



THE STATE OF THE  
World's Midwifery  
2021

Supplements

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## Supplement 1. Adolescents

### Overview

For many of the world's 1.25 billion adolescents (aged 10–19) the right to health care, including sexual and reproductive health (SRH) services, remains unfulfilled. Although the global adolescent birth rate (births per 1,000 girls aged 15–19) has declined over the last 30 years, progress across regions is uneven, and an estimated 12 million girls aged 15–19 years still give birth each year, mostly in Africa and Asia (1). Maternal conditions are the second leading cause of mortality among girls aged 15–19 (2). Moreover, childbearing under age 15, still common in some countries (3), is associated with high risk of mortality and serious health and social problems for very young mothers and their children (4, 5).

Pregnant adolescents need special attention due to the increased risks of maternal and newborn complications and mortality, but their needs have largely been neglected. They are less likely than adult women to get the SRH care they need (6) and more likely than adult women to be mistreated when seeking care (7, 8). Adolescent girls often face a triple stigma: out-of-marriage sex, out-of-marriage pregnancy and abortion (9). Pregnancies may be the result of sexual abuse and violence (10). Access to modern contraceptives and comprehensive abortion services are proven to protect women's and girls' reproductive rights and improve health outcomes. However, in many countries access is insufficient, particularly for adolescent girls, leading to unsafe abortions and forced marriages (1).

### Challenges faced by the health workforce in providing adolescent health services

Sexual, reproductive, maternal, newborn and adolescent health (SRMNAH) workers face numerous challenges in providing adolescents with high-quality services, and are often insufficiently equipped to respond to their needs (11). Adolescent-specific health content is rarely embedded in pre-service education, and often inconsistently implemented in in-service training programmes (12). Therefore, SRMNAH workers often lack the technical competency, preparedness and confidence to deliver adolescent care. Moreover, adolescent health standards are seldom included in supervision and quality improvement systems, so measures to ensure accountability are often also missing (13). Social factors can contribute to providers denying adolescent-appropriate services or withholding health information due to fear that they would be viewed by the community as encouraging inappropriate behaviour (14). The absence of enabling laws and policies promoting adolescents' rights to health services can also prohibit SRMNAH workers from carrying out their work, even if they are equipped to do so. These challenges have been exacerbated by the Covid-19 pandemic.

### Requirements for an adolescent-responsive health system

An adolescent-responsive health system requires a supportive environment, with laws and policies that prioritize adolescents' right to access comprehensive SRH care, including access to contraceptive services and comprehensive abortion care within the legal framework of the country. Complementing efforts to strengthen the health system's adolescent-responsiveness, adolescents themselves require comprehensive SRMNAH information, the skills and assets necessary to make healthy decisions, and supportive and more gender-equitable relationships, families and communities. Building an adolescent-competent SRMNAH workforce is key to an adolescent-responsive health system. It requires specific pre-service education and in-service training for SRMNAH workers, and ongoing supportive supervision and mentorship (13).

## Country case studies

Governments and non-governmental organizations (NGOs) across the world are increasingly recognizing the unmet needs and unfulfilled rights of adolescents and acting on them to improve access to high-quality adolescent SRMNAH services.

### India

In India's Maharashtra State, the Institute of Health Management Pachod (IHMP) is an NGO operating in the urban slums of Pune city and the rural areas of Aurangabad district. It works to protect adolescent girls from early marriage and childbearing and their negative consequences.

A 2015 survey of adolescents by IHMP identified high levels of early marriage and childbearing, low use of maternal health services by pregnant adolescents, and frequent reports of antenatal and postnatal health problems. In response, IHMP developed and tested an initiative to improve the knowledge and understanding of adolescent girls and their partners about the importance of using SRMNAH services. It also sought to improve their access to such services, including supporting health workers to respond effectively to adolescents' needs (6). IHMP's approach is primarily community-based, with linkages to facility-based services when needed. It includes three elements:

- developing monthly "microplans" by carrying out monthly assessments of the health and information needs of pregnant adolescents, through household visits by community volunteers (Accredited Social Health Activists) with support from auxiliary nurse-midwives, backed by community-based monitoring through Village Health, Sanitation and Nutrition Committees;
- educating and providing counselling at the household level, creating demand for services and community support for adolescents' use of health services; and
- facilitating access to health services for those who need them by building links with health workers in primary health centres and at Village Health and Nutrition Days.

