GenderCollab
Advancing Gender Intentionality in Health Systems

SUMMARY NOTE | Virtual Learning Event | 21 March 2024
Nurse Midwives at the Forefront: Advancing Gender Equity in Health

This document summarises the fourth virtual learning event on midwifery organised by GenderCollab on 21 March 2024. The discussion was moderated by **Dr Anchita Patil**, (Bill & Melinda Gates Foundation, India Country Office), and featured **Dr Geeta Chhibber** (Jhpiego India Country Office, New Delhi), **Dr Aparajita Gogoi** (White Ribbon Alliance India (WRAI) & Centre for Catalyzing Change (C3)), **Dr Janhavi Nilekani** (Aastrika Foundation, Bangalore), **Ms Indie Kaur** (Fernandez Foundation, Hyderabad), **Ms Renuka** (National Midwifery Educator, National Midwifery Training Institute (NMTI), Meerut), and **Dr Poonam Shivkumar** (Mahatma Gandhi Institute of Medical Sciences (MGIMS), Wardha) as panellists.

Dr Anchita Patil opened the session by setting the context on the state of midwifery in India. She invited the panellists to respond to a series of questions on the perceptions of midwifery, training methods, and nurse practitioner midwives in service, and more broadly, the role of midwifery in advancing gender equity in health. This was followed by a Q&A with the audience.

See the event recording here and the presenter slides here.

BACKGROUND

Oxford Policy Management (OPM) is currently implementing a project on 'Adaptive Learning for Gender Responsive Health System' supported by the Bill & Melinda Gates Foundation (India Country Office) following their continued support to action towards gender integration in health systems in their areas of investment. As a part of the project, OPM set up the GenderCollab— a new Community of Practice that brings together partners to work towards advancing gender intentionality within the health systems. It is anchored by OPM and facilitated by Quicksand.

Towards the objective of fostering knowledge exchange with practitioners and researchers who work on Gender and Health System Strengthening (GHSS) related issues, GenderCollab hosts virtual learning sessions.

CONTEXT SETTING

Midwifery is the '**skilled, knowledgeable, and compassionate care'** for **childbearing women, new-born infants and families** across the continuum throughout **pre-pregnancy, pregnancy, birth, postpartum** and the early weeks of life. Core characteristics include optimising normal biological, psychological, social, and cultural processes of reproduction and early life; timely prevention and management of complications; consultation with and referral to other services; respect for women's individual circumstances and views; and working in partnership with women to strengthen women's own capabilities to care for themselves and

their families.' (Lancet Series on Midwifery, 2014).

India has come a long way in improving maternal and newborn health with a significant decline in the Maternal Mortality Ratio (MMR) from 130 in 2014-16 to 97 per lakh live births in 2018-20 (PIB, MoWCD, 2022). However, despite all efforts, each day 74 women die during pregnancy and childbirth in the country (UNFPA, 2022). Nearly 46% of all maternal deaths and 40% of neonatal deaths (deaths of newborns within 28 days of birth) happen during labour or the first 24 hours after birth. There are several regional disparities, and there is an overall lack of respectful women-centred care. Additionally, the lack of skilled human resources for delivery has led to low institutional delivery rates in some states and an over-medicalization of births (rising C-section rates) in other states.

Especially in remote areas and marginalised communities, **midwives can play a pivotal role in handling routine pregnancy and childbirth care— recognising complications promptly, providing initial stabilising care and ensuring meaningful referral** to other providers / and/or facilities (ibid.).

In 2018, the Government of India enabled the creation of a new category of healthcare providers, '**Nurse Practitioners in Midwifery**' or NPMs and launched the Guidelines on Midwifery Services. NPMs were envisioned as **a dedicated cadre capable of providing positive birth experiences to women by promoting physiological birth** (thus reducing over-medicalization), providing respectful maternity care, and decongesting higher-level health facilities by providing services in midwife-led care units (MOHFW, 2018).

In India, an NPM is a registered nurse-midwife who has completed an additional post-basic education of 18 months that has been developed by the Indian Nursing Council in collaboration with ICM and that incorporates the essential competencies set by the ICM (MOHFW, 2018). Seven National Midwifery Training Institutes have been designated for training midwifery educators in the country and, in 2019, midwifery educator training was initiated at one of these institutes. These NPM educators are then expected to set up, work at and train NPMs at the State Midwifery Training Institutes (SMTIs). Following the training, midwifery services will initially be offered in high-case-load health facilities, as part of a comprehensive primary healthcare package (SoWMy, 2021).

