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RESEARCH BRIEF

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Creating Supportive Legal and Regulatory Frameworks for Midwifery Models of Care

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Introduction

There is widespread recognition that midwifery models of care have the potential to transform the provision of maternal healthcare globally. When fully integrated into healthcare systems, professional midwives can dramatically improve health outcomes, enhance patient experiences, and reduce healthcare costs. According to the World Health Organization (WHO), midwives can provide up to 90% of essential sexual, reproductive, maternal, newborn, and adolescent health interventions across the life course.[1] If there were universal coverage of midwife-delivered interventions, approximately 67% of maternal deaths, 64% of neonatal deaths, and 65% of stillbirths could be averted, saving an estimated 4.3 million lives globally each year by 2035.[2] Midwifery models of care are also associated with fewer unnecessary medical interventions and better health outcomes, making them a cost-effective and patient-centered approach to delivering care.[3]

In recognition of this potential, global stakeholders, including the United Nations (UN agencies), development partners, and public health actors, have increasingly championed midwifery models of care as a key strategy for providing quality, dignified maternal healthcare in countries around the world.In October 2024, the WHO launched its first-ever position paper on transitioning health systems towards midwifery models of care and endorsing them as a cost-effective approach to improving health outcomes while minimizing unnecessary interventions, and in June 2025 it published implementation guidance on transitioning to midwifery models of care.[4] In April 2025, a global coalition of partners (UNFPA, UNICEF, WHO, ICM, and Jhpiego) launched the Midwifery Accelerator—a unified, evidence-based initiative to significantly scale up midwifery models of care.[5] This framework prioritizes seven "accelerators" as key drivers for effectively implementing midwifery models of care, the first of which is strengthening policy and regulatory frameworks.[6]

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1 World Health Organization, *Transitioning to Midwifery Models of Care: Global Position Paper*, (2024), https://iris.who.int/bitstream/handle/10665/379236/9789240098268-eng.pdf?sequence=1.

2 Andrea Nove et al., *Potential Impact of Midwives in Preventing and Reducing Maternal and Neonatal Mortality and Stillbirths: A Lives Saved Tool Modelling Study*, The Lancet 9, E24-E32 (2020), https://doi.org/10.1016/S2214-109X(20)30397-1.

3 Caroline Homer et al., *The Projected Effect of Scaling up Midwifery*, The Lancet 384, 1145-1157 (2014), https://doi.org/10.1016/S0140-6736(14)60790-X. WHO, *Transitioning to Midwifery Models of Care: Global Position Paper* (2024) at 19; Katy Kozhimannil et al., *Policy Brief: More Midwife-Led Care Could Generate Cost Savings and Health Improvements*, University of Minnesota School of Public Health 1, 2 (2019), https://www.sph.umn.edu/sph-2018/wp-content/uploads/docs/policy-brief-midwife-led-care-nov-2019.pdf; Prosper Koto et al., *Relative Effectiveness and Cost-Effectiveness of The Midwifery-Led Care in Nova Scotia, Canada: A Retrospective, Cohort Study*, 77 Midwifery 144, 149 (2019).

4 WHO, *Transitioning to Midwifery Models of Care: Global Position Paper* (2024); WHO, *Implementation guidance on transitioning to midwifery models of care* (2025).

5 UNFPA et al., *The Midwifery Accelerator* (2025), https://www.unfpa.org/sites/default/files/pub-pdf/The%20Midwifery%20Accelerator_09042025.pdf

6 *Id.*, at 15, 18 ff.

As recognized by the Midwifery Accelerator, weak policy and regulatory frameworks hinder the integration of midwifery care in many countries.[7] This includes gaps in legal recognition, limited autonomy for midwives, and undefined or restrictive scopes of practice that prevent them from delivering essential services. **Yet, the full scope and impact of these legal and regulatory barriers are not well understood. Identifying and unpacking these barriers is essential to the effective scale-up of midwifery models of care.**

BOX 1: Defining Midwifery Models of Care

In accordance with the WHO and the International Confederation of Midwives (ICM), midwifery models of care are characterized by centering trained, competent, licensed, and regulated midwives as the primary healthcare providers for women and newborns.[8] Midwives autonomously provide respectful, high-quality care across their full scope of practice, while collaborating and coordinating with an interdisciplinary team across the healthcare system.[9] They use the midwifery philosophy of care, which "promotes a person-centered approach to care; values the woman-midwife relationship and partnership; optimizes physiological, biological, psychological, social, and cultural processes; and uses interventions only when indicated."[10]

7 *Id.*, at 18.
8 WHO, *Transitioning to Midwifery Models of Care: Global Position Paper* (2024), at 12; ICM, *Midwifery Models of Care – the Way Forward* (2025), https://internationalmidwives.org/midwifery-models-of-care-the-way-forward/.
9 *Id.*
10 WHO, *Transitioning to Midwifery Models of Care: Global Position Paper* (2024), at 12.

Methods

This study examines how laws, policies, and regulatory frameworks hinder the adoption and implementation of midwifery models of care in six jurisdictions: Colombia, India, Kenya, Nigeria, Romania, and the state of Hawai'i in the United States. These jurisdictions were selected based on geographic diversity and the Center's existing partnerships or presence, positioning the study to inform strategic legal and policy change. We conducted a desk review of legislation, policy documents, ministerial guidelines, and regulatory frameworks, as well as a series of expert consultations to understand the history and legal status of midwifery in each target jurisdiction. In most cases, pro bono attorneys conducted the initial research, with an emphasis on research being conducted by attorneys licensed in the respective jurisdictions they were researching. This research was reviewed by legal staff at the Center, who also conducted complementary research. These findings were then validated by experts on midwifery in those respective countries.

This report will first provide a summary of the synthesized key findings and trends across jurisdictions and then present a series of case studies from a selection of the jurisdictions explored. The case studies provide a more detailed analysis of the legal, policy, and regulatory frameworks, identifying key gaps and challenges, and describing the impact on midwifery models of care within each jurisdiction. Given the potentially vast scope of the research and the distinct differences in legal and health systems across countries, this research does not offer an exhaustive review, but instead highlights key legal barriers, opportunities for reform, and the vital role of law in advancing midwifery models of care.

Throughout this text, we strive to consistently use gender inclusive language such as "pregnant person." The one exception to this is where the legal or policy framework to which we are referring uses explicitly gendered language, and changing the terminology could impact the report's accuracy.

PART 1

Human Rights Norms

Human Rights Standards on Midwifery Models of Care: Progress and Gaps

Over the past two decades, international human rights bodies have firmly recognized maternal health as a human rights issue grounded in the rights to health, equality and non-discrimination, bodily autonomy, and privacy, among others. Human rights law establishes that States have an affirmative obligation to ensure access to quality maternal healthcare and address disparities in maternal mortality and morbidity.[11] Human rights bodies also recognize that individuals have the right to a skilled birth attendant, such as a midwife, and States are obligated to ensure their adequate training, resourcing, and integration with the healthcare system. For example, the U.N. Committee on Economic, Social and Cultural Rights (CESCR) recognizes that states are required to ensure "emergency obstetric care and skilled birth attendance, including in rural and remote areas...".[12] The Special Rapporteur on the Right to Health has emphasized that the entitlement to the highest attainable standard of health requires that all pregnant individuals can access a skilled birth attendant as part of an effective and integrated health system in order to prevent maternal deaths.[13] The CEDAW Committee has urged States to prioritize "the provision of qualified midwives and prenatal assistance" to reduce maternal mortality rates.[14] Importantly, such measures to promote maternal health must occur alongside efforts to ensure a functioning healthcare system with adequate access to hospitals, clinics and other health-related buildings, trained medical and professional personnel, and essential medicines.[15] These must be accessible and affordable to all and provided without discrimination.[16]

Notably, human rights bodies are increasingly recognizing the critical role that traditional birth attendants play in providing culturally appropriate care and have called on states to ensure they are not criminalized for providing care, integrated into the healthcare system, and given adequate training.[17] However, most regional human rights bodies have said very little about midwifery, and more human rights standards must be developed.

Against this backdrop, recent jurisprudence from the European Court of Human Rights is worth noting. In a series of decisions on homebirths, the European Court of Human Rights has recognized states' authority to regulate and restrict midwives' ability to attend home births. In *Ternovszky v. Hungary* (2010), the lower chamber of the Court acknowledged that the right

11 *See, e.g.*, CEDAW, Art. 12 (states must "ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."); Alyne da Silva Pimentel Teixeira v Brazil, CEDAW Committee, Commc'n No. 17/2008, UN Doc. CEDAW/C/49/D/17/2008 (2011); CESCR, General Comment No. 22 on the Right to Sexual and Reproductive Health, U.N. Doc. E/C.12/GC/22 (2016).

12 CESCR, General Comment No. 22 on the Right to Sexual and Reproductive Health, UN Doc. E/C.12/GC/22, para. 28 (2016).

13 Report of the Special Rapporteur on The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, UN Doc. A/61/338, paras. 13 f. (2019).

14 CEDAW, General Recommendation No. 37 on the Gender-Related Dimensions of Disaster Risk Reduction in the Context of Climate Change, UN Doc. CEDAW/C/GC/37, para. 68(d) (2018).

15 CESCR, General Comment No. 14 on the Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4, paras. 14, 12 (2000).

16 CESCR, General Comment No. 14 on the Right to the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4, para.12(b) (2000).

17 CEDAW, General Recommendation No. 39 on the Rights of Indigenous Women and Girls, UN Doc. CEDAW/C/GC/39, para. 51 (2022); UN Special Rapporteur on the Rights of Indigenous Peoples, Report on Indigenous Women and the Development, Application, Preservation and Transmission of Scientific and Technical Knowledge, UN Doc. A/HRC/51/28, para. 76 (2022); UN Special Rapporteur on the right to health, Visit to Ecuador, UN Doc. A/HRC/44/48/Add.1, para. 33 (2020); Working Group on discrimination against women and girls, Report on Women's and Girls' Sexual and Reproductive Health Rights in Crisis, UN Doc. A/HRC/47/38, para. 65 (2021).

to privacy under Article 8 of the European Convention on Human Rights includes the right to choose the circumstances of childbirth, including home birth.[18] The Court found that Hungary's failure to provide a clear legal framework and the risk of prosecution for midwives assisting home births violated this right.[19] However, in *Dubská and Krejzová v. Czech Republic* (2014, 2016), the Court reversed course, deferring to states' wide margin of appreciation in regulating maternal health policies.[20] The Court ruled that banning midwives from assisting home births was not a violation of the European Convention on Human Rights, citing potential medical risks and the lack of consensus among European states. It stated that even in the event of a low-risk pregnancy, "unexpected difficulties can arise during the delivery which would require immediate specialist medical intervention, such as a Cesarean section or special neonatal assistance. Moreover, a maternity hospital can provide all the necessary urgent medical care, whereas this would not be possible in the case of a home birth, even with a midwife attending."[21] Subsequent rulings in cases from Croatia (2018) and Lithuania (2019) have followed this doctrine,[22] allowing significant restrictions on midwifery practice related to home births and highly restricting pregnant people from exercising bodily autonomy and making choices about their birth experience.

Scholars have criticized these cases for reinforcing the overmedicalization of childbirth and failing to critically examine states' characterizations of the medical risks associated with childbirth and home birth. For example, in reaching its decision, the Court selectively relied on medicalized perspectives, disregarding evidence such as data from the WHO and meta-studies supporting the safety of home births for low-risk pregnancies.[23] The Court also excluded amicus curiae interventions from human rights and reproductive rights organizations, while giving leave to submissions from medical professionals that reinforced the notion that hospital birth is the default and safest option.[24] The Court consistently used a medicalized framing for childbirth that assumes the risk associated with pregnancy and childbirth is significant enough to invalidate people's right to make decisions about their bodies and medical care.

Not only does this fail to adequately weigh the birthing person's autonomy and choice, this framing also perpetuates harmful and patronizing stereotypes about birthing people as irrational and incapable of making informed decisions regarding their bodies and their children.[25] By deferring to state discretion in regulating home births, the Court undermines the autonomy of pregnant individuals and imposes significant barriers to midwifery practice, disregarding evidence-based standards. Notably, midwifery practice and midwifery models of care are often restricted based on the same underlying assumptions the European Court adopted in these

18 ECtHR, Ternovszky v. Hungary, Appl. No. 67545/09, Judgment of 14 December 2010.
19 *Id.*
20 ECtHR, Dubska and Krejzova v. Czech Republic, Appl. No. 28859/11 and 28473/12, Judgment of 11 December 2014; ECtHR, Dubska and Krejzova v. Czech Republic, Appl. No. 28859/11 and 28473/12, Judgment of 15 November 2016.
21 ECtHR, Dubska and Krejzova v. Czech Republic, Appl. No. 28859/11 and 28473/12, Judgment of 15 November 2016, at 186.
22 ECtHR, Pojatina v. Croatia, Appl. No. 18568/12, Judgment of 4 October 2018; ECtHR, Kosaite-Cypiene and Others v. Lithuania, Appl. No. 69489/12, Judgment of 4 June 2019.
23 *See in detail* Fleur van Leeuwen, *Epistemic Blind Spots, Misconceptions and Stereotypes: The Home Birth Jurisprudence of the European Court of Human Rights,* 35 EJIL 153, 167 f, (2024), http://ejil.org/pdfs/35/1/3397.pdf.
24 *Id.*; Fleur van Leeuwen, *The Missing Voice of Pregnant Women: Third Party Intervention in the Dubska and Krejzova Case,* Strasbourg Observers Nov 23, 2015, https://strasbourgobservers.com/2015/11/23/the-missing-voice-of-pregnant-women-third-party-interventions-in-the-dubska-and-krejzova-case-2/.
25 *Cf.* Fleur van Leeuwen, *Epistemic Blind Spots, Misconceptions and Stereotypes: The Home Birth Jurisprudence of the European Court of Human Rights,* 35 EJIL 153, 170 (2024), http://ejil.org/pdfs/35/1/3397.pdf.

decisions – that childbirth is inherently risky, and a hospital setting is the best option, which in turn justifies restricting or nullifying pregnant people's choice, autonomy, and decision-making.