Contributed by: Venkatraman Chandra-Mouli, Marina Plesons, Alka Barua, Hedieh Mehrtash, Özge Tunçalp, Manasi Kumar and Ashok Dyalchand (WHO).

### Guinea

The Center for Research in Reproductive Health in Guinea (CERREGUI) is a research group affiliated with the University National Hospital-Donka in Conakry. CERREGUI was the country's coordinating centre for a World Health Organization (WHO)-led study on mistreatment of women during facility-based childbirth in Ghana, Guinea, Myanmar and Nigeria.

This study revealed that more than one third of women experience mistreatment during childbirth in health facilities, and that adolescents are more likely than adults to experience such mistreatment (15). Following the publication of these findings, CERREGUI convened a meeting with representatives from the Ministry of Health, maternity hospitals, NGOs, professional associations and international agencies. Together, they developed a set of recommendations which could be implemented at the national level to reduce mistreatment of women and adolescents during childbirth (16). These recommendations included: practical steps that health workers and health facilities can take, such as allowing women and adolescents to choose their birth companions and accepting the birth position desired by women; and health system changes, such as scaling up training in respectful maternity care and strengthening governance and oversight.

In early 2020, these recommendations were endorsed by the Ministry of Health and incorporated

into the Reproductive, Maternal, Newborn, Infant, Adolescent Health and Nutrition (SRMNIA-N 2020–2024) Strategic Plan and the MUSKOKA Action Plan of 2021. Many health facilities have since taken steps to implement these recommendations: for example, birth companions of choice are being accommodated in the National Teaching Hospital, Ignace Deane.

Contributed by: Venkatraman Chandra-Mouli, Marina Plesons, Alka Barua, Hedieh Mehrtash, Özge Tunçalp, Manasi Kumar and Ashok Dyalchand (WHO).

### **Sierra Leone**

In 2019, the Ministry of Health and Sanitation in Sierra Leone identified early pregnancy and poor reproductive outcomes among adolescents as one of the more pervasive problems affecting the country's health, social, economic and political progress and the empowerment of women and girls. In response, with support from the United Nations Population Fund (UNFPA), WHO and Save the Children, it developed a new guideline for service providers (17).

This guideline sets out key considerations and practical recommendations for working with pregnant adolescents and first-time adolescent mothers, including the factors that influence their health outcomes and how to establish high-quality, responsive health services for them. It outlines adaptations in the delivery of care (at the facility level and in the community) required to provide services for this group before and during pregnancy and childbirth and in the postpartum period, including post-abortion care. Finally, it provides guidance on the first weeks and months as an adolescent mother, including responsive caregiving and mental health support.

Contributed by: Venkatraman Chandra-Mouli, Marina Plesons, Alka Barua, Hedieh Mehrtash, Özge Tunçalp, Manasi Kumar and Ashok Dyalchand (WHO).

### **Democratic Republic of the Congo**

Launched in March 2018, the Bien Grandir Plus (BG+) project is being implemented in the Tshangu district in Kinshasa Province. With funding from Global Affairs Canada, Save the Children is working in partnership with the Ministries of Health and Education to deliver programming to improve the health and well-being of very young adolescent girls and boys aged 10–14 and older adolescents aged 15–19. BG+ works at multiple levels, targeting adolescents, their parents, teachers, health providers and community leaders, to address harmful social norms and gender-based barriers that adolescents face in accessing SRH information and services. In particular, BG+ supports the empowerment of adolescent girls to make their own decisions on and exercise their rights to SRH (18).

BG+ engages adolescents through participatory, age-appropriate material that provides accurate information about SRH and encourages dialogue and reflection on social and gender norms through interactive sessions among in-school and out-of-school girls and boys. Parents, caregivers and community members are similarly engaged in dialogue-based sessions using video testimonials featuring community members who have adopted targeted gender-equitable behaviours.