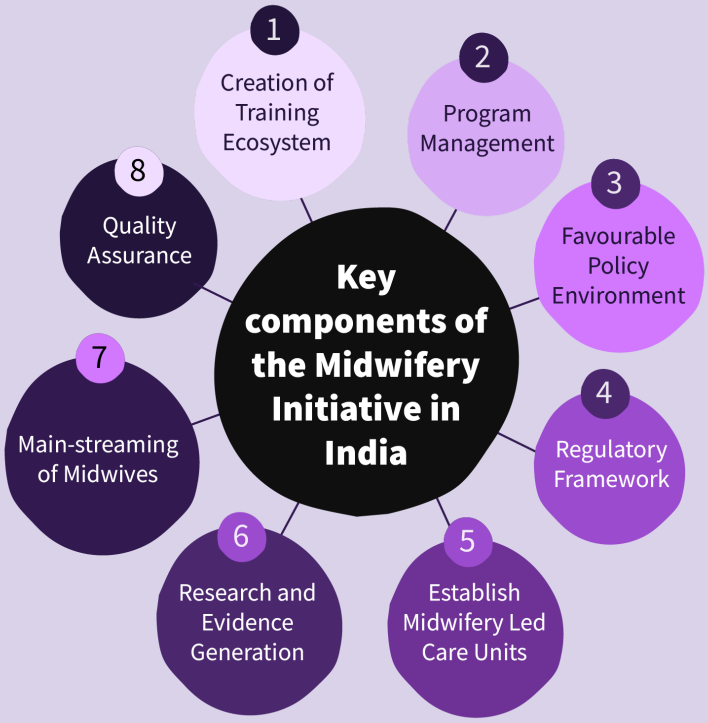
Gender intentionality is integral to the core concept of midwifery service and the cadre of NPMs. As recognised by GoI, midwifery-led care is meant to ensure "skilled and compassionate woman-centric care" (MOHFW, 2018). Central to its definition is the concept of respectful and empowering care. However, there are a range of reasons why midwives are not accorded the recognition and compensation they deserve despite the crucial role they play in achieving Universal Health Coverage (UHC) in Sexual, Reproductive, Maternal, and Newborn Health (SRMNAH). They often endure violence, threats, harassment, discrimination, and the stigma associated with working in a predominantly gendered profession. A joint WHO and GoI study identified barriers and enablers within midwifery, spanning education, training, supervision, deployment, lack of recognition of midwifery as an autonomous profession, and limited roles that hinder midwives from practising to their full capacity. Challenges on the service front included low coverage and quality of some services, poor working environments, and lack of equipment and supplies. (SoWMy, 2021).

Read further on the context in the concept note here. This panel discussion attempted to shed light on the perceptions of midwifery and its distinctness from the predominant 'medical-based nurse model', the effectiveness of training methods, the experience of NPMs placed within obstetric-modelled hospitals, and the opportunities that exist for NPMs in terms of leadership roles.

THE STATE OF MIDWIFERY IN INDIA

Dr Anchita Patil opened the session by sharing key developments in the space of midwifery in India. There have been pilots for professional midwifery in the states of West Bengal, Gujarat, Telangana, and Madhya Pradesh since the early 2000s, where nurses underwent additional training to become midwives. However, these programmes focussed primarily on education, not the other aspects of the profession and didn't define midwifery in alignment with the International Confederation of Midwifery (ICM) definition.

The **2018 Guidelines on Midwifery Services in India** (MOHFW, 2018) aimed to train midwives to be autonomous and responsible, providing quality care in partnership with women. They were designed to **reduce over-medicalization, detect complications early, and ensure timely management or referrals**. Beyond training, a supportive regulatory and policy environment was recognized as essential for midwives to practice autonomously. Several critical pillars, including regulatory frameworks and policy support, were identified for the successful implementation of the program on a national scale.



Major Pillars of the National Midwifery Initiative. Source: Guidelines on Midwifery Services in India (MOHFW, 2018)

NEED FOR COMMUNICATING HOW THE MIDWIFERY INITIATIVE IS DIFFERENT FROM THE MEDICAL OR NURSING MODEL OF CARE

Noting that the midwifery model is a distinct, evidence-based one, Dr Geeta Chhibber noted the four core tenets identified by the International Confederation of Midwifery (ICM).