In contrast to the ECtHR's reasoning, global health guidelines from ICM, WHO, and UNFPA all explicitly affirm that midwives should be able to provide care in various settings, including the home of the pregnant person.[26] ICM further stipulates that as part of midwifery education, students must gain sufficient experience in both facility-based and community care settings, including home births, to meet the ICM Essential Competencies for Midwifery Practice.[27] This is supported by a substantial body of research demonstrating that midwives can safely provide care in home settings when they are adequately trained, resourced, integrated into healthcare systems, and able to refer to other providers as needed.[28]

In line with this, some UN human rights bodies and experts have acknowledged the safety and importance of home birth. For example, the UN Working Group on Discrimination against Women has called on States to "[e]nd the penalization of women and midwives for home births and ensure that health authorities establish cooperation with midwives to guarantee that women have access to the highest standards of healthcare while respecting their autonomous decision-making."[29] It also acknowledges that "[o]vermedicalization may reduce access to or affordability of services needed by women, creating a barrier to the development of adequate alternative services, which can be competently provided by nurses, midwives, or auxiliary nurses, either at clinics or at home."[30] Furthermore, the Special Rapporteur on the Right to Health has recognized that planned out-of-hospital births can be an affordable and accessible option, stressing that women have the right to make informed choices and receive support from healthcare personnel if they opt for homebirth.[31]

26 ICM, *International Definition and Scope of Practice of the Midwife* (2024), at 1 f., https://internationalmidwives.org/resources/international-definition-of-the-midwife; UNFPA, *The State of the World's Midwifery* (2021), at 7, 63, https://www.unfpa.org/sites/default/files/pub-pdf/21-038-UNFPA-SoWMy2021-Report-ENv4302_0.pdf; WHO, *Transitioning to Midwifery Models of Care: Global Position Paper* (2024), at 8 f., 12.

27 ICM, *Global Standards for Midwifery Education – Practical/Clinical Experience Supplementary Guide Global Education Standards* (2024), standard 3.6, https://www.internationalmidwives.org/wp-content/uploads/Practical-Clinical-Experience-Supplementary-Guide-1.pdf.

28 *See, e.g.,* Angela Reitsma et al., *Maternal Outcomes and Birth Interventions Among Women Who Begin Labour Intending to Give Birth at Home Compared to Women of Low Obstetrical Risk Who Intend to Give Birth in Hospital: A Systematic Review and Meta-Analyses,* 21 eClinicalMedicine 100319 (2020), https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(20)30063-8/fulltext; Patricia A Janssen et al., *Outcomes of Planned Home Birth with Registered Midwife versus Planned Hospital Birth with Midwife or Physician,* 181 CMAJ 6 (2009), https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(20)30063-8/fulltext; Kenneth C Johnson & Betty-Anne Davis, *Outcomes of Planned Home Births with Certified Professional Midwives: Large Prospective Study in North America,* 330 BMJ 1416 (2005), https://pubmed.ncbi.nlm.nih.gov/15961814/.

29 Working Group on the Issue of Discrimination Against Women in Law and Practice, Visit to Honduras, UN Doc. A/HRC/41/33/Add., para. 77 (2019).

30 Working Group on the Issue of Discrimination Against Women in Law and Practice, UN Doc. A/HRC/32/44, para. 75 (2016).

31 UN Special Rapporteur on the Right to Health, Visit to Ecuador, UN Doc. A/HRC/44/48/Add.1, paras. 33 and 77(m) (2020).

PART 2

Key Findings

Background

The legal and regulatory frameworks of the six jurisdictions included in this research varied considerably. Whereas some had strong, newly developed laws and policies on midwifery (such as India), others had outdated policy and regulatory frameworks (such as Nigeria), and in other contexts, there was a legal and regulatory vacuum (such as Colombia). Despite these differences, there were common legal and regulatory barriers to the effective adoption and implementation of midwifery models of care. The most common types of barriers identified were those related to 1) recognition and routes of entry; 2) licensure and registration; 3) appropriate oversight bodies; and 4) autonomy and scope of practice. This report will highlight the relevant standards set by global health authorities across these issue areas, provide country-level examples of how states are not conforming to these standards in ways that undermine midwifery models of care, and provide recommendations on how the legal and regulatory frameworks should be strengthened.

BOX 2: The International Confederation of Midwives

The International Confederation of Midwives (ICM) is a global organization that represents over 136 midwives' associations across 117 countries. ICM creates and promotes globally recognized standards and guidelines on how midwifery models of care can best be developed, implemented, and sustained in different contexts across the globe.

I. Recognition, Regulation, and Routes of Entry

According to ICM, the purpose of regulations on midwifery should be to protect the public by ensuring that "safe, competent midwives provide high-quality care."[32] ICM recognizes that legislation should clearly define who is legally permitted to practice as a midwife and use the title "midwife". This ensures that individuals receive care from a qualified professional who adheres to established professional and ethical codes of conduct, and that there are accountability mechanisms for any grievance/redress.[33]

Regulations on midwifery should explicitly define who is considered a midwife to ensure clarity on whom such regulations apply.[34] The WHO adopts the International Labour Organization (ILO)'s definition of midwifery professionals as those who:

> **"plan, manage, provide and evaluate midwifery care services before, during and after pregnancy and childbirth. They provide delivery care for reducing health risks to women and newborn children according to the practice and standards of modern midwifery, working autonomously or in teams with other healthcare providers. They may conduct research on midwifery practices**

32 ICM, *Legislation to Regulate Midwifery Practice* (2024), at 1, https://internationalmidwives.org/resources/legislation-to-regulate-midwifery-practice-2/.
33 ICM, *Global Standards for Midwifery Regulation* (2011), at 15, https://www.internationalmidwives.org/wp-content/uploads/global-standards-for-midwifery-regulation-eng.pdf.
34 *Id.*, at 15.

> **and procedures and implement midwifery education activities in clinical and community settings."[35]**

ICM recommends the use of both direct-entry programs, which require a minimum of 36 months, and post-nursing or healthcare provider (post-registration) programs, which require at least 18 months to address the competencies necessary for midwifery practice.[36] ICM emphasizes that "legislation...should provide for entry to the profession that is based on competencies and standards and which makes no distinction between routes of entry."[37] Therefore, the pathway that a person takes to become a midwife should not later dictate their scope of practice.

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Nearly every country surveyed has specific policy and regulatory frameworks on routes of entry for midwives and clearly defines who qualifies as a midwife. There were significant variations in this regard, as countries' frameworks aimed to be responsive to their respective needs. Yet, our research identified a handful of challenges, such as multiple and confusing routes of entry, the use of the term "midwife" by some providers lacking comprehensive midwifery training, and a lack of overall regulation. For example:

- In **Kenya**, there are multiple routes to become a midwife, including direct-entry, post-nursing, and general nursing programs with midwifery components, each leading to varying titles and scopes of practice.[38] This has created a fragmented system where the title "midwife" is inconsistently used and often conflated with nursing. Although only some qualifications technically confer midwife status, many other providers carry out similar tasks, and all are employed under the general title "Nursing Officer" in healthcare facilities.[39] This lack of clarity around roles and qualifications, and more importantly, the scope of practice, causes significant confusion and uncertainty for patients about the limits of care they are receiving.[40] At the same time, the lack of clarity among other healthcare providers as to what each type of "midwife" is able and capable of doing limits recognition of midwives as distinct professionals with specialized expertise.[41]
- Although **India** is transitioning to a system where midwifery care will predominately be provided by nurse practitioner midwives who have undergone training that aligns with ICM educational standards and competencies, there are currently several types of professionals who use the term "nurse-midwife" in their titles but who are more akin to obstetric nurses and have not necessarily been trained on midwifery models of

35 WHO, *Transitioning to Midwifery Models of Care: Global Position Paper* (2024), at 7.
36 ICM, *Global Standards for Midwifery Education* (2024), at 7, https://www.internationalmidwives.org/wp-content/uploads/Practical-Clinical-Experience-Supplementary-Guide-1.pdf.
37 ICM, *Legislation to Regulate Midwifery Practice* (2024), at 3.
38 The approved pathways and resulting titles include Registered Midwife (KRM), Registered Midwife at Degree Level (BScM), Registered Nurse-Midwife (KRN/M), Registered Community Health Nurse (KRCHN), Registered Nurse at Degree Level (BScN), see Nursing Council of Kenya, *Scope of Practice for Entry-Level Programmes* (2020), https://nckenya.com/wp-content/uploads/2020/08/Scope_of-Practice_For_Entry_Level_Programmes_17.08.2020.pdf.
39 Public Service commission [Kenya], *Revised Scheme of Service for Nursing Personnel* (2014), https://knun.or.ke/echoopsy/2020/09/scheme-of-service-for-nursing-personnel.pdf.
40 Interview with Eunice Atsali, National Secretary, Midwives Association of Kenya (Dec. 5, 2024).
41 Interview with Eunice Atsali, National Secretary, Midwives Association of Kenya (Dec. 5, 2024).

care and/or have competencies that align with ICM's standards.[42]

- In **Colombia**, no legislation defines or recognizes midwifery as a profession, creating a complete legal vacuum and a total lack of recognition for this profession, which would be the first necessary step in integrating MMoC into the healthcare system. Although in some parts of Colombia, particularly in very remote and underserved areas, traditional birth attendants are the only providers of maternal healthcare and play a critical cultural role, they are not recognized as legitimate healthcare providers and are not integrated into the formal healthcare system, meaning that they are unable to access essential medicines and often do not have an effective mechanism to refer patients who require a higher level of care.[43]

It is critical that states regulate midwifery in a manner that promotes the provision of equitable rights-based healthcare, particularly for populations that have historically been underserved and marginalized, while also ensuring public health, safety, and proper oversight.

II. Licensure and Registration

As defined by ICM, licensure and/or registration "is the legal right to practise as a midwife and acts as the entry to the profession."[44] WHO also supports requiring formal licensure and/or registration of midwives to ensure competency and protect public safety.[45] Generally, the national midwifery regulatory authority sets licensure and/or registration standards and verifies competencies.[46] Further, ICM recommends implementing a requirement for regular license renewal that includes confirmation of ongoing competence, separate from the initial registration.[47] ICM also underscores the importance of public transparency, recommending that midwifery registers be publicly accessible and indicate practicing status.[48] A previous UNFPA survey on licensure and registration found that over 20% (17 out of 79) of responding countries did not have any licensing system for midwives, and one-quarter did not have a system for periodic renewal of their licensing,[49] demonstrating how a lack of licensure and registration can hinder the effective scaling up of midwifery models of care.

42 Interview with Geeta Chhibber, Senior Technical Advisor for Jhpiego, India Country Office (Dec. 13, 2024).
43 R. 1077/17, junio 3, 2017, Diario Oficial [D.O.] (Colom.), https://normograma.mincultura.gov.co/mincultura/compilacion/docs/resolucion_mincultura_1077_2017.htm.
44 ICM, *Legislation to Regulate Midwifery Practice* (2024), at 1.
45 UNFPA, *The State of the World's Midwifery* (2021), at 20; WHO, *Transitioning to Midwifery Models of Care, Global Position Paper* (2024), at 12, 25.
46 ICM, *Global Standards for Midwifery Regulation* (2011), at 18 f.
47 ICM recommends that the re-licensure process should go beyond a mere fee payment, as historically seen in some countries, and incorporate elements such as continuing education, minimum practice requirements, competency assessments, and engagement in professional activities; see ICM, *Global Standards for Midwifery Regulation* (2011) at 21 f.; ICM, *Legislation to Regulate Midwifery Practice* (2024), at 3.
48 ICM, *Global Standards for Midwifery Regulation* (2011), at 20.
49 "Countries use a variety of terms to describe the legal right to practise as a midwife. Half (49%) of 79 responding countries have both a licensing system and a registration system that are separate and mandatory processes, a quarter (25%) have registration only, 13% have licensing only and 12% have another type of system. Of 73 reporting countries, 17 have no licensing system at all, and 20 require their midwives to be licensed only once after qualifying, with no requirement for periodic renewal of the licence. The remaining 36 countries have a system involving periodic renewal, but only 24 of them require continuing professional development.", UNFPA, *The State of the World's Midwifery* (2021), at 18 f.