Most notably for the focus of the SoWMy 2021 report, the project partnered with the Ministry of Health to enhance provision of adolescent SRH information and services, including efforts at the health system, health facility and community levels. Much was achieved in the project's first three years. For example, BG+ trained Ministry of Health trainers and supported Ministry of Health-led cascade training of the SRMNAH workforce on adolescent-friendly SRH services in 60 health facilities. Of the 251 health-care workers trained, 105 were found to have significantly improved

their knowledge on gender equality and adolescent responsive services. Refresher training and supportive supervision are planned to ensure all staff have the appropriate skills.

Twenty-nine Ministry of Health staff from the national, provincial and zonal levels were trained on supportive supervision of adolescent-friendly and gender-sensitive SRH services, introducing adolescent health supervision tools and supporting validation by the Ministry of Health for national use.

BG+ supported Ministry of Health-led cascade training for 186 SRMNAH providers on adolescent-friendly contraceptive services. Most (84%) of the trained staff reported increased knowledge and skills in relation to the counselling and provision of modern contraceptive methods. In addition, 56 health-care workers were trained in supply chain management to improve access to contraceptive products and mitigate supply disruptions.

BG+ facilitated more than 50 exchange visits by groups of adolescents to health facilities to connect them to the health system and gain information about the services available to adolescent girls and boys in order to encourage future service use. Discussion sessions were organized with health providers who were invited to youth clubs in schools and community centres to present lessons on puberty and sexuality to very young adolescents, and on family planning methods and myths to older adolescents.

BG+ also created and updated mapping (in collaboration with UNFPA) of sexual and gender-based violence response services, including medical, psychosocial care, prevention, legal and judicial support and reintegration support. More than 200 community health and child protection volunteers and staff were briefed on the mapping and sexual and gender-based violence prevention and response, with the objective of enhancing referral mechanisms.

Contributed by: Callie Simon (Save the Children).

### **Lao People's Democratic Republic**

In collaboration with provincial and district health departments, Save the Children is supporting government and community partners in the implementation of the Primary Health Care Programme (PHCP) and Sustainable Change Achieved through Linking Improved Nutrition and Governance (SCALING) project in the Lao People's Democratic Republic (19). The project works with SRMNAH providers and community volunteers in five northern provinces to improve maternal, newborn and child health and nutrition.

A key element of the PHCP and SCALING project is to utilize participatory research findings involving ethnic minority communities, including adolescent girls and boys and adolescent mothers, to contextualize the design of SRMNAH approaches. An example is building the skills of midwives and other SRMNAH providers to provide high-quality and respectful maternity care to adolescent mothers and ethnic minority women. Key elements of the approach include:

- robust mentoring to build skills and capacity of midwives and other SRMNAH workers for improved quality of care at the time of birth, including respectful care for adolescents;
- in-facility skills training, using simulators or during a real delivery, from a more experienced provider trained in mentorship;
- strengthening the Ministry of Health supportive supervision processes and supporting peer-to-peer supervision through inter-district visits; and
- improving linkages and referrals between facility-based health services and communities through "First 1,000 Day" home visits conducted by community volunteers. Home visits are essential for young mothers who may have no other support. Community volunteers are

selected by community members and thus include under-represented ethnic minorities and adolescents who are highly motivated to provide peer support. Community volunteers are supervised by local health facility staff and a multisectoral district team.

To date, the project has trained 422 health providers from five provincial hospitals, 28 district hospitals, and 86 health centres. In addition, there are 1,107 home visit volunteers, 79% of whom are from ethnic minorities.

Contributed by: Callie Simon (Save the Children).

### Mitigating the impact of Covid-19 on adolescents' access to the SRMNAH workforce

The Covid-19 pandemic is more likely to affect adolescents because they already had higher rates of unmet need for SRMNAH services, including contraceptive services, and they experience more social and logistical barriers to accessing care. Lockdowns and movement restrictions prevent adolescents from travelling to clinics for care, and school closures have halted sex education and access to school-based health centres offering care (20). Some of these challenges have been mitigated by the rapid implementation of successful new modes of service delivery and innovative approaches to ensure service continuity and access to the SRMNAH workforce, as illustrated in the following case studies.