- **Midwives apply a health-oriented model** as opposed to a disease-oriented model; and are trained to support normal physiological processes, working and promoting positive outcomes, while being able to anticipate and prevent complications
- **Midwives work in partnership with women**, respecting the individual needs of each woman; building a mutually trusting and respectful relationship
- **Midwives promote women's capabilities to care for themselves** and their families; developing freedom and power to make informed choices
- **Midwives have a collaborative approach** between themselves and other healthcare professionals while working within a multidisciplinary context

> Midwifery is an and-model and not an instead-of-model of care. You can see the spectrum across which professional midwives are expected to provide care. They are trained, licensed, educated, and regulated in India to provide care from antenatal to postnatal and beyond. It's quite distinctive both as a cadre and a model of care, which makes the shift away from a very medicalised way of looking at things to looking at normality instead.
>
> *- Dr Geeta Chhibber, Jhpiego India*

Dr Janhavi Nilekani highlighted the significant difference in training between midwives and nurses in India. Midwifery instructors and **midwives undergo a rigorous 18-month training, far surpassing the two-day training on respectful care provided to nurses.** This comprehensive training equips midwives with specialised knowledge, focusing extensively on women's rights, respectful maternity care, and mother-centric approaches.

Moreover, Dr Nilekani emphasised that in recent years, the Indian government has clearly defined the scope of practice for professional midwives, which is broader than that of nurses in most cases. In midwife-led care units such as those **in Bangalore or Sewagram, midwives autonomously make decisions and take responsibility for patient outcomes**—something not yet seen in nursing in India.

Furthermore, the midwifery model of care is rooted in **evidence-based practices, starting with the belief that birth is a physiological and normal process.** Midwives intervene only

when there is strong evidence of benefit, such as in the active management of the third stage of labour or administration of vaccines.

Dr Aparajita Gogoi shared key strategies to highlight the unique value of the midwifery-led model, focusing on:

- **Leading with the evidence**: Midwifery-led care leads to better health outcomes, including reduced maternal and neonatal mortality rates, lower over-medicalization, and greater cost-effectiveness compared to obstetric care.
- **Building support and buy-in**: It's crucial to garner support from stakeholders within the health system and drive demand from women themselves.

Other recommendations that Dr Gogoi's team made to the midwifery task force include making the following three distinctions:

- midwifery-led care is **specialized care** given by trained professionals in a collaborative setting
- midwifery-led care is **women centric**, respecting their choices and concerns at their pace.
- midwifery-led care is **compassionate care** that extends beyond the physical, emotional and mental well-being of women and provides continuous companionship along the way.

Dr Gogoi also noted that it is very **important to establish what midwifery-led care is not.** Midwives are not replacements, assistants, or gatekeepers to OB-GYNs. Midwives are not just advanced general nurses but on a separate track to themselves. Midwives are not a one-stop solution but work within a collaborative model. Finally, especially in India, it's important to dispel the misconceptions that NPMs are about a revival of the traditional midwifery practice (*dais*).

> We should talk about how midwives provide end-to-end care through dedicated maternity care units, how this is a collaborative model where midwives offer innovative methods for pain management, for emotional care, for companionship. But, we also need to add that autonomous decision-making happens within their realm of medico-legal responsibilities. Often, a lot of pushback comes about, with questions such as—what will happen if something goes wrong? In India, we're still not very clear about medico-legal responsibilities of midwives.
>
> *- Dr Aparajita Gogoi, White Ribbon Alliance India*

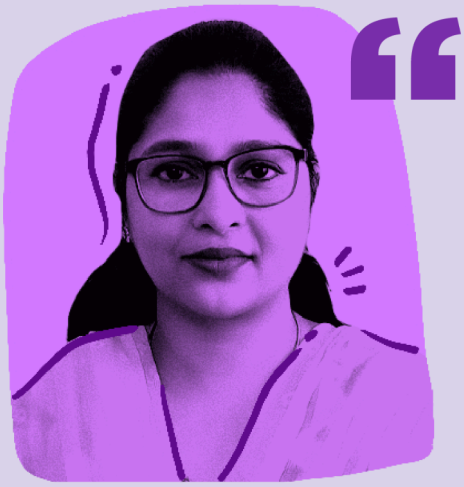
MIDWIFERY TRAINING IMPARTING THE CORE PHILOSOPHY OF MIDWIFERY

Speaking from her experience of imparting training for many years with the Fernandez Foundation, Ms Indie Kaur, noted that midwifery training embodies a women-centred philosophy focused on gender empowerment, recognising women's reproductive rights, voice and agency. Midwifery training is grounded in improving the experiences of women receiving care by—

- **going through case scenarios** following the woman, newborn and the family through the journey, starting from the pre-partem stage.
- training **how to screen, how to look at the first assessment** with the doctor, and reflections evaluations and feedback mechanisms that follow.
- getting **feedback from those who have directly experienced midwifery care**
- including birth companions
- **becoming advocates** for women and their families

Ms Kaur mentioned that the training for midwives is hands-on and is delivered by other midwives. She added that midwives in Fernandez Foundation are also training PG students as midwifery-led care needs to be translated into the medical model of care too.