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While most countries surveyed require licensure and registration of midwives, maintain a publicly available roster of midwives, and require regular license renewal, there were also notable challenges. For example,

- The lack of legislation defining and recognizing midwifery in **Colombia** means that there is no licensure or registration process for any type of midwife. Although there is a significant number of traditional birth attendants in Colombia, there are also some people who trained as birth attendants or received accreditation as midwives in other countries where the profession is formally recognized and regulated.[50] Some of these individuals provide midwifery services in urban settings in Colombia and are not part of particular cultural communities.[51] The lack of licensure and regulation means that both traditional birth attendants and midwives operate in a legal vacuum that exposes them to potential liability for practicing and are not effectively integrated into the healthcare system. This also prevents them from accessing essential medicines or supplies, creating strong referral pathways, and being compensated through the public health insurance system.
- In 2019, after two decades without restrictions on midwifery practice, **Hawai'i** enacted the Midwifery Restriction Law, which required individuals to obtain a state license to practice midwifery or use the title "midwife."[52] This law did not provide local residents with an accessible pathway to licensure and placed unworkable requirements on Native Hawaiian traditional midwives seeking to continue cultural practices that are protected under the Hawai'i constitution.[53] Further, the law threatened to impose criminal penalties on nearly anyone providing advice, information, or care during pregnancy, birth, and postpartum without a state midwifery license, essentially barring support typically provided by doulas, lactation consultants, counselors, childbirth educators, cultural practitioners, extended family members, and friends.[54] The Center for Reproductive Rights, the Native Hawaiian Legal Corporation, and Perkins Coie filed a lawsuit (*Kaho'ohanohano v. Hawai'i*) challenging the law and successfully blocked enforcement of certain aspects of it.[55]

States should take measures to ensure that all licensed midwives meet certain competency standards and that it is clear to pregnant people and the general public who qualifies as a licensed midwife. More importantly, states must also establish and invest in accessible pathways to train and integrate midwives and traditional birth attendants whose training and experience do not align with those standards. The exclusion of such providers can disrupt the continuity of care among patients and undermine access to care in underserved communities. In turn, these providers may be excluded from the infrastructure and institutions that support pregnant and birthing people, such as compensation through public health programs/insurance, access to

50 *See, e.g.*, Observatorio de la Universidad Colombiana, *Justicia ordena reconocer como profesión, en Colombia, el trabajo de una partera*, 6 February 2019. Available at: https://www.universidad.edu.co/via-justicia-reconocen-a-la-parteria-como-una-profesion/;
51 *Id.*
52 HRS §§ 457J-3, 457J- 5.
53 HRS §§ 457J-3, 457J- 5; Kaho'ohanohano v. Hawai'i, No. 1CCV-24-0000269 (Haw. Circ. Ct. July 23, 2024).
54 *Id.*
55 Kaho'ohanohano v. Hawai'i, No. 1CCV-24-0000269 (Haw. Circ. Ct. July 23, 2024)

essential medicines, and the ability to refer patients to and share medical records with other healthcare providers.

III. Oversight Bodies

ICM recommends that "nursing legislation is inadequate to regulate midwifery practice"[56] and that regulatory frameworks should recognize midwifery as a profession that is autonomous, separate, and distinct from nursing and medicine.[57] ICM further urges that the regulatory body should be composed mainly of midwives and reflect the diversity of practice within the country, along with lay members representing childbearing women.[58]

COUNTRY FINDINGS

Across jurisdictions, our research demonstrates that midwifery is often not fully recognized as an autonomous profession and is conflated with nursing. Furthermore, midwives are often not adequately represented on relevant oversight bodies, in contradiction to ICM standards. For example:

- In **Kenya**, the Nurses and Midwives Act establishes the Nursing Council of Kenya as the regulatory body for both nursing and midwifery, yet it consistently conflates the two professions.[59] Midwifery remains marginalized within the Council, which includes only one midwife among its eight board members, with the rest being nurses.[60]
- In **India**, the recently enacted National Nursing and Midwifery Commission Act is an important step towards recognizing midwifery as a distinct profession, although the Act consistently conflates midwifery and nursing throughout. It repeatedly refers to "nursing and midwifery professionals" without distinction between nurses and midwives.[61] This impacts how these professions are reflected in the Commission and its subsidiary bodies, which have important supervisory and adjudicatory functions, such as regulating professional conduct, including ensuring compliance with the codes of professional and ethical conduct, serving as an appellate body for disciplinary actions taken by State Commissions, and establishing mechanisms for complaints and redressing grievances.[62]
- In **Nigeria**, the Nursing and Midwifery Act regulates the profession and establishes the Nursing and Midwifery Council by merging the previously separate Nursing Council

56 ICM, *Global Standards for Midwifery Regulation* (2011), at 1.
57 ICM, *Regulation Toolkit* (2016), at 2, https://internationalmidwives.org/resources/regulation-toolkit/; ICM, *Global Standards for Midwifery Regulation* (2011), at 7.
58 ICM, *Global Standards for Midwifery Regulation* (2011), at 16.
59 *See, e.g.,* Nurses and Midwives Act (1983, rev. 2022), S. 18A, 18B [Kenya] (only referring to "nurse" while meaning nurse or midwife).
60 Nurses and Midwives Act (1983, rev. 2022), S. 4 [Kenya]; Interview with Eunice Atsali, National Secretary, Midwives Association of Kenya (Dec. 5, 2024) (regarding the current composition).
61 *See, e.g.,* The National Nursing and Midwifery Commission Act, 2023 (India).
62 The National Nursing and Midwifery Commission Act, 2023, § 20(1) (India).

and Midwifery Board.[63] The Act often conflates nursing and midwifery[64] and specifically reserves only one out of 22 seats on the Council for a midwife.[65] Even the National Association of Nigerian Nurses and Midwives, the national professional body intended to advocate for their professional interests, represents both fields,[66] which further dilutes midwifery's status as an independent profession.

- In **Romania**, the Order of Nurses, Midwives, and Medical Assistants functions as the regulatory body for nurses, midwives, and medical assistants, overseeing qualification attestations, maintaining the National Register, enforcing professional standards, and addressing breaches of ethics.[67] The regulatory framework lacks provisions to ensure midwifery representation.[68]

The perpetual conflation of nursing and midwifery undermines the unique role midwives play in maternal and newborn health. It is critical that oversight bodies are knowledgeable about midwifery models of care, midwives' competencies, and their respective scopes of practice to ensure they can effectively fulfill their essential functions. This requires that oversight bodies have distinct mandates around midwifery and are predominantly composed of qualified midwives.

IV. Autonomy and Authority/Scope of Practice

International standards recognize the autonomy of midwives as essential for providing high-quality care throughout pregnancy, labor, birth, and the postnatal period. According to ICM:

> **"The autonomous midwife provides care during the course of pregnancy, labour, birth and the postnatal period and makes decisions in partnership with each woman in her care. The midwife is responsible and accountable for all decisions she makes and the care she provides without delegation from or supervision or direction by any other health care provider."[69]**

Importantly, "autonomous" does not mean alone or isolated. The Midwifery Model of Care is based on midwives being integrated into the healthcare system, collaborating "within networks of care as part of interdisciplinary teams characterized by equality, trust and respect."[70] This collaboration should be embedded in functional health systems with streamlined consultation

63 Nursing and Midwifery Act (1979, amended 2021) Cap. (143) [Nigeria]; NMCN, *Our History*, https://nmcn.gov.ng/our-history/ (accessed May 20, 2025).
64 *See, e.g.*, Nursing and Midwifery Act (1979, amended 2021) Cap. (143), §§ 2, 12-14, 16-17, 23 (Nigeria). *Contra* Nursing and Midwifery Act (1979, amended 2021) Cap. (143), §§ 8-9 (Nigeria); these sections regulate the registration of midwives separately from the registration of nurses.
65 While not required by the regulatory framework, in practice many Nigerian nurses also hold a midwifery qualification, with currently around 50-60% of the members of the Nursing and Midwifery Council being dually qualified, Interview with Chizoma Ndikom, Senior Lecturer, Department of Nursing, University of Ibadan, Nigeria (Dec 17, 2024).
66 NANNM, *National Association of Nigeria Nurses and Midwives*, https://nannm.com.ng (accessed May 20, 2025).
67 Government Emergency Ordinance No. 144/2008 (2008), Art. 40 [Romania]; Statute of the Romanian Order of Nurses, Midwives and Medical Assistants (2009) [Romania], https://www.oamr.ro/wp-content/uploads/2023/02/Statut-OAMGMAMR-forma-consolidata-1.pdf.
68 *See* Government Emergency Ordinance No. 144/2008 (2008), Art. 45(a) [Romania].
69 ICM, *Global Standards for Midwifery Regulation* (2011), at 8.
70 WHO, *Transitioning to Midwifery Models of Care: Global Position Paper* (2024), at 12.

and referral processes to make sure that women and newborns receive "personalized care, tailored to their health needs," while ensuring midwives' independence in providing care aligned with midwifery philosophy.[71]

The scope of practice is the "activities which midwives are educated, competent and authorised to perform."[72] It describes the "circumstances in which the midwife may make autonomous clinical decisions and in what circumstances the midwife must practise in collaboration with other health professionals such as doctors."[73] International expert organizations agree that the midwifery scope of practice should be broad, encompassing maternal and newborn care, emergency interventions, and preventive health services.[74] This scope should be applicable across diverse settings, including homes, communities, hospitals, clinics, and health units.[75] Midwives should have the autonomy to provide care throughout pregnancy, birth, and the postpartum period, including conducting deliveries, assessing risks, performing screenings and diagnostic tests, monitoring and treating complications, and administering medications.[76] Importantly, midwives' scope of practice should also include the provision of contraception,[77] abortion care,[78] providing essential newborn care,[79] and breastfeeding support.[80]

If complications arise beyond the midwives' scope of practice, they should work with specialists, such as obstetricians and pediatricians, to ensure optimal care.[81] Once stabilized, midwives resume their primary role, continuing collaboration as necessary.[82] Notably, in some contexts, such as where there are significant resource constraints, a very limited number of healthcare providers, and/or in humanitarian and conflict settings, this type of collaboration and referral may not be possible. In such instances, midwives may have moral and ethical duties to prevent potential harm to those who otherwise would not have access to care.[83]

COUNTRY FINDINGS

Our research demonstrates that midwives are often prevented from practicing autonomously and are required to be under the formal supervision of an obstetrician-gynecologist, which in turn reinforces a medicalized form of care that may not be patient-centered and/or respect the physiology of birth. This also reinforces the idea that midwives themselves are not competent enough to provide care autonomously. Further, midwives' scope of practice commonly does not align with evidence-based practices and excludes many healthy pregnant people from being seen

71 *Id.*
72 ICM, *Legislation to Regulate Midwifery Practice* (2024), at 1.
73 ICM, *Global Standards for Midwifery Regulation* (2011), at 5.
74 ICM, *International Definition and Scope of Practice of the Midwife* (2024), at 1 f.; UNFPA, *The State of the World's Midwifery* (2021), at 7, 63; WHO, *Transitioning to Midwifery Models of Care: Global Position Paper* (2024), at 8 f., 12.
75 *Id.*
76 *Id.*
77 ICM, *Essential Competencies for Midwifery Practice* (2024), https://internationalmidwives.org/resources/essential-competencies-for-midwifery-practice/, at 23.
78 *Id.* at 26.
79 WHO, *Transitioning to Midwifery Models of Care: Global Position Paper* (2024), at 8.
80 ICM, *Essential Competencies for Midwifery Practice* (2024), at 41.
81 WHO, *Transitioning to Midwifery Models of Care: Global Position Paper* (2024), at 8 f.
82 *Id.*
83 *See* ICM, *Global Standards for Midwifery Regulation* (2011), at 2 (recognizing that legislation should "[s]upport the midwife in the use of life-saving knowledge and skills in a variety of settings in countries where there is no ready access to medical support").

by midwives. Additionally, in many contexts, midwives are limited to administering services only in certain facilities and are excluded from providing home births. For example,

- In **India**, Nurse Practitioners in Midwifery must practice under the supervision of an obstetrician-gynecologist.[84] While the guidelines on midwifery services aim to adopt a risk-based model of collaborative care, substantial aspects of the triage framework are not evidence-based. For example, people who weigh over 70 kg, are less than 145 centimeters tall, under age 17, over age 40, or have had more than five births are excluded from midwifery-led care.[85] Pregnant people with a previous history of prolonged labor, eclampsia, previous cesarean section, early neonatal death, or stillbirth, among other conditions, are also excluded from midwifery-led care. This approach does not provide any nuance in examining the person's level of risk for their current pregnancy or considering any preventative measures that may have been taken.
- In **Kenya**, midwives' scope of practice is determined by their route of entry, where those with higher degrees are permitted to carry out more tasks independently,[86] and by the level of the healthcare facility.[87] This is especially relevant for prescribing medication, which is subject to different levels of physician oversight depending on the context and institutional guidelines.[88] At lower-level facilities, midwives are explicitly authorized to prescribe and administer medications independently, while at higher-level hospitals, prescribing is typically reserved for physicians.[89] As a result, midwifery autonomy varies significantly by facility level. Although national abortion guidelines permit "trained healthcare providers" to offer abortion care, in practice, midwives in Kenya avoid performing abortions due to the high risk of criminalization.[90] While abortion care is not mentioned in the scope of practice, post-abortion care is explicitly included.[91] Historically, only radiologists were permitted to perform ultrasound procedures in Kenya, even with manual devices.[92] In an important step forward, in 2024, the Ministry of Health issued National Obstetrics Point-of-Care Ultrasound (O-POCUS) Guidelines recommending that all registered midwives and other qualified clinical officers, including nurses with midwifery training, receive O-POCUS training to perform ultrasounds during obstetric and gynecological examinations.[93]

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84 Ministry of Health and Family Welfare [India], *Guidelines on Midwifery Services in India* (2018), at 3, https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCHA/MH/Guidelines/Guidelines_on_Midwifery_Services_in_India.pdf ("The MLCUs will...operate under the overall supervision of Medical Officer (MO)/ OB&GY Specialist in the high caseload facilities with minimum 250 deliveries/month viz. Medical College Hospitals, District Hospitals, Sub District Hospitals, Community Health Centers/ CHC FRUs and equivalent facilities.").