#### Country case studies

##### Kenya

In Kenya, the “Implementing mental health interventions for pregnant adolescents in primary care low- and middle-income country settings” (INSPIRE) study is led by researchers at the University of Nairobi (21). It aims to develop and refine WHO mhGAP (22) depression screening and care cascades for pregnant adolescents in primary health-care settings, and to provide care to severely depressed pregnant adolescents using interpersonal group psychotherapy.

With the emergence of Covid-19 in early 2020, a range of new stressors contributed to heightened mental health needs among pregnant and parenting adolescents. INSPIRE leveraged its existing infrastructure and personnel to respond to these needs, in partnership with Nairobi metropolitan services, the Ministry of Health, the United Nations High Commissioner for Refugees, GIZ, Kenya Red Cross and other agencies. The approach includes four elements:

- developing e-training for health workers in: rapid identification of mental distress and illness among pregnant and parenting adolescents, strengthened integration of mental health services in antenatal and postnatal care, and Covid-19 prevention and mitigation;
- providing training and supportive supervision on these issues, and on psychological first aid and support to deal with burnout and stress, to community and facility-based health workers, youth leaders and members of community-based organizations serving adolescents;
- establishing a mental health helpline; and
- online interpersonal psychotherapy.

Contributed by: Venkatraman Chandra-Mouli, Marina Plesons, Alka Barua, Hedieh Mehrtash, Özge Tunçalp, Manasi Kumar and Ashok Dyalchand (WHO).

## Colombia

In 2019, Save the Children set up an SRH Unit in Maicao, La Guajira, to provide comprehensive SRH services (according to the minimum initial service package for reproductive health in emergency settings) to Venezuelan migrants, Colombian returnees without social security and uninsured Colombians (23). Adolescents account for 25% of the unit's clients. The unit implemented four key strategies to maintain services during the Covid-19 pandemic.

First, resources and online training were developed to emphasize the importance of continuing to provide SRH services during the pandemic, as well as key information concerning infection prevention and control, to equip health-care workers with tools and guidance to operate in this new context.

Second, there was a shift to remote care for people who have experienced gender-based violence to prevent the disruption of service provision.

Third, telemedicine was used to follow up with clients and provide information on warning signs for pregnant women, care-seeking during pregnancy and Covid-19 prevention measures, signs and symptoms; follow-up tele-counselling for family planning was also offered to clients.

Finally, the SRMNAH workforce was offered training to help cope with stress and mitigate negative mental effects of Covid-19.

In 2020, the clinic served 62 adolescents who had experienced violence, and provided family planning counselling to 926 adolescents.

Contributed by: Callie Simon and Meroji Seban (Save the Children).

## Conclusion

Because of their younger age and lower social and economic status, pregnant adolescents and adolescent parents have needs that are slightly different from those of older and more empowered women and parents. These needs are often not met by existing health workers and systems because they are either unable or unwilling to recognize and respond to them. The Covid-19 pandemic has exacerbated the challenges faced by adolescents accessing high-quality SRH services.

To respond to these adolescent needs, a number of governments and NGOs have put in place projects that have shown promise. To ensure that these approaches are sustained and scaled up, they need to be mainstreamed into health systems to make them truly adolescent-responsive.

An adolescent-responsive health system: incorporates gathering, analysis and use of data on the needs of adolescents in health management information systems; develops guidelines and puts in place policies that require high-quality and respectful care for adolescents; includes care for pregnant adolescents and adolescent parents in the job descriptions of health workers and builds their capacity to deliver such care; strengthens linkages with the relevant health and social services when mental distress or intimate partner violence is suspected or identified; and works to engage partners and family members (24).



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## Supplement 2. Women, newborns and adolescents in humanitarian and fragile settings

### Overview

Worldwide, 36 million children and 16 million women were displaced in 2017. The number of non-displaced women and children living within 50 km of armed conflict increased from 185 million women and 250 million children in 2000 to 265 million women and 368 million children in 2017 (1). Women and girls living in these settings frequently lack access to essential sexual, reproductive, maternal, newborn and adolescent health (SRMNAH) services, including adolescent-specific services, contraception, safe abortion and post-abortion care (2). Even when services are available, they may be denied due to discrimination based on age, marital status, ethnicity or lack of documentation confirming migration status (3). Sexual and gender-based violence in emergencies also cause ill-health, deprivation and neglect of women and girls. Up to one third of adolescent girls living in humanitarian settings report their first sexual encounter as forced (4, 5). These challenges make it extremely difficult for the SRMNAH workforce, who also face their own risks in these settings (6), to deliver essential services, requiring additional efforts to ensure availability, quality and continuity of care.