Ms Renuka shared her experiences as a student and then an educator at the National Midwifery Training Institute (NMTI), Meerut, noting that the training, delivered as per the standards of ICM competencies, **includes informed choice, autonomy in decision making, respectful maternity care, protecting the rights of women and children, cultural sensitivity.** At the end of the 18-month training, at the midwifery care unit, the transformation is clearly visible in the behaviours and attitudes of the midwives.



> Practicing midwives recognise in their own empathetic and compassionate care that they are doing something different than what they were doing earlier [as nurses]. Even I felt the same way when I started learning about midwifery. This process of change is truly remarkable and indicative of the gradual evolution within the field of midwifery in India, even though there is a long way to go. [ ] Women are empowering other women through this midwifery program— it is a life-changing experience
>
> *— Ms Renuka (National Midwifery Educator, National Midwifery Training Institute (NMTI), Meerut)*

Speaking of training for women-centred care, Dr Poonam Shivkumar (Mahatma Gandhi Institute of Medical Sciences (MGIMS), Wardha) shared the need to **add layers of technical and social aspects** in the work towards improving knowledge, attitudes, and practice. She added that especially with the skills lab where training is provided on mannequins, there is a focus on building a humane approach in the attitudes and practices of midwives. Additionally, training components such as **non-pharmacological pain-relief methods, bringing in birth companions, and engaging from the antenatal period onwards, all contribute towards patient and family-centered care**. Speaking of inter-professional collaboration as a pillar to the success of the training, Dr Shivkumar described how informal dialogues facilitated conversations between midwives, OB-GYNs, and nurses. **Over several meals, they came to discuss and realise that midwives are not stealing the jobs of doctors but only supporting and promoting** the functioning of medical care.

I'll give you a small example, when a midwife performs a delivery, she brings the husband inside with all precautions for infection prevention and then lets him cut the umbilical cord. We have seen how things change completely— both the husband and wife become responsible as parents. They both feel connected with the baby and treat them as their own. This is the beginning of a transformed family dynamic. [ ] Midwifery can play a major role in involving the father or partner during the antenatal period and ensuring that they have equal responsibility in terms of birth preparedness and complication readiness.

— Dr Poonam Shivkumar (Mahatma Gandhi Institute of Medical Sciences (MGIMS), Wardha)

Dr Shivkumar and Dr Chibber also spoke about critical components that would make training more fruitful in practice—

- **Infrastructure**— Midwifery-led care units need to be placed next to high-risk labour rooms for better flow and coordination between them.
- **Appropriate and engaging methodologies**— remember that this training is for adults and needs to be practice and observation-oriented, delivered by midwives.
- **Champion Obstetricians**—who can support midwifery units to be well-resourced and located close to labour rooms.

"I remember Doctor Evita Fernandez pointing out that between the midwifery-led unit and Obgyn unit, there is a corridor closed with doors. She said it was both the door and the corridor that was important. That physical separation makes you think about the autonomy of practice for the midwife and the woman. But the corridor establishes collaboration, which is super important.

— Dr Anchita Patil, Bill & Melinda Gates Foundation (India Country Office)

An audience member, drawing from her nursing experience in a particular state, pointed to the stagnant quality of compassionate care despite numerous training sessions. The root cause, she felt, was a lack of attitudinal shift among nurses. She questioned how the knowledge gained from training modules translates into practice for midwives.

Dr Chhibber responded that while there is a specific module on respectful maternity care developed by the IMC, **the essence of compassion is interwoven throughout the entire training package**. This includes practical aspects like speaking patiently with women, refraining from using the term "patient," and adopting more collaborative language such as "facilitator" and "learner" instead of the traditional "teacher" and "student" dynamic.