85 Ministry of Health and Family Welfare [India], *Guidelines on Operationalization of Midwifery Units*, at 45, https://nhm.gov.in/images/pdf/programmes/maternal-health/guidelines/Operationalization-of-Midwifery-Units.pdf (accessed May 14, 2025).

86 Nursing Council of Kenya, *Scope of Practice for Entry Level Nurses and Midwives* (2020), Annex 2, https://nckenya.com/wp-content/uploads/2020/08/Scope_of-Practice_For_Entry_Level_Programmes_17.08.2020.pdf. *See also* Ministry of Health [Kenya], *National Task Sharing Guidelines 2017-2030* (2027), at 27, https://hesma.or.ke/wp-content/uploads/2017/02/Task-Sharing-Guideline-2017.pdf.

87 Nursing Council of Kenya, *Scope of Practice for Entry Level Nurses and Midwives* (2020), Annex 4, https://nckenya.com/wp-content/uploads/2020/08/Scope_of-Practice_For_Entry_Level_Programmes_17.08.2020.pdf.

88 *Id.*

89 *Id.*

90 Interview with Eunice Atsali, National Secretary, Midwives Association of Kenya (Dec. 5, 2024).

91 Nursing Council of Kenya, *Scope of Practice for Entry Level Nurses and Midwives* (2020), Annex 2, https://nckenya.com/wp-content/uploads/2020/08/Scope_of-Practice_For_Entry_Level_Programmes_17.08.2020.pdf

92 The Radiographers Act, No. 28 (2022) Kenya Gazette Supplement.

93 Ministry of Health [Kenya], *National Obstetrics Point-of-Care Ultrasound (O-POCUS) Guidelines* (2024).

- In **Nigeria**, midwives' scope of practice is not positively defined in law, and instead, the legal framework imposes vague and restrictive limitations, such as prohibiting midwives from managing pregnancy-related "abnormalities" or "diseases."[94] As a result, midwives' scope of practice is shaped by the midwifery school curriculum[95] as well as internal facility protocols, resulting in significant variation across levels of care.[96] At primary health centers, midwives operate with the highest level of autonomy, prescribing medications, conducting examinations and clinical procedures, and attending deliveries without physician supervision.[97] In secondary facilities, midwives manage uncomplicated deliveries independently while doctors oversee complicated cases.[98] In tertiary hospitals, midwives work under close physician supervision and are not authorized to autonomously perform medical procedures or prescribe medications.[99] The official Midwives Regulations also retain outdated hygiene procedures, such as douching before examinations, as well as gendered expectations, like prescriptive standards for personal grooming and home cleanliness.[100] Although many of these provisions are no longer enforced, their persistence in law reflects a narrow and dated role of midwifery that is misaligned with international health standards.
- In **Romania**, the scope of practice is inconsistently regulated and varies significantly between independent and hospital-based midwives. Independent midwives are required to operate under formal contracts with authorized healthcare institutions that require physician oversight.[101] Their scope of practice is highly restricted: they cannot attend births without a physician physically present and are prohibited from prescribing medications or independently ordering and performing diagnostic tests.[102] Home births are effectively banned, since independent midwives are not authorized to attend deliveries on their own,[103] and even for physicians, the professional deontological code strongly discourages practice in surroundings outside of formal healthcare facilities.[104] Hospital-based midwives, on the other hand, operate in a legally ambiguous framework with no specific standardized regulations governing their practice, which relegates them to largely supportive roles for supervising physicians.[105]

94 Nursing and Midwifery Act (1979, amended 2021) Cap. (143), § 22 (Nigeria).
95 Nursing and Midwifery Act (1979, amended 2021) Cap. (143), § 23(1) (Nigeria) ("A nurse or midwife registered under this Act shall be entitled to carry out nursing or midwifery care as provided for in the training curriculum prescribed and approved by the Council.").
96 Interview with Chizoma Ndikom, Senior Lecturer, Department of Nursing, University of Ibadan, Nigeria (Dec 17, 2024); Interview with Amina Suleiman Rajah, Midwifery Lecturer, Bayero University, Kano (Jan 27, 2025).
97 Interview with Amina Suleiman Rajah, Midwifery Lecturer, Bayero University, Kano (Jan 27, 2025).
98 *Id.*
99 *Id.*; Interview with Chizoma Ndikom, Senior Lecturer, Department of Nursing, University of Ibadan, Nigeria (Dec 17, 2024).
100 Midwives Regulations No. (135) (1967), §§ 22, 28 (Nigeria).
101 Methodological Norms concerning the exercise of the profession of independent nurse, midwife and medical assistant, Ord. No. 1454/2014 of Dec. 2, 2014, Art. 5 (Rom.). *See also* Law No. 95/2006 on healthcare reform, as republished Sept. 20, 2016, Art. 140^10(e) (Rom.).
102 Methodological Norms concerning the exercise of the profession of independent nurse, midwife and medical assistant, Ord. No. 1454/2014 of Dec. 2, 2014, Annex 1, Art. 4 (Rom.).
103 Methodological Norms concerning the exercise of the profession of independent nurse, midwife and medical assistant, Ord. No. 1454/2014 of Dec. 2, 2014, Annex 1, Art. 4 (Rom.).
104 Medical Deontological Code, No. 981 of Dec. 7, 2016, Art. 22(5) (Rom.).
105 Although Government Emergency Ordinance No. 144/2008 mandates that midwifery activities align with standards established by the Ministry of Health in collaboration with the Order of Nurses, Midwives, and Medical Assistants of Romania, no such standards currently exist for hospital-based midwifery practice, *see* Government Emergency Ordinance No. 144/2008 (2008), Art. 5(4) [Romania].

These country-level findings demonstrate a stark disconnect between international standards on midwives' autonomy and scope of practice and the legal and regulatory frameworks that are currently in effect. By preventing midwives from providing care to the full extent of their training and competencies, these regulatory systems undermine the vast benefits of midwifery models of care and diminish pregnant people's access to essential services. Legal and regulatory frameworks must recognize midwives as autonomous healthcare providers, remove physician-oversight requirements, enable midwives to practice to the full extent of their training and competencies, including in diverse practice settings such as individuals' homes, the community, hospitals, and health clinics.[106]

106 *See* ICM, *International Definition and Scope of Practice of the Midwife* (2024), at 1 f.

Recommendations

In order to fulfill the potential of midwifery models of care in advancing maternal health and rights, disabling legal and regulatory frameworks must be reformed. This should include:

LICENSURE AND REGISTRATION

- Where countries do not yet have legal and regulatory frameworks for midwifery models of care, such frameworks should be established to ensure that midwives are formally recognized and can be fully integrated into the healthcare system.
- States should ensure that changes to licensure and registration create accessible pathways for all midwives to continue practicing to the full extent of their competencies to ensure continuity of care for pregnant people, particularly those from marginalized and underserved populations facing the greatest barriers in accessing care. This should include actively investing in upskilling current midwives whose training and experience do not align with changes in such standards, while also continuing to prioritize the provision of culturally competent care.

OVERSIGHT BODIES

- To align with the recommendations of the ICM, countries must revise their legal and regulatory frameworks to recognize midwifery as a distinct and autonomous profession. This includes establishing separate regulatory bodies or ensuring that existing bodies are predominantly composed of qualified midwives and include the voices of childbearing women.

AUTONOMY AND AUTHORITY/SCOPE OF PRACTICE

- States should reform legal and regulatory frameworks to recognize midwives as autonomous healthcare providers and remove physician oversight and authorization requirements, including requirements that midwives enter into collaborative agreements with physicians. This includes regulations requiring physician participation and/or oversight in the creation and or operation of birthing centers.
- States should enable midwives to practice to the full extent of their competencies, including to provide care throughout pregnancy, birth, and the postpartum period, including conducting deliveries, assessing risks, performing screenings and diagnostic tests, monitoring and treating complications, and administering medications.[107] Importantly, midwives scope of practice should also include the provision of contraception,[108] abortion

107 ICM, *International Definition and Scope of Practice of the Midwife* (2024), at 1 f.; UNFPA, *The State of the World's Midwifery* (2021), at 7, 63; WHO, *Transitioning to Midwifery Models of Care: Global Position Paper* (2024), at 8 f., 12.
108 ICM, *Essential Competencies for Midwifery Practice* (2024), at 23.

care,[109] providing essential newborn care,[110] and support for breastfeeding.[111]States should remove provisions that unnecessarily preclude certain individuals from seeking care from a midwife without adequate regard for how collaborative models of care and strong referral networks can enable such women to still benefit from midwifery models of care. In recognition that some individuals will inevitably require a higher level of care, states should put in place strong, evidence-based systems for detection and referral and ensure that there are also an adequate number of obstetricians and other specialized providers.

- States should explicitly recognize midwives' ability to provide care in diverse practice settings such as individuals' homes, the community, hospitals, and health clinics[112] and repeal punitive measures on competent midwives who provide homebirths.

Additionally, international and regional human rights bodies should recognize how midwifery models of care promote a broad range of human rights including the rights to health, dignity, bodily autonomy, and equality and non-discrimination. They should urge states to adopt, invest in, and scale up these models of care as a way to improve maternal health outcomes while also promoting bodily autonomy and self-determination.

109 *Id.*, at 26.
110 WHO, *Transitioning to Midwifery Models of Care: Global Position Paper* (2024), at 8.
111 ICM, *Essential Competencies for Midwifery Practice* (2024), at 41.
112 *Id.*; ICM, *International Definition and Scope of Practice of the Midwife* (2024).

Conclusion

Midwifery models of care provide an evidence-based approach to improving maternal health outcomes and advancing health equity. Yet, despite increased global investment, our analysis reveals that legal and regulatory frameworks often obstruct rather than enable their adoption and implementation. In some countries, midwives do not exist as regulated providers, and only obstetricians or family physicians are legally recognized to provide maternal care. In others, midwifery is conflated with nursing, limiting midwives' ability to practice autonomously and to the full extent of their competencies. Even in contexts where midwives are formally integrated, their scope of practice is often overly restrictive and misaligned with international standards, preventing midwives from providing essential health services. These legal and regulatory barriers perpetuate harmful aspects of current health systems, such as overmedicalization and disrespectful care, and disproportionately impact marginalized populations, limiting their access to quality maternal care. In extreme cases, midwives face criminalization for assisting with practices such as home births. These legal and regulatory challenges not only obstruct progress toward global health goals but also violate the fundamental rights to health, autonomy, and non-discrimination. As countries seek to scale up midwifery models of care, legal and regulatory reform must be prioritized. Aligning national frameworks with WHO and ICM standards is crucial to realize the full potential of midwifery models of care and ensure equitable access to quality care for all pregnant people.

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PART 3

Country Case Studies

COLOMBIA

Regulating Midwifery: The Legal & Policy Framework of Colombia

SNAPSHOT OF MIDWIFERY IN COLOMBIA

- **Types of midwives:** There is no cadre of "professionalized" midwives integrated within the formal healthcare system. There is a cadre of *parteras tradicionales* ("traditional midwives" or traditional birth attendants) who come from and serve Afro-Colombian and Indigenous populations.
- **Routes of entry:** The Colombian government and some sub-national departments have taken steps towards the formal recognition of traditional birth attendants, including the recognition of traditional midwifery as an intangible national heritage.
- **Key challenges:**
  - » Despite national-level recognition of the importance of traditional midwives, legal efforts to recognize this cadre remain fragmented, integration of traditional midwives into the health system is limited, and there is inadequate protection for both midwives and birthing people who utilize traditional midwives.
  - » There is still no national legislation recognizing, defining, and protecting traditional midwives, and traditional practices are often stigmatized and devalued within the formal healthcare system.
  - » While some traditional midwives are legally allowed to register births, there are still significant barriers to them doing so in practice.
  - » Lack of resources is a critical issue for many traditional midwives as they do not have access to essential medications and supplies, are not paid for their work, and often live and provide care in remote and isolated communities.