### Midwives' impact in humanitarian and fragile settings

Midwives are more likely than other SRMNAH workers to be posted to, and remain in, humanitarian and fragile settings throughout a crisis (7). In such settings, the challenges facing health-care workers are amplified, including threats to personal safety. The need for midwives in these settings is vital given the high burden of preventable maternal and neonatal death.

A systematic review of the role and scope of practice of midwives in humanitarian settings has provided examples of midwives' involvement during the three phases of the emergency management cycle: preparedness, response and recovery (8). There is very limited global guidance on the role that midwives can play in the mitigation and preparedness phase, relating to involvement in the community, particularly in vulnerable communities, in monitoring or reducing risks for vulnerable communities by reducing underlying risk factors, or in providing population-based health education.

Preparing for emergencies (natural disasters, conflict etc.) must be included in all pre-service education and in-service training of midwives. Other important components in a humanitarian and fragile setting include: addressing safety and security, providing supportive supervision and mentoring, managing the workload through appropriate task allocation and leadership that ensures visibility of and professional respect for midwives.

### Country case studies

Bangladesh, Somalia and the European Union each provide unique examples of how midwives are responding to the challenges of providing care in humanitarian and fragile settings.

#### **Bangladesh**

Bangladesh hosts almost a million Myanmar Rohingya refugees. In 2016, there was an influx of 80,000 refugees. The following year 750,000 more arrived: a massive humanitarian crisis. The United Nations Population Fund (UNFPA) has supported the delivery of sexual and reproductive health and rights care for refugees here since 2010, but the arrivals in 2016–2017 made it necessary to scale up SRMNAH services rapidly to ensure lifesaving treatments for those needing them, and protection of

their rights. Coincidentally, 2016 saw the graduation of the first class of Bangladesh midwives educated to International Confederation of Midwives (ICM) standards: they became part of the solution. Over 700 of these new midwives were awaiting deployment, and 200 were recruited to provide care in the refugee camps.

In early 2016, before the large influx, midwives were deployed to the two health facilities in the refugee camps in Cox's Bazaar. They endeared themselves to the refugee communities and provided much-needed woman-centred care. When the large influx arrived, 20 more midwives were sent to health facilities in and surrounding the camps. Midwives shared heart-breaking stories of receiving women in labour still wet from the ocean, and unmarried adolescent girls pregnant as a result of rape, some desperate to terminate the pregnancy safely, others with their families in emotional turmoil: all of them grateful for kind, supportive midwifery care. As the midwives stabilized obstetric emergencies, and established other sexual and reproductive health services, and UNFPA and partners struggled to ensure logistics and supplies, the second much larger influx of refugees arrived.

Within weeks, hundreds of midwives were deployed, as health facilities in tents and vans, and eventually bamboo structures, were erected. In pairs, midwives staffed facilities, often without other support staff. The community and the existing health systems welcomed them. Although the facilities were basic, the midwives were passionate to help, and systems for ongoing support and improved living conditions were established. All midwives were immediately trained in clinical management of the aftermath of rape and abortion. Ambulances and referral systems were activated, and midwives were trained in emergency obstetric and newborn care (EmONC) (9, 10).

Midwives were supported in providing respectful midwife-led care with follow-up by a known care provider. Facebook posts appeared of babies in skin-to-skin contact with mothers, some even with a trace of hope in their eyes. Within a week, basic EmONC was established; within a month abortion services were available; in the following months midwives were trained to screen for sexually transmitted infections and cervical cancer. Efforts continued to improve quality and support the midwives in addressing logistical challenges. Three international midwife mentors were hired and paired with peer midwife supervisors to further develop in-service training, enabling environments and problem-solving skills.