Furthermore, Dr Chibber emphasised the importance of competency-based education, which focuses not only on knowledge and skills but also on attitudes—now referred to as behaviours. While behaviours can't be directly measured, they can be modelled and cultivated. Hence, **it's crucial for the national program that the training is led by midwives rather than obstetricians or nurses, so that the attitudes and behaviours essential for compassionate care are effectively passed on and practiced.**

EXPERIENCE OF NPMs PLACED WITHIN MEDICAL-MODELLED HOSPITALS

Speaking about her experience, Ms Renuka shared that **acceptance for NPMs within a medical model depends upon the hospital culture, policies and attitudes** towards midwifery. Midwives are likely to encounter varying levels of both acceptance and resistance from colleagues, the administration and patients. To improve this, Ms Renuka stressed the need for **strengthening inter-role collaboration through effective communication, respecting and recognising** each other's professional expertise, and fostering a collaborative environment. She said that ultimately, all the providers work together for **a single purpose—a mother's welfare**.

MIDWIFERY AS A GENDER TRANSFORMATIVE INTERVENTION

Dr Patil stated that she views midwifery as gender transformative not just for the women who receive care and the healthcare providers that deliver it, but also for the communities within which these units are located. She asked all the speakers about their experiences in how midwifery serves to reduce the prevalent gender inequities.

> I'm most excited by midwifery and the increasing movement towards mainstreaming respectful maternity care in India. The recent government policies— LAQSHYA, Suman, or the midwifery guidelines, have all consistently prioritised RMC, at the high level at least. It's a question of all of us working together to implement it further
>
> *— Dr Janhavi Nilekani (Aastrika Foundation, Bangalore)*

Dr. Nilekani emphasized that while midwives play a crucial role in addressing the shortage of skilled human resources in RMNCH, **the issue of disrespect and abuse in labour rooms persists across the country**. This problem varies across different societal segments and, although it may have improved somewhat, it still ranges from privacy violations, lack of confidentiality, and inadequate provisions like curtains or blankets for mothers, to verbal abuse, slapping, pinching, and even physical violence.

She highlights that **maternity departments often face worse conditions compared to mixed-gender departments like orthopedics or oncology**, and this may be gender-related. Having a cadre like midwives, whose role includes ensuring respectful maternity care, is inherently transformative for a health facility. This extends to ensuring informed consent, rather than fear-based consent, a practice that is often lacking even in elite hospitals.

Highlighting the gender inequities that impact midwives themselves, Dr Gogoi shared that across the world, **women's labour often remains unseen, underappreciated, subject to stereotypes, and deemed less valuable** compared to men's work. She highlighted the need to help midwives deal with discrimination that all women face due to patriarchy. As part of the global study on 'What Midwives Want', the White Ribbon Alliance met about 11,000 midwives across 28 states and three union territories to ask what midwives wanted for midwifery-led care to be successful in India. The biggest asks were **autonomy, recognition, non-discrimination, and leadership; midwives wish to occupy spaces that enable them to contribute to policy and program decisions about midwifery**. Referring to the National Nursing and Midwifery Commission Act (2023) that proposes midwifery commissions at the state and national levels, Dr Gogoi urged for intentionally having midwives in leadership positions across levels that have traditionally gone to male leaders, to ensure equity.

When discussing respectful maternity care from the perspective of clients, Dr Chhibber emphasised **the importance of investing in capturing data on positive care experiences with midwives**. It is commonly observed that many women who receive care from midwives return months later to express gratitude for their support. This data, gathered within India, showcases how specific midwifery practices positively impact clinical outcomes and can help dispel scepticism towards midwifery within the healthcare system.

Dr. Chhibber also noted the gap within policy spheres, between data from the West and practices in India. To bridge this gap, she suggests:

- Investing in midwifery education
- Integrating midwives into an enabling health system
- Supporting leadership roles for midwives to influence policies and programmatic interventions.

Dr Shivkumar suggested several ideas where midwifery care can help address prevalent gender inequities—

- **Introducing Male Midwives**— Even though there are prevalent cultural factors and a national policy that allows only women to be midwives, there are many states where male gynaecologists are doing very well. There is no need for midwives only to be female.
- **Encouraging male birth companions**— for husbands to help out actively rather than just stand outside. While there are issues of limited infrastructure to support this, provisions such as LDR (Labour Delivery Recovery) format units are now part of LAQSHYA guidelines.
- **Increasing Paternity leaves**— Once the midwifery model is set up and the paternal role is established as equal, then we can go to the government and demand for increasing paternity leaves.