Background

In Colombia, approximately 97% of births are attended by doctors[1] and there is no cadre of "professionalized" midwives integrated within the formal healthcare system. Instead, midwifery in Colombia is largely practiced by *parteras tradicionales* ("traditional midwives" or traditional birth attendants) who come from and serve Afro-Colombian and Indigenous populations.[2] These populations are commonly underserved and marginalized within the formal healthcare system, lack access to healthcare services and facilities, and experience poorer health outcomes overall, including concerning pregnancy and childbirth.[3] Many places served by traditional midwives are geographically remote, difficult to access, and lack access to reliable transportation.[4]

Although there is increasing recognition across Colombia of the need to better integrate traditional midwives into the formal healthcare system, midwifery (both "professionalized" and traditional) is generally unregulated in Colombia. Therefore, there is no regulatory body, standardized educational requirements or routes of entry, licensure or certification requirements, or a defined scope of practice. In the absence of a cohort of "professional" midwives, as defined by the International Confederation of Midwives, this case study will mostly examine the system in which *parteras tradicionales* operate. The phrase "traditional midwives" will be used throughout this case study in alignment with the common Spanish terminology. Importantly, there are some formally-trained "professional" midwives in Colombia, including in some urban settings,[5] who must contend with similar challenges as traditional midwives due to the lack of legal recognition, regulation, and integration with the public health system.

While only about 2% of births in Colombia are attended by traditional midwives,[6] this percentage has been steadily increasing since 2008, and in some parts of the country, rates may be as high as 100%.[7] In the department of Chocó, nearly 30% of births were attended by traditional midwives in 2021, as were 18% of births in the department of Amazonas.[8] The rates were considerably higher in some municipalities: In three different municipalities (Medio Atrato in Chocó, Paya in Boyacá and Santa Barbara in Santander), In , traditional midwives attended 100% of births. These rates are followed by Bagadó (87.89%), Alto Baudó (83.19%), and Litoral de San Juan (79.12%).[9]

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1 Departamento Administrativo Nacional de Estadística (DANE) [Colombia], *Partería Tradicional y Su Incorporación en las Estadísticas Vitales de Colombia* (2023), at 31, https://colombia.unfpa.org/sites/default/files/pub-pdf/06022023-notaestadistica-parteratradi-evcolombia.pdf.

2 DANE, *Partería Tradicional y Su Incorporación en las Estadísticas Vitales de Colombia* (2023), at 36, https://colombia.unfpa.org/sites/default/files/pub-pdf/06022023-notaestadistica-parteratradi-evcolombia.pdf.

3 DANE, *Partería Tradicional y Su Incorporación en las Estadísticas Vitales de Colombia* (2023), at 31, https://colombia.unfpa.org/sites/default/files/pub-pdf/06022023-notaestadistica-parteratradi-evcolombia.pdf.

4 Jorge Martín Rodríguez Hernández et al., *Analysis of Inequalities and Inequities in Maternal Mortality in Chocó, Colombia,* 20 Int J Environ Res Pub Health 6095 (2023), https://doi.org/10.3390/ijerph20126095.

5 See Movimiento SSR, *Parto Planificado en casa con Partera,* https://www.movimientossr.com/parto-respetado-en-col/p-casapartera#:~:text=Saberes%20multiculturales,tradiciones%20ancestrales%20y%20medicina%20alternativa.

6 DANE, *Partería Tradicional y Su Incorporación en las Estadísticas Vitales de Colombia* (2023), at 31, https://colombia.unfpa.org/sites/default/files/pub-pdf/06022023-notaestadistica-parteratradi-evcolombia.pdf.

7 DANE, *Partería Tradicional y Su Incorporación en las Estadísticas Vitales de Colombia* (2023), at 32-33, https://colombia.unfpa.org/sites/default/files/pub-pdf/06022023-notaestadistica-parteratradi-evcolombia.pdf.

8 DANE, *Partería Tradicional y Su Incorporación en las Estadísticas Vitales de Colombia* (2023), at 32, https://colombia.unfpa.org/sites/default/files/pub-pdf/06022023-notaestadistica-parteratradi-evcolombia.pdf.

9 DANE, *Partería Tradicional y Su Incorporación en las Estadísticas Vitales de Colombia* (2023), at 32-33, https://colombia.unfpa.org/sites/default/files/pub-pdf/06022023-notaestadistica-parteratradi-evcolombia.pdf.

Colombia's maternal mortality rate (MMR) has largely decreased over the past twenty years and is currently 59 maternal deaths per 100,000 live births, which is below the Sustainable Development Goal target of 70 maternal deaths per 100,000 live births.[10] However, the MMR for Indigenous groups is almost 4.5 times higher than that of non-Indigenous groups, and the MMR of Afro-descendent groups is almost twice as high as that of non-Afro-descendent groups.[11] Indeed, the areas with disproportionately high maternal mortality rates and otherwise poor maternal health outcomes coincide with those that largely rely on traditional midwives, as these populations are underserved by the formal healthcare sector and face significant structural inequalities.[12] Many do not have access to obstetricians, medical doctors, and other formal healthcare systems.

For these populations, the role of traditional midwives goes beyond that of a typical health care provider or "professional" midwife. They often have a spiritual and ancestral role that aligns with the pregnant person's belief system and cultural values, and this distinct role holds great significance for pregnant women and the larger community. Furthermore, traditional midwifery is common in communities and among populations where there are histories of coercion, discrimination, and abuse in the formal healthcare system, which may also make individuals less likely to use this system even when it is accessible. Notably, these regions are also ones affected by armed conflict, where access to health services is further limited due violence, confinement imposed by armed groups, and the risks individuals face in transit. In these contexts, traditional midwives are often the only option for skilled attendance at birth and safe pregnancy, delivery and post-partum care.[13]

Despite being the primary providers of maternity care for these populations, traditional midwives remain largely excluded from the formal healthcare system.[14] As a result, midwifery is often assumed to be "illegitimate and unsafe" by healthcare workers, which is reinforced by the overmedicalization and institutionalization of childbirth in Colombia.[15] Traditional midwives are unable to access essential medicines and lack prescriptive authority, meaning they do not have the option of incorporating these into their practice alongside traditional herbs and medicines. Midwives have reported that upon referral of pregnant women to health facilities, women are often reprimanded for consulting a midwife, further discouraging women from

10 World Health Organization (WHO), *SDG Target 3.1 Maternal mortality*, https://www.who.int/data/gho/data/themes/topics/sdg-target-3-1-maternal-mortality (accessed Apr. 23, 2025).

11 Instituto Nacional de Salud (INS) [Colombia], *Mortalidad Materna Colombia 2020* (2019), at 8, https://www.ins.gov.co/buscador-eventos/Informesdeevento/MORTALIDAD%20MATERNA_2020.pdf.

12 DANE, *Partería Tradicional y Su Incorporación en las Estadísticas Vitales de Colombia* (2023), at 33, https://colombia.unfpa.org/sites/default/files/pub-pdf/06022023-notaestadistica-parteratradi-evcolombia.pdf.

13 *See, e.g.*, Unidad para las Víctimas, *Entre balas y vientres: La resistencia de las parteras en medio de conflicto armado*, https://www.unidadvictimas.gov.co/entre-balas-y-vientres-resistencia-parteras-en-medio-conflicto-armado/; ILEX, *La partería y la resistencia de las mujeres afrocolombianas* (Mar. 29, 2021), https://ilexaccionjuridica.org/la-parteria-y-la-resistencia-de-las-mujeres-afrocolombianas/

14 R. 1077/17, junio 3, 2017, Diario Oficial [D.O.] (Colom.), https://normograma.mincultura.gov.co/mincultura/compilacion/docs/resolucion_mincultura_1077_2017.htm. ("Otra situación que genera tensión es el hecho de que las parteras y los parteros no están autorizados por el Sistema de Salud a registrar a los nacidos vivos. "Esto se debe a que en la actualidad no somos reconocidas como profesionales de la salud por parte del Sistema, ni se ha creado una figura especial para nombrar nuestra labor y ser reconocidas oficialmente como otro agente de salud. El no poder llevar nuestros propios registros de nacidos vivos, y tener que recurrir a un profesional de la salud para ello, además de poner de manifiesto las asimetrías en la relación parteras-médicos, hace invisible el impacto real de nuestro saber".)

15 R. 1077/17, junio 3, 2017, Diario Oficial [D.O.] (Colom.), https://normograma.mincultura.gov.co/mincultura/compilacion/docs/resolucion_mincultura_1077_2017.htm. ("El desconocimiento y la desinformación a nivel interno y externo de las comunidades sobre la función y labor de la partería afropacífica contribuye a juzgar esta práctica como ilegítima e insegura. De igual forma, a raíz de la medicalización y la institucionalización del parto, hay muchas mujeres, sobre todo jóvenes, que ignoran que la partería también es una opción posible a la hora de atender un parto.")

formalized care.[16] Additionally, when traditional midwives bring patients to health clinics, they report being prohibited from assisting during labor and delivery, as well as a general disregard for their knowledge.[17] Historically, midwives have been unable to register live births, deepening their reliance on other healthcare workers and delegitimizing their knowledge, expertise, and capabilities.[18] Further, they are often not directly remunerated for their work.[19]

It is important to situate efforts towards recognition and integration of traditional midwifery within the historical context of birth regulations and the medicalization of childbirth. Beginning in 1938, Decree 2311 prohibited midwives without diplomas or certificates from a medical school from providing services in Colombia.[20] Later, Decree 1260 of 1970 stipulated that only a doctor or nurse who had attended a birth could register it.[21] Law 100 of 1993, which established the social security system, did not include midwives, which further deepened the medicalization of pregnancy and birth, including by marginalizing the role of midwives during birthing. In 2000, the Minister of Health's Resolution 412 continued undermining the role of midwives during birth by only allowing doctors to care for pregnant women.[22] By 2017, there was a shift underway, as Decree 356 of 2017 recognized that birth certification could be completed by a doctor, nurse, or midwife.[23] This was followed by Resolution 3280 of 2018, which permitted midwives to attend low-risk births. Yet despite this positive progress, most births in Colombia are still attended by a doctor.[24] While the participation of midwives in certain types of births has only been legally permitted recently, the increasing attempts to recognize traditional midwifery need to be understood in the historical context of highly medicalized pregnancies and the limited role of professional midwives.

16 R. 1077/17, junio 3, 2017, Diario Oficial [D.O.] (Colom.), https://normograma.mincultura.gov.co/mincultura/compilacion/docs/resolucion_mincultura_1077_2017.htm. ("Una de las principales problemáticas que enfrenta la partería tradicional afropacífica son las dificultades y tensiones en la relación con el Sistema de Salud, que regula la práctica biomédica y la prestación de este servicio en el país. Estas tensiones se evidencian a diario en situaciones que suelen confrontar directamente a las parteras y a los parteros con las mujeres y las familias a las que atienden. "Aunque muchas veces somos nosotras mismas quienes remitimos a las mujeres –o a un enfermo– a las clínicas y hospitales, es común que el personal de la salud en esos lugares reprenda a las mujeres por consultar a una partera, generando prevención y desanimándolas a continuar bajo nuestros cuidados")

17 R. 1077/17, junio 3, 2017, Diario Oficial [D.O.] (Colom.), https://normograma.mincultura.gov.co/mincultura/compilacion/docs/resolucion_mincultura_1077_2017.htm. ("Algunos médicos y personal de salud reaccionan con escrúpulos hacia las formas de trabajo propias de la partería tradicional, y en muchos casos relegan a la partera del proceso de parto y acompañamiento cuando las parturientas son llevadas por ellas al centro de salud.")

18 DANE, *Partería Tradicional y Su Incorporación en las Estadísticas Vitales de Colombia* (2023), at 44-45, https://colombia.unfpa.org/sites/default/files/pub-pdf/06022023-notaestadistica-parteratradi-evcolombia.pdf.

19 ILEX Acción Jurídica (ILEX), *Alumbradoras de vida: una radiografía de la partería en Colombia*, https://ilexaccionjuridica.org/alumbradoras-de-vida-historias-de-parteras-en-colombia/ (accessed Apr. 23, 2025).

20 D. 2311/38 diciembre 20, 1938, Diario Oficial [D.O.] (Colom.), https://www.mineducacion.gov.co/portal/ejes-tematicos/Normas-sobre-Educacion-para-el-Trabajo/102735:Decreto-2311-de-Diciembre-20-de-1938.

21 DANE, *Partería Tradicional y Su Incorporación en las Estadísticas Vitales de Colombia* (2023), at 15, https://colombia.unfpa.org/sites/default/files/pub-pdf/06022023-notaestadistica-parteratradi-evcolombia.pdf.

22 Interview with UNFPA Colombia by Katy Mayall, Director of Strategic Initiatives at the Center for Reproductive Rights (Jan. 13, 2025).

23 D. 356/17, marzo 3, 2017, Diario Oficial [D.O.] ¶ 3 (Colom.), https://www.funcionpublica.gov.co/eva/gestornormativo/norma.php?i=79927.

