-19 and political challenges.

← GO BACK TO TABLE OF CONTENTS

A woman holds her newborn in a hospital in the West Bank, occupied Palestinian territory. © ICM

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Annex I.
Development process of the implementation guidance

This guidance was developed by the World Health Organization (WHO) after the Strategic and Technical Advisory Group of Experts (STAGE) for Maternal, Newborn, Child, and Adolescent Health and Nutrition recommended in May 2022 that WHO develop implementation guidance with a multidisciplinary working group, to support countries in transitioning to midwifery models of care requiring professional midwives.

Following this recommendation, a STAGE midwifery working group was established in November 2022. The working group identified the need for a global position paper to define midwifery models of care, outline their guiding principles and provide rationale for transitioning to these models. The position paper, developed with contributions from over 90 individuals and organizations and endorsed by STAGE, was published by WHO in October 2024. This publication laid the groundwork for subsequent guidance development.

Role of the WHO STAGE midwifery secretariat

The WHO Secretariat, led by the Department of Maternal, Newborn, Child and Adolescent Health and Ageing (MCA), was supported by various WHO departments, including the Office of the Chief Nurse, the Health Workforce Department and the Department of Integrated Health Services. Its responsibilities included ensuring alignment with WHO policies, coordinating with STAGE members, providing technical and administrative support and overseeing the writing, production and publication of the guidance.

Structure and responsibilities of external groups

Three distinct groups were convened to contribute to the guidance development process. Group members were selected with consideration of geographical and field of expertise balance while ensuring midwifery representation as recommended by STAGE.

The Working Group

- **Purpose:** provide overall direction for guidance development, steer the development process and ensure expertise across relevant disciplines.
- **Composition:** co-chaired by Sally Pairman (ICM) and Jane Sandall (STAGE member), the group included 20 experts in midwifery, health systems, policy and implementation science, including STAGE members, professional associations representatives, women's groups representatives and UN partners.

The core group

- **Purpose:** offer technical expertise, detailed feedback and case study identification while supporting the drafting of guidance.
- **Composition:** included two representatives from women's groups experienced in community engagement and 10 professionals from academia, professional associations, governments and programme management, each with at least seven years of relevant experience.

The expert group

- **Purpose:** provide additional feedback on draft guidance upon request.
- **Composition:** included two representatives from women's groups experienced in community engagement and 10 professionals from academia, professional associations, governments and programme management, each with at least seven years of relevant experience.

Development process

Identification of enablers, barriers and transition process to midwifery models of care. To develop the document's outline and content, and the transition framework assessment tool, the Secretariat identified enablers, barriers, process and required actions for transitioning to midwifery models of care through:

1. A review of published articles, grey literature, national reports and key publications from WHO, the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF), Jhpiego and the International Confederation of Midwives (ICM) on midwifery, health workforce, primary health care and health systems.

2. Insights from national policy dialogues on the transition to midwifery models of care supported by the WHO Regional Office for South-East Asia in December 2023 in Bangladesh, Indonesia and Nepal which helped identify key milestones in the transition of each of these countries.

3. Country consultations

- **July 2024:** regional technical meeting on the operationalization of Every Newborn Action Plan and the Ending Preventable Maternal Mortality in Lusaka, Zambia.
- **September 2024:** UNFPA pre-conference ahead of the ICM Regional Congress Africa and Eastern Mediterranean in Kigali, Rwanda.
- **September 2024:** discussion at the ICM regional congress in Kigali, Rwanda with Chief Midwives, Directors of Midwifery Services or equivalent from the Ministry of Health and Medica Education of the Islamic Republic of Iran, the Ministry of Health Uganda, and Ministry of Health of Zambia.
- **January 2025:** virtual consultation organized by the Chief Nurse and Chief Midwives or equivalent from the Ministry of Health and Family Welfare of India, the Ministry of Health and Medical Education of the Islamic Republic of Iran, the Ministry of Health Uganda and Ministry of Health of Zambia.

4. Technical experts guidance from the Core Group, Working Group, and STAGE members through:

- Weekly core group technical meetings between August and December 2024 to discuss the content, including the recommended actions by transition area and the transition framework assessment tool.
- Three Working Group meetings for additional inputs between September 2024 and January 2025. The Gorking group also regularly met between November 2022 and July 2024 to develop the WHO global position paper on transitioning to midwifery models of care. Technical expertise provided during this process was also considered when relevant to the guidance.

5. Technical guidance and recommendations from STAGE members:
   Presentations by WHO secretariat and technical discussions with STAGE members and partners took place at the 6th STAGE meeting in November 2022, 7th STAGE meeting in May 2023, 8th meeting in November 2023 and at the 10th meeting in

Guidance development

The WHO Secretariat drafted the guidance based on these findings. All three groups of STAGE members, key partners and WHO staff reviewed the draft. After consolidating feedback, the document was finalized for validation by STAGE.

Transition stories and examples identification

Transition stories and country examples are not intended to represent definitive best practices. Rather, they offer adaptable options that may inspire context-specific solutions. These examples have been identified through a literature review and consultations with partners and members of various groups, based on the following criteria:

- Documented transitions to midwifery models of care, including detailed descriptions of implementation processes and measured outcomes, where available.
- Representation of diverse midwifery models of care (e.g. continuity of midwife care, birth centres).
- Geographic diversity, with examples from both high-income countries and low- and middle-income countries.
- Variation in implementation scope (e.g. facility level, national level)

Identification of useful resources

Useful resources were identified, screened and selected by the WHO Secretariat in collaboration with relevant departments and units. Only WHO resources were included.

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