> Through this training, I've seen some of our trainers and learners not getting paid. As part of a group of women, pay structure is also important. Additionally, I've witnessed that some valuable members of the staff do not continue through the course of the training because of the way they're treated.
>
> *— Ms Indie Kaur (Fernandez Foundation, Hyderabad)*

MEDICO-LEGAL RESPONSIBILITIES AND LEADERSHIP OF MIDWIVES

The speakers discussed the current legal system's failure to recognize midwives' autonomy. Dr. Shivkumar suggested that if the health system can support first-year residents with medical procedures, it should also support midwives who undergo intensive training for 18 months after their nursing program. She emphasised the **critical role of obstetrician leadership and support**, particularly in taking responsibility when something goes wrong.

Ms. Renuka emphasised the importance of midwives knowing their scope of practice and acting within those boundaries, referring to an obstetrician as needed. Dr. Manju Chhugani of the Society of Midwives in India (SOMI) responded that **this approach places the responsibility solely on individual obstetricians** and recommended legal protection for midwives.

Dr. Nilekani added that currently, **midwives have no more legal protection than nurses, and the burden of medico-legal liability falls on obstetricians if something goes wrong**. She noted that this system is a disservice to all stakeholders, as midwives lack legal responsibility for their scope of practice, and the future of midwifery depends on champion obstetricians trusting the work of midwives.

Dr. Nilekani recommended pushing for midwives to have a legally autonomous scope in the long term. In the meantime, she suggested giving midwives **opportunities to represent their profession and advocating for appropriate remuneration**, as currently, there is a reluctance to pay trained midwives more than nurses in some regions like Karnataka. She also highlighted the need to invest in leadership skills, create an enabling work environment, provide advocacy spaces for midwives, and enable them to lead research, in addition to technical training.

> *"You need to **create roles and progressions for the midwife to develop into leaders** and heads of their department, separate from nursing. This will also encourage more persons to enter the profession and think of it as a career. One day, I would see an NPM in my position as the director of midwifery." — Ms Indie Kaur (Fernandez Foundation, Hyderabad)*

MONITORING & EVALUATION FOR MIDWIFERY

Angel from the Institute of Public Health in Bangalore expressed satisfaction at the nationwide rollout of midwifery programs and emphasised the importance of sharing successes, lessons, and challenges among implementers. She inquired about platforms and monitoring frameworks facilitating cross-learning. Dr. Patil responded that **there isn't a comprehensive monitoring framework within the government beyond tracking the number of midwives trained**. Although there have been some attempts to bring partners together to share their experiences, these efforts have been irregular and unstructured due to factors like the COVID-19 pandemic and leadership changes.

Dr Patil added that the Gates Foundation has set up a partnership with Indian Institute of Public Health (IIPH), Gandhinagar to look at different challenges and innovative solutions being implemented across different states. These actions and innovations include—

- getting the training institute approved by the Indian Nursing Council
- getting certificates for the nurses
- coordinating across multiple departments— health, medical education, state nursing council, universities, etc
- developing state midwifery task forces

At the moment, there is limited institutional memory of the 2018 launch within the government, but the partners working on this are pushing for collating learning and building a robust monitoring mechanism.

Dr Patil concluded by saying that **respectful midwifery is about recognising the agency of women and the autonomy over their own bodies**— not merely ending abuse. Therefore, it goes beyond maternity care into the realm of family planning, and partner involvement, and works toward creating a shared sense of sexual and reproductive health. She wishes that the **collaborative ethos of midwifery gets diffused across other health professions— to learn to accord respect for patients and clients**.

She stated that **midwifery is a profession that highlights that being with people is a skill that is just as valuable as learning how to cut, suture, and give medicines**. Midwifery is also a profession that reminds us that pregnancy is physiological, not a disease.

> "Midwives are distinct professionals— not mini OB-GYNs or higher nurses. **They are specialists in normality**. They need to be given space to operate, designations, appropriate salaries, leadership skills and voice to advocate for themselves." — Dr Anchita Patil, Bill & Melinda Gates Foundation (India Country Office).

Additional Reading Material

1. The State of the World's Midwifery (United Nations Population Fund, 2021)
2. Scope of Practice for Midwifery Educator & Nurse Practitioner Midwife (Ministry of Health & Family Welfare, Government of India, 2021)

3. Essential Competencies for Midwifery Practice (International Confederation of Midwives, 2019)
4. Guidelines on Midwifery Services in India (Ministry of Health & Family Welfare, 2018)
5. Midwifery: An Autonomous Profession (International Confederation of Midwives, 2017)
6. Midwifery (The Lancet, 2014)

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