24 DANE, *Partería Tradicional y Su Incorporación en las Estadísticas Vitales de Colombia* (2023), at 44-45, https://colombia.unfpa.org/sites/default/files/pub-pdf/06022023-notaestadistica-parteratradi-evcolombia.pdf.

Recognition and Integration of Traditional Midwifery

Recently, the Colombian government and some sub-national departments have taken steps towards the formal recognition of traditional midwives, including the recognition of traditional midwifery as an intangible national heritage. However, these measures are fragmented, resulting in limited integration of traditional midwives into the health system and the lack of adequate protection for both midwives and birthing people. There is still no national legislation recognizing, defining, and protecting traditional midwives, and the lack of formal integration from the health system stigmatizes and invalidates their traditional practices.[25] Likewise, the decrees and resolutions issued to recognize traditional midwives' capacities to register births or accompany pregnant women are not always implemented. In 2022, the Constitutional Court issued a groundbreaking decision in the case of T-128/22, recognizing traditional midwifery as protected under the Constitution and recognizing a constitutional duty to integrate midwives into the National Health System (described further below).[26]

RECOGNITION AS NATIONAL INTANGIBLE CULTURAL HERITAGE

In 2017, the Ministry of Culture adopted Resolution 1077, which added "Knowledge associated with Afro-Pacific midwifery" to Colombia's list of national intangible cultural heritage *(Patrimonio Cultural Inmaterial del ámbito Nacional*). This Resolution defines the "Knowledge associated with Afro-Pacific midwifery" as including "the knowledge and techniques over the body, plants and their use, that has been developed primarily by women in the region to care and assist the reproductive cycles of women and diagnose and treat illnesses of the community in general, through the use of plants, and the relationship of midwives with the biodiversity in the countries they live in."[27] As part of recognizing Afro-Pacific midwifery as a form of intangible cultural heritage, this Resolution also approved a Special Safeguarding Plan (*Plan Especial de Salvaguardia*) that seeks to strengthen, revitalize, and promote traditional midwifery.[28]

In 2023, UNESCO recognized "Midwifery: knowledge, skills and practices" as Intangible Cultural Heritage of Humanity.[29] Both the Colombian and UNESCO resolutions were achieved as a result of advocacy efforts by organizations that included traditional midwives.[30] This was reinforced in the Constitutional Court's 2022 decision (described below), which further recognized and exalted traditional midwifery as an ancestral knowledge and intangible cultural heritage.[31]

25 Corte Constitucional [C.C.] [Constitutional Court], abril 18, 2022, Sentencia T-128, Para. 47 (Colom.).
26 Corte Constitucional [C.C.] [Constitutional Court], abril 18, 2022, Sentencia T-128, Para. 75 (Colom.).
27 R. 1077/17, junio 3, 2017, Diario Oficial [D.O.] (Colom.), https://normograma.mincultura.gov.co/mincultura/compilacion/docs/resolucion_mincultura_1077_2017.htm.
28 Asociación de Parteras Unidas del Pacífico (AsoParuPa), *Plan Especial de Salvaguardia de los Saberes Asociados a la Partería Afro del Pacífico* (2017), https://patrimonio.mincultura.gov.co/SiteAssets/Paginas/plan-especial-de-salvaguardia-de-los-saberes-asociados-a-la-parter%c3%8da-afro-del-pac%c3%8dfico/20-parter%c3%ada%20afro%20del%20pac%c3%adfico%20-%20pes.pdf.
29 UNESCO, *Eighteenth session of the Intergovernmental Committee for the Safeguarding of the Intangible Cultural Heritage* (2023), https://ich.unesco.org/es/18com; UNESCO, *Decision of the Intergovernmental Committee: 18.COM 8.B.26* (2023), https://ich.unesco.org/en/decisions/18.COM/8.B.26; UNESCO, *Midwifery: knowledge, skills and practices* (2023), https://ich.unesco.org/es/RL/parteria-conocimientos-competencias-y-practicas-01968.
30 Interview with Ledy Manuela Mosquera Moreno, Nurse and Executive Director of the Association of the Interethnic Network of Midwifery Practitioners of the Department of Chocó (Asoredipar Chocó) (Dec. 10, 2024).
31 Corte Constitucional [C.C.] [Constitutional Court], abril 18, 2022, Sentencia T-128, Para. 46 (Colom.).

CONSTITUTIONAL RECOGNITION: CASE T-128/22 (COLOMBIAN CONSTITUTIONAL COURT)

In 2021, the Pacific United Midwives Association (Asoparupa), the Interethnic Network of Midwives of Chocó (Asoredipar Chocó), and ILEX Acción Jurídica filed a claim against the Ministry of Health and Social Protection, the Departmental Secretariat of Health, Protection, and Social Welfare of Chocó, and the Departmental Health Secretariat of Valle del Cauca, claiming that these authorities' failure to prioritize midwives in the COVID-19 vaccination plan, provide health protection supplies, and include them in the financial recognition offered by the Government to health workers who provided services during the COVID-19 lockdown violated their fundamental rights. In determining whether the authorities had violated the plaintiffs' fundamental rights, the Constitutional Court recognized midwifery as ancestral knowledge and intangible heritage, a form of cultural and ethnic expression, a manifestation of national plurality, and a means of protecting the reproductive rights of women in the communities where this knowledge is practiced. It held that the Ministry of Health and Social Protection and the Departmental Health Secretariats of Valle del Cauca and Chocó had violated the midwives' rights to health, physical integrity, equality, non-discrimination, and ethnic diversity.

Furthermore, the Court held that midwifery is not adequately integrated into the General System of Social Security in Health and that the Ministry of Health has a constitutional and legal duty to integrate midwifery into this system as a form of ancestral medicine. The Court emphasized the state's positive and negative obligations in this regard – the state's positive obligation is to integrate midwives into the Social Security Health System and grant them the same rights, benefits, and responsibilities as other healthcare professionals, within limits defined by the Ministry. Alternatively, the state's negative obligation prevents the Ministry from imposing educational or training requirements similar to allopathic medicine for midwives' integration into the Social Security Health System.[32] The Court recognized that this integration must respect the knowledge of traditional midwifery, recognize midwifery as a form of medicine, either as ancestral medicine or its own category, and requires the Ministry of Health to develop a census to determine the number of midwives in the country.[33]

Consequently, the Court ordered the Minister of Health to pay the petitioners (traditional midwives who are members of Asoredipar and Asoparupa Chocó) the additional remuneration issued to healthcare workers during the COVID-19 pandemic within a period of six months. The Court further urged Congress to legislate on midwifery and urged the Ministry of Health to initiate and complete all necessary initiatives to effectively integrate midwives into the General System of Social Security in Health.

32 Corte Constitucional [C.C.] [Constitutional Court], abril 18, 2022, Sentencia T-128, Para. 72 (Colom.).
33 Corte Constitucional [C.C.] [Constitutional Court], abril 18, 2022, Sentencia T-128, Para. 72 (Colom.).

LAW 2244 OF 2022

Law 2244 of 2022 recognizes and guarantees the rights of women during pregnancy and childbirth. Article 11 requires the state to promote the training of midwives and support existing training processes as a measure for realizing women's and newborns' fundamental rights. These initiatives must respect midwives' duties and beliefs, while also ensuring that people have access to the appropriate care depending on the level of risk associated with their pregnancy.[34] Additionally, this law recognizes pregnant people's right to be accompanied by a person of their choice. It also guarantees pregnant people the right to a trained and experienced healthcare professional without prejudice towards the practices of traditional and ancestral medicine of ethnic groups.[35]

ADDITIONAL RECOGNITION

There are several other laws and policies recognizing the importance of traditional midwifery in guaranteeing the right to health. The National Rural Health Plan under the Peace Accords' Comprehensive Rural Reform includes strategies to prioritize public health as part of the post-conflict setting. As part of the strategy to ensure better access and quality of maternal and infant health in rural communities, the Plan requires the adoption of a differential and gendered approach, which includes strengthening social and community networks through the coordinated work of midwives, among other actors.[36]

Law 1164 of 2007 recognizes the right to practice traditional medicine by people authorized by their respective communities and requires the Government to establish a mechanism to oversee and monitor the practices of traditional medicine. The Constitutional Court noted that midwives are also part of this group, yet lamented that they are still not explicitly recognized in the text of the law.[37] While Law 1164 of 2007 requires persons engaged in traditional medical practices to register in the *Registro Unico Nacional del Talento Humano en Salud* and be given an identification,[38] the Constitutional Court clarified in its Ruling C-942 of 2009 that this cannot be understood as a formal requirement and must not be interpreted as a required condition to exercise midwifery.

Additionally, in 2023 the Ministry of Health issued regulations on abortion care which recognize that midwives can participate in the provision of guidance and support for access to abortion care.[39]

34 L. 2244/22, art. 11, julio 11, 2025, Diario Oficial [D.O.] (Colom.).
35 L. 2244/22, arts. 4, 17, julio 11, 2025, Diario Oficial [D.O.] (Colom.).
36 Ministerio de Salud y Protección Social [Colombia], *Plan Nacional de Salud Rural* (2022), at 52-53, https://portalparalapaz.gov.co/wp-content/uploads/2022/07/Archivo-Digital-08-Plan-Nacional-de-Salud.pdf.
37 L. 1164/07, paras. 49, 53, octubre 3, 2007, Diario Oficial [D.O.] (Colom.).
38 L. 1164/07, art. 20, octubre 3, 2007, Diario Oficial [D.O.] (Colom.).
39 Ministerio de Salud y Protección Social, *Resolución No. 00006051 de 2013*, ¶ 4.2.2 (Jan. 12, 2023) (Colom.), https://www.minsalud.gov.co/Normatividad_Nuevo/Resoluci%C3%B3n%20No.%20051%20de%202023.pdf.

Integration of traditional midwifery into the formal health system

A. BIRTH REGISTRATION

In 2017, Decree 356 was enacted and recognized that traditional midwives could register live births.[40] Before this decree, birth certificates could only be issued by doctors or nurses. Although this created a pathway for midwives to register births, additional measures are needed to enable the effective implementation of this decree. This process has started with the adoption of a series of resolutions and agreements with organizations of traditional midwives and Indigenous communities. Beginning in the department of Chocó in 2021, Resolution 3676 authorized midwives who are members of the *Asociación de la Red Interétnica de Parteras y Parteros del Departmento de Chocó* (Association of the Network of Interethnic Midwives of the Department of Chocó (Asoredipar Chocó)) to use a National Administrative Department of Statistics (DANE) form for the notification and registration of the birth of newborns belonging to ethnic groups.[41] DANE has also worked with other departments and communities to permit their traditional midwives to register births, including the Kuankama Community (Sierra Nevada, Santa Marta), Wayúu Community (Guajira), the organisation Asociación de Parteras Unidas del Pacífico, and ASOPARUPA[42] (Buenaventura, Valle del Cauca). In May 2025, Colombia's National Civil Registry (Registraduría Nacional del Estado Civil) and the National Administrative Department of Statistics (DANE) issued Joint Circulars 001, 002, and 003 of 2025 authorizing traditional midwives in certain municipalities of Nariño, as well as Indigenous authorities in specific communities in Amazonas, Magdalena, and La Guajira, to officially certify births occurring in their territories.[43]

However, even in these cases, traditional midwives still face obstacles in registering births. Some of them, especially the elderly, are illiterate. Many of them also live in remote, inaccessible areas, and transporting the paperwork to the registry (sometimes by boat and across waterways) increases the risk of the papers getting lost or wet. DANE is working on improving the handling of these logistics to ensure that births can be registered. For example, in some cases, DANE has permitted the submission of registration forms via WhatsApp.[44]

40 D. 356/17, art. 2.2.6.12.3.1.(3), marzo 3, 2017, Diario Oficial [D.O.] (Colom.) ("El nacimiento deberá acreditarse con el certificado de nacido vivo, expedido por el médico, enfermera o partera..."). *See also* DANE, *Partería Tradicional y Su Incorporación en las Estadísticas Vitales de Colombia* (2023), https://colombia.unfpa.org/sites/default/files/pub-pdf/06022023-notaestadistica-parteratradi-evcolombia.pdf.

41 R. 3676/2021, abril 26, 2021, Diario Oficial [D.O.] (Colom.).

42 AsoParuPa, *Asociación de Parteras Unidas del Pacífico*, https://www.asoparupa.org/ (accessed Apr. 23, 2025).

43 *Parteras y parteros en Narino y autoridades indígenas del Amazonas, Magdalena y La Guajira podrán certificar nacimientos*, Registraduría Nacional del Estado Civil (May 12, 2025), https://www.registraduria.gov.co/Parteras-y-parteros-en-Narino-y-autoridades-indigenas-del-Amazonas-Magdalena-y.html

44 Interview with UNFPA Colombia by Katy Mayall, Director of Strategic Initiatives at the Center for Reproductive Rights (Jan. 13, 2025).