When Covid-19 arrived in 2020, midwifery teams acted to ensure that midwife-led care continued. Clinical guidelines were disseminated, and midwives played an active role in infection prevention and control, triage and separating maternity areas. Consequently, service utilization exceeded pre-Covid-19 rates. Challenges remain, but lives are being saved, and midwives and women have opportunities to use their power. Bangladesh is proud of its new midwifery profession.

Contributed by: Rondi Anderson (UNFPA Bangladesh) and Afsana Karim (Save the Children).

## **Somalia**

Somalia is considered one of the world's most fragile states, decades of conflict, insecurity and natural disasters having resulted in a deeply fragmented health system characterized by poor governance and management. Nearly 5.2 million people are in need of humanitarian assistance (11). Poor SRMNAH indicators are partly attributable to limited access to both modern contraception and skilled health personnel at birth. Gender-based violence, including female genital mutilation, is also common (12). Health facilities and SRMNAH workers are insufficient in number, especially in rural areas.

Despite the paucity of regulation and legislation governing midwifery, and the absence of a defined scope of practice, efforts are under way to register all qualified midwives. In Somalia, midwives provide a wide range of SRMNAH services across the continuum of care, including management of complications from female genital mutilation. In security-compromised areas, midwives also provide care for trauma patients, home births and complicated pregnancies.

Many midwives lack a formal job description, and health facilities lack standard protocols. Midwives are not always adequately trained and equipped with the skills and experience to deliver high-quality SRMNAH services. There is poor regulation of midwifery education, a lack of funding for pre- and in-service training, and shortages in midwife tutors with adequate teaching competencies (13).

UNFPA is promoting the advancement of midwifery by supporting 13 midwifery schools. So far, 1,651 midwives have graduated from these schools. The graduates, selected from rural and hard-to-reach areas, are encouraged to work in their community of origin. UNFPA also supported the development and endorsement of a national midwifery strategy, the nationwide adoption of midwifery and nurse-midwifery training curricula based on international standards, and the establishment and strengthening of midwifery associations.

Contributed by: Jihan Salad (UNFPA Jordan).

### **European Union**

In response to the needs of vulnerable migrant women and babies arriving in refugee camps in Europe, a maternity care model, the “Operational Refugee and Migrant Mothers Approach” (ORAMMA) project (14) was put into place between 2017 and 2019. This was at the height of the refugee crisis from Syria. The project was funded by the European Union and evaluated by three universities across Europe. The ORAMMA model involved maternity peer supporters to enhance the quality of care in camp settings and address barriers to high-quality and respectful care, including cultural and language barriers and lack of resources within health facilities.

Midwives with experience of working in complex settings and with refugees were recruited through professional networks and undertook additional training conducted by ORAMMA (15). They then provided primary midwifery care, mostly antenatal and postnatal services. Studies of their experiences revealed that poor conditions within health facilities and lack of amenities and equipment in the camps hampered their ability to provide high-quality care. They were also frustrated by their inability to provide intrapartum care at the camps: they were not authorized to do so even for low-risk cases, despite having the necessary competencies.

To facilitate the provision of high-quality midwife-led care, midwives called for support by further training and national legislation; access to appropriate guidelines, documentation, resources and training materials were developed (16, 17). Other barriers to high-quality care identified included: poor follow up by refugee women seeking postnatal care, partly because of transportation and financial constraints and lack of cultural understanding among health-care workers; hospital bureaucracy; lack of interpreters (especially women); and weak links between primary health-care facilities and hospitals. Suggestions to improve care quality included the introduction of electronic health records, simplifying referral systems, recruitment of more women midwives and interpreters, and training health workers to provide respectful and dignified care to combat racism.

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## Conclusion

During humanitarian crises, the SRMNAH needs of women, newborns and adolescents are often unmet, with devastating consequences. Midwives play a vital role in these settings given the high burden of preventable maternal and neonatal death, and are involved in all components of the emergency management cycle. However, there remain many barriers to access and provision of care by midwives and the broader SRMNAH workforce given the highly challenging environment.

Action is required to strengthen political commitment and leadership at country level, SRMNAH health systems, community engagement and the capacity of all the health workforce in order to achieve sustainable benefits for the health and well-being of women, newborns and adolescents in humanitarian and fragile settings.

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