B. ACCOMPANYING PREGNANT WOMEN DURING CHILDBIRTH

In some contexts, traditional midwives are permitted to accompany pregnant women who require a higher level of care to the hospital.[45] However, it is important to note that this is an informal process and there is a lack of regulation clarifying the role that traditional midwives can assume in this context.[46] Therefore, depending on the facility, the specific midwife, and the circumstances, they may be allowed to accompany pregnant women into the hospital and wait in the waiting area (whereas before, they would not have been allowed to accompany the person into the hospital). They are then called when the pregnant woman needs something from them, and in some cases, they are even allowed to assist in birthing. The latter case is more common in Municipio Yuto, where the hospital has two traditional midwives hired as part of their personnel. However, there have been instances where traditional midwives are not permitted to accompany the women inside the hospital in cases where hospital personnel do not recognize the role of midwives or when they do not identify themselves as traditional midwives.

C. OTHER MEASURES

The Ministry of Health's 2022-2031 Decennial Public Health Plan *(Plan Decenal de Salud Pública*) also includes strategies to make traditional midwifery visible and recognize the ancestral knowledge and traditional practices of midwives. It further intends to create knowledge-sharing spaces between birth practitioners of Western and traditional medicine.[47]

Likewise, there have been some pilot initiatives within different departments in Colombia to incorporate traditional midwives into the health care system as a way of implementing Ruling T-128/22. In Chocó, traditional midwives are starting to be part of the basic healthcare teams providing primary healthcare to communities alongside doctors and nurses. Traditional midwives go door-to-door in communities to identify any signs of distress during pregnancy and then notify a doctor and/or nurse to provide care.[48] However, there are claims that traditional midwives are still not fully integrated into these teams, and that healthcare providers are hesitant to fully integrate them. In some cases, traditional midwives have been engaging in administrative tasks instead of practicing midwifery. Cultural awareness and a better understanding of what role traditional midwives should play in these teams are essential. UNFPA is working on how to better integrate traditional midwives in these teams.[49]

45 Interview with Ledy Manuela Mosquera Moreno, Nurse and Executive Director of the Association of the Interethnic Network of Midwifery Practitioners of the Department of Chocó (Asoredipar Chocó) (Dec. 10, 2024); *and* Interview with UNFPA Colombia by Katy Mayall, Director of Strategic Initiatives at the Center for Reproductive Rights (Jan. 13, 2025).

46 Interview with UNFPA Colombia by Katy Mayall, Director of Strategic Initiatives at the Center for Reproductive Rights (Jan. 13, 2025). UNFPA is working on a pioneer project of *rutas de articulación* (roadmaps) with traditional midwives and health institutions to explain what to do when a pregnant woman is at risk, when to transfer pregnant women to hospitals, etc.

47 Ministerio de Salud Protección Social [Colombia], *Plan Decenal de Salud Pública 2022-2031* (2022), at 381-382, https://www.saludcapital.gov.co/Planes_Estrateg_Inst/2022/Sectoriales/Plan_Decenal_Salud_2022-2031.pdf; *see also* DANE, *Partería Tradicional y Su Incorporación en las Estadísticas Vitales de Colombia* (2023), at 16, https://colombia.unfpa.org/sites/default/files/pub-pdf/06022023-notaestadistica-parteratradi-evcolombia.pdf.

48 Interview with Ledy Manuela Mosquera Moreno, Nurse and Executive Director of the Association of the Interethnic Network of Midwifery Practitioners of the Department of Chocó (Asoredipar Chocó) (Dec. 10, 2024); *and* Interview with ILEX by Katy Mayal, Director of Strategic Initiatives at the Center for Reproductive Rights (Dec. 17, 2024).

49 Interview with UNFPA Colombia by Katy Mayall, Director of Strategic Initiatives at the Center for Reproductive Rights (Jan. 13, 2025).

Conclusion

Despite the measures adopted by the government, various departments, and the Constitutional Court's ruling, traditional midwives still face considerable obstacles in providing care and being integrated into the formal healthcare system. The lack of legislative recognition and protection undermines traditional midwives' ability to practice traditional medicine and become integrated into the formal healthcare system. To date, there have been multiple attempts by Congress to legislate on these issues, but none have been successful.[50]

Furthermore, implementation of the existing legal framework is not always adequate.[51] For instance, midwives are not always allowed inside the hospitals[52] or permitted to register births.[53] The lack of implementation is also due to the prevailing stigma and discrimination around traditional midwives,[54] including from actors within formal healthcare systems, often impeding their meaningful integration.[55] As traditional midwives are not paid for their work, and they often live and work in remote and isolated communities, limited resourcing remains a critical obstacle, especially concerning further training, access to medicines, and access to equipment.[56] There is also a need for more information on the practices employed by traditional midwives, how these align with or diverge from best practices, and how they can be better resourced and capacitated to provide higher-quality care.

50 *Proyecto de Ley No. 019 de 2009 Senado – 272 de Cámara "por medio del cual se reconoce y regula la actividad de las parteras"*, Gaceta del Congreso No. 595 de 2009, https://leyes.senado.gov.co/proyectos/images/documentos/textos%20radicados/ponencias/2009/gaceta_595%20%20.pdf (Bill No. 019 of 2009 Senate – 272 of the Chamber "by means of which the activity of midwives is recognized and regulated", published in the Congressional Gazette No. 595 of 2009); *Proyecto de Ley No. 263 de 2019 Cámara "por medio del cual se definen la partería tradicional afro del Pacífico colombiano, se exalta y reconoce como oficio ancestral y se adoptan medidas para su salvaguardia, transmisión y protección"*, publicado en la Gaceta del Congreso No. 982 de 2019, https://leyes.senado.gov.co/proyectos/images/documentos/textos%20radicados/ponencias/2019/gaceta_982.pdf (House Bill No. 263 of 2019 "by means of which traditional Afro midwifery of the Colombian Pacific is defined, exalted and recognized as an ancestral profession and measures are adopted for its safeguarding, transmission and protection", published in the Congressional Gazette No. 982 of 2019).

51 Interview with Ledy Manuela Mosquera Moreno, Nurse and Executive Director of the Association of the Interethnic Network of Midwifery Practitioners of the Department of Chocó (Asoredipar Chocó) (Dec. 10, 2024); *and* Interview with ILEX by Katy Mayal, Director of Strategic Initiatives at the Center for Reproductive Rights (Dec. 17, 2024).

52 Interview with Ledy Manuela Mosquera Moreno, Nurse and Executive Director of the Association of the Interethnic Network of Midwifery Practitioners of the Department of Chocó (Asoredipar Chocó) (Dec. 10, 2024).

53 Interview with ILEX by Katy Mayal, Director of Strategic Initiatives at the Center for Reproductive Rights (Dec. 17, 2024).

54 Interview with ILEX by Katy Mayal, Director of Strategic Initiatives at the Center for Reproductive Rights (Dec. 17, 2024).

55 Interview with UNFPA Colombia by Katy Mayall, Director of Strategic Initiatives at the Center for Reproductive Rights (Jan. 13, 2025).

56 Interview with Ledy Manuela Mosquera Moreno, Nurse and Executive Director of the Association of the Interethnic Network of Midwifery Practitioners of the Department of Chocó (Asoredipar Chocó) (Dec. 10, 2024).

HAWAI`I

Regulating Midwifery: The Legal & Policy Framework of Hawai`i

Background

Maternal health disparities in Hawai'i are stark and well-documented. Hawai'i has an overall maternal mortality rate of approximately 12-16 maternal deaths per 100,000 live births[57]; however, certain populations are disproportionately impacted by maternal morbidity and mortality. Although Native Hawaiian and Other Pacific Islander women comprise only 22% of the female population in Hawai'i, they accounted for 44% of pregnancy-related deaths between 2015 and 2017.[58]

The maternal health landscape in Hawai'i is heavily influenced by its geography and history. Hawai'i is geographically isolated, situated in the middle of the Pacific Ocean approximately 2,000 miles from the continental U.S. Hawai'i became the 50th U.S. state in 1959, and its path to statehood followed decades of colonization and the illegal overthrow of the Hawaiian Kingdom.[59] Today, the legacies of colonization persist in the form of socioeconomic disparities, systemic discrimination, and significant health inequities. Native Hawaiians continue to experience higher rates of poverty, limited access to quality healthcare, and poorer health outcomes across many measures, particularly in maternal and reproductive health.[60]

57 The CDC and other sources have not published an MMR for Hawai'i due to concerns about reliability and confidentiality restrictions; however, other sources have produced estimated MMRs based on published data. *See Hawai'i Maternal & Infant Health Data*, KFF, https://www.kff.org/interactive/womens-health-profiles/hawaii/maternal-infant-health/; *Maternal Mortality in Hawaii*, America's Health Ranking, https://www.americashealthrankings.org/explore/measures/maternal_mortality_c/HI; *Maternal deaths and mortality rates*, Ctr. for Disease Control & Prevention, https://www.cdc.gov/nchs/maternal-mortality/mmr-2018-2021-state-data.pdf.

58 Melanie Maykin & Stacy Pai-Jong Tsai, *Our Mothers Are Dying: The Current State of Maternal Mortality in Hawai'i and the United States*, 79 Haw. J Health & Soc. Welfare 302 (2020). This aligns with national statistics; according to the CDC, in the United States (US), Native Hawaiian and Other Pacific Islander women are 4.5 times more likely to die from pregnancy-related causes than white women. *See Pregnancy Mortality Surveillance System: Pregnancy-Related Deaths by Race/Ethnicity*, Ctr. for Disease Control & Prevention (Mar. 23, 2023), https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillancesystem.htm

59 Kelli Y. Nakamura, *Hawaii's Long Road to Becoming America's 50th State*, History (May 5, 2022), https://www.history.com/articles/hawaii-50th-state-1959.

60 Proposed Findings of Fact and Conclusions of Law at ¶ 98, Kaho'ohanohano v. Hawai'i, No. 1CCV-24-0000269 (Haw. Circ. Ct. June 24, 2024)

A statewide shortage of providers and facilities is an additional strain on the maternal healthcare landscape, particularly in rural areas.[61] There are no freestanding birth centers in the state, and each of the seven inhabited islands has, at most, a handful of hospitals with a labor and delivery unit.[62] These units also tend to be concentrated in certain areas of each island. As a result, many residents must travel long distances, sometimes on winding and highly trafficked roads, to access maternity care. Furthermore, certain procedures may not be available on specific islands at all. For example, research from 2024 showed that there were some islands without any providers who would support women to have a vaginal birth after cesarean section (VBAC), necessitating that they fly to Oʻahu to access this care.[63]

The predominant model of maternity care in Hawaiʻi, and the U.S. as a whole, is a medical model in which most births occur in hospitals and are heavily managed by obstetricians, who are trained as physician-surgeons.[64] Evidence shows that in hospital settings, there may be an over-reliance on medical interventions such as cesarean sections (c-sections). For example, in 2022, over 27% of births in the state were via c-section[65], a procedure associated with a host of risks for both the parent and baby, including longer hospital stays and lower breastfeeding rates.[66] According to the WHO, c-section rates higher than 10% are not associated with reductions in rates of maternal or newborn mortality.[29]

Despite the entrenchment of this medicalized model, pregnancy and birth hold deep cultural, spiritual, and communal significance for many.[67] Native Hawaiian traditions have long emphasized holistic and community-based approaches to childbirth. Generations of legal interference and cultural suppression have eroded these practices, leaving few to carry them on.[68] Nonetheless, there is a resurging interest in culturally grounded, community-led midwifery, driven by Native Hawaiian practitioners and advocates seeking to reclaim their birthing traditions, improve maternal health outcomes, and restore dignity and autonomy to the birth experience.[69]

Traditionally, *pale keiki* or *kahuna ho ohānau* performed duties similar to those of Western obstetricians and midwives.[70] Their knowledge, traditions, and customs related to pregnancy, childbirth, and childcare are passed down from generation to generation. *Pale keiki* practices are comprised of religious/spiritual and medicinal/practical elements, and include activities now

61 *Id.* at ¶ 99.
62 *Id.* at ¶ 100.
63 Plaintiff's Complaint for Declaratory and Injunctive Relief at ¶ 40, Kahoʻohanohano v. Hawaiʻi, No. 1CCV-24-0000269 (Haw. Circ. Ct. Feb. 27, 2024).
64 Nat'l Acad. of Sciences, Eng'g, & Med., Birth Settings in America: Outcomes, Quality, Access, and Choice 18 (The Nat'l Acad. Press 2020).
65 Proposed Findings of Fact and Conclusions of Law at ¶ 105, Kahoʻohanohano v. Hawaiʻi, No. 1CCV-24-0000269 (Haw. Circ. Ct. June 24, 2024)
66 Hawaii Department of Health, *Cesarean Delivery Factsheet* (Oct. 2021), https://hhdw.org/wp-content/uploads/2023/07/Ceasarian-Delivery-Factsheet.pdf.
67 Proposed Findings of Fact and Conclusions of Law at ¶ 15, Kahoʻohanohano v. Hawaiʻi, No. 1CCV-24-0000269 (Haw. Circ. Ct. June 24, 2024).
68 Plaintiffs' Complaint for Declaratory and Injunctive Relief at ¶ 71-75, Kahoʻohanohano v. Hawaiʻi, No. 1CCV-24-0000269 (Haw. Circ. Ct. Feb. 27, 2024).
69 *Id.* at ¶ 115-23.
70 *Id.* at ¶ 67.

commonly referred to as midwifery.[71] Midwives trained as *pale keiki* enable pregnant people to sustain a connection with Native Hawaiian birthing practices and can support home births on a family's *āina kūpuna* (ancestral lands).[72]

History of Midwifery Regulation in Hawai'i

Beginning in the 1930s, when Hawai'i was still a U.S. territory, the Territorial Board of Health sought to end midwifery practice by encouraging people to give birth in hospitals with physicians and requiring midwives to register with the government.[73] By 1941, it was illegal to practice midwifery without a license, and only nurse-midwives were eligible for licensure.[74] This practice remained for over 40 years, although some unlicensed midwives continued practicing despite the threat of penalties. In 1998, the midwifery licensure requirement was repealed, and the Board of Nursing took over licensure and regulation of nurse-midwives.[75] Accordingly, nurse-midwives were brought under the purview of the Board of Nursing, with other advanced-practice nurses, all of whom were required to have a nursing license.[76] But a license was no longer required to practice midwifery, nor were midwives required to be nurses, and the practice of midwifery was effectively re-opened to apprenticeship-trained and traditional midwives.[77]

The revitalization of traditional midwifery practices faced significant challenges due to years of colonial efforts that marginalized cultural practitioners and their knowledge.[78] Restoring these practices required drawing on a wide range of experiences and sources of wisdom. Following the legal change in 1998, midwives with extensive experience, often gained in informal or underground settings, began teaching others the skills they had developed.[79] These midwifery mentors represented the state's growing ethnic diversity and included individuals who were not Native Hawaiian. At the same time, *kūpuna* (respected Native Hawaiian elders) with deep cultural insights into childbirth and pregnancy contributed their knowledge, even if they hadn't practiced midwifery themselves.[80] Over the next quarter-century, Native Hawaiian midwives and those from other cultural backgrounds collaborated through hands-on, mentorship-driven training models.[81] Together, they rebuilt a network of culturally grounded, safe, and sustainable birthing care, especially in underserved rural regions and communities of color across Hawai'i.

71 *Id.* at ¶ 63.
72 *Id.* at ¶ 68.
73 *Id.* at ¶ 71.
74 *Id.*
75 *Id.* at ¶ 72.
76 *Id.*
77 *Id.*
78 *Id.* at ¶ 74.
79 *Id.*
80 *Id.*
81 *Id.* at ¶ 75.

The Midwifery Restriction Law

In 2019, after two decades without restrictions on midwifery practice, Hawai'i enacted the Midwifery Restriction Law, which required individuals to obtain a specific state license from the Department of Commerce and Consumer Affairs (DCCA) to practice midwifery or use the title "midwife".[82] This law undermined access to quality, culturally competent care by criminalizing the provision of advice and support during pregnancy and childbirth without a license, limiting pathways to midwifery licensure, and lacking protections for traditional Native Hawaiian birthing practices (*pale keiki*, *hoʻohānau*, and *hānau*).

BROAD DEFINITION OF MIDWIFERY

The Law broadly defined midwifery as:

> **"The provision of one or more of the following services:**
>
> **(1) Assessment, monitoring, and care during pregnancy, labor, childbirth, postpartum and interconception periods, and for newborns, including ordering and interpreting screenings and diagnostic tests, and carrying out appropriate emergency measures when necessary;**
>
> **(2) Supervising the conduct of labor and childbirth; and**
>
> **(3) Provision of advice and information regarding the progress of childbirth and care for newborns and infants."[83]**

In doing so, the law essentially required anyone providing advice, information, or care during pregnancy, birth, and postpartum to have a state license. Although the law notes that it shall not "prohibit a person from administering care to [their] spouse, domestic partner, parent, sibling, or child," due to the breadth of this language, the law restricted trusted midwives, doulas, lactation consultants, counselors, childbirth educators, cultural practitioners, extended family members, and friends. Indeed, in response to questions about the law, the Attorney General confirmed that the "provision of any one service, or one service in combination with another service included in the definition of midwifery, constitutes the practice of midwifery for which a license is required" and that the law bars "grandparents, aunties, uncles, cousins, or broader hānai family" from engaging in what the Law broadly defines as "midwifery" unless they have a license to do so.[84] As one example, much of doulas' core work centers around the "provision of advice and information regarding the progress of childbirth", which under the Law, might require a midwifery license, thereby reducing access not only to midwives, but also doulas. This is particularly concerning given strong evidence that support from a doula contributes to better maternal health outcomes.[85]

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82 Haw. Rev. Stat. §§ 457J-3, 457J- 5 (2024).

83 Haw. Rev. Stat. § 457J-2 (2024).

84 Letter from Shari Wong, Deputy Attorney General of Hawaii (Jan. 17, 2024), at 3, https://tinyurl.com/HawaiiAttorneyGeneralLetterPDF. *Hānai* is defined as fostered or adopted, as well as to raise and feed. Traditionally, this form of adoption was done at infancy, as opposed to adult "hoʻokama" adoptions that also occurred in ancient times. *Hānai* has become a local Hawai'i colloquialism to refer to a person's "chosen family," as is the case here. The Supreme Court of the Kingdom of Hawai'i first addressed *hānai* in *In re Estate of Nakuapa*, 3 Hawai'i 400 (Haw. Kingdom 1872) which focused on traditional *hānai* relationships.

85 See Lara S. Lemon et al., *Quantifying the association between doula care and maternal and neonatal outcomes*, 232 Amer. J. Obstet. Gynecol. 387.e1 (2025).

LIMITED ROUTES OF ENTRY FOR MIDWIFERY

To obtain a midwifery license from the State, the Law required that midwives provide proof of certification as a "certified midwife" (CM) or "certified professional midwife" (CPM).[86] Certified Nurse Midwives (CNMs) are also licensed by the State, but through the Board of Nursing rather than the Midwifery Licensing Program established by the Midwifery Restriction Law.[87] In the United States, CMs and CPMs are licensed through two separate private, non-governmental entities: the American Midwifery Certification Board (AMCB) and the North American Registry of Midwives (NARM), respectively. The requirements for certification under these programs pose unique challenges for individuals in Hawai'i.

All CPMs are certified by NARM and must pass an exam administered by NARM. CPMs may qualify to sit for the exam after (1) apprenticing with a qualified preceptor through the "Portfolio Evaluation Process (PEP)" or (2) graduating from a midwifery program accredited by the Midwifery Education Accreditation Council (MEAC). The PEP and MEAC pathways are similar. The MEAC pathway includes attending formal schooling and apprenticeship, where the student learns by doing, observes, assists, and then eventually takes the lead under supervision. The PEP pathway begins at the apprenticeship stage and includes independent forms of study, such as informal book-based learning, study groups, online courses, and self-study. There is no evidence that midwives trained through the MEAC pathway have better clinical outcomes than those who trained through the PEP pathway.[88]

Notably, under the Midwifery Restriction Law, only some CPMs were eligible for licensure in Hawai'i:

1. CPMs who earn their certification via the MEAC pathway were eligible for a license.
2. CPMs who earn their certification via the PEP pathway were only eligible for State licensure if they obtained the credential *before* January 1, 2020; after that date, aspiring CPMs in Hawai'i, including those who were in the process of obtaining the credential on January 1, 2020, would thereafter need to complete a MEAC program. Additionally, CPMs who obtained the credential after that date and maintained licensure in another state that does not require completing an MEAC program were eligible for licensure.[89]

Permitting those who maintained licensure in another state that does *not* meet the Hawai'i Law's requirements privileged out-of-state midwives and discriminated against Hawai'i residents. Although out-of-state training can be valuable, it does not enable midwives to build knowledge and relationships with the communities they plan to serve. Midwives who train out of state and then move to Hawai'i may also be temporary residents, disrupting the development of strong, long-term relationships with the community and other providers.

86 Haw. Rev. Stat. § 457J-8(3) (2024).
87 See Haw. Rev. Stat. § 457J-6(a)(1) (2024).
88 Proposed Findings of Fact and Conclusions of Law at ¶ 38, Kaho'ohanohano v. Hawai'i , No. 1CCV-24-0000269 (Haw. Circ. Ct. June 24, 2024).
89 Haw. Rev. Stat. § 457J-8.

For people in Hawai'i seeking to become a CPM and who were not licensed in another state, the only pathway remaining was graduation from an MEAC-accredited program. However, at the time the law was enacted, there were only *eight* MEAC programs in the entire U.S. and none located in Hawai'i.[90] Students faced the prospect of either relocating to the continental U.S. (thousands of miles away), completing hybrid programs, or online distance learning. Even "hybrid" MEAC programs require students to demonstrate their clinical skills in person at the school.[91] Fully remote programs require stable internet connections, which can be especially challenging for people in rural areas of Hawai'i. Further, MEAC-school tuition is thousands of dollars annually, and programs can take 3 years to complete for people attending full-time – it often takes more than 3 years for student midwives balancing their training with earning a living. Attending an in-person or hybrid program that requires some on-campus presence means leaving one's home and community, or relocating with family, and raising funds for out-of-state travel and lodging expenses.

Furthermore, students may be required to apprentice under a registered preceptor (an experienced practitioner under whom an apprentice trains), but there are limited qualified preceptors in Hawai'i.[92] This can create untenable delays and financial challenges, as students may also be forced to relocate to find available preceptors and pay for additional semesters of a midwifery education program. Such challenges are compounded by the fact that students are generally not paid as midwives in training, and many are pursuing part-time or full-time paid work to support themselves while completing their midwifery training.

The Midwifery Restriction Law also included a time-limited exemption that enabled "birth attendants" to practice midwifery without a state-issued license, subject to certain limitations and disclosure requirements.[93] During this time, the legislature was to "enact statutes that will incorporate all birth practitioners and allow them to practice to the fullest extent under law."[94] According to the legislature, the three years from when the licensure requirement took effect in 2020 and the expiration of the birth attendant exemption in 2023 would afford the legislature needed time to better define this group of "birth attendants" and develop common standards, accountability measures, and disclosure requirements.[95] During those three years when that exemption was in effect, the legislature considered proposals to amend the Law to extend an exemption from State licensure and to provide a path to State licensure for CPMs credentialed through the apprenticeship-based training path (the Portfolio Evaluation Process or PEP) after January 1, 2020. None of those measures passed.

90 Proposed Findings of Fact and Conclusions of Law at ¶ 42, Kaho'ohanohano v. Hawai'i, No. 1CCV-24-0000269 (Haw. Circ. Ct. June 24, 2024)
91 *Id.*
92 Plaintiffs' Complaint for Declaratory and Injunctive Relief at ¶ 90, Kaho'ohanohano v. Hawai'i, No. 1CCV-24-0000269 (Haw. Circ. Ct. Feb. 27, 2024).
93 *Id.* at ¶ 94.
94 S.B. 1033, S.D. 2, H.D. 2, 30th Leg., Reg. Sess. (2019), § 1 (2019 Hawai'i Act 32).
95 S.B. 1033, S.D. 2, H.D. 2, 30th Leg., Reg. Sess. (2019), § 1 (2019 Hawai'i Act 32).

LACK OF PROTECTIONS FOR NATIVE HAWAIIAN TRADITIONAL AND CUSTOMARY PRACTICES

Although the Midwifery Restriction Law referenced protections for Native Hawaiian traditional and customary practices, it did not provide meaningful protections for *pale keiki*. The Law stated that it does not "prohibit healing practices by traditional Hawaiian healers engaged in traditional healing practices of prenatal, maternal, and child care" who are recognized by traditional healing councils of elders (*kūpuna* councils) convened by Papa Ola Lokahi, a non-governmental Native Hawaiian health organization.[96] However, Papa Ola Lokahi does not convene such councils; it instead recognizes a small number of councils under limited circumstances. Additionally, although there were existing *kūpuna* councils with expertise in Native Hawaiian healing practices that overlapped with midwifery care, the councils recognized by Papa Ola Lokahi did not have expertise specific to *pale keiki* practices and declined to recognize such practitioners. Further, efforts to convene a new *kūpuna* council that could recognize *pale keiki* practitioners were unsuccessful. Accordingly, the Law created no workable pathway for *pale keiki* to engage in their traditional birthing practices without risk of criminalization and thus threatened to extinguish those practices.

HARSH CRIMINAL AND CIVIL PENALTIES

Violating the Midwifery Restriction Law could have resulted in both penalties under that law and the pre-existing Uniform Professional and Vocational Licensing Act.[97] Practicing midwifery without a license could result in imprisonment for up to one year and a criminal fine of up to $2,000 per day.[98] There were also civil fines of up to $1,000 per day[99] and the potential for denial of future licensure.[100] The Department of Commerce and Consumer Affairs ("DCCA"), which administers the midwifery licensing program, also has the authority to sue individuals to stop them from practicing midwifery without a license, which in turn can impose additional civil damages.[101] Further, using the title "midwife" when one does not have a state license to practice midwifery could result in $1,000 in fines for each day that the individual held themselves out as a midwife[102] and could result in the denial of a future license.[103] The law also imposed substantial civil fines on licensed providers who "aid and abet" unlicensed midwifery,[104] which is defined as "employing, utilizing, or attempting to employ or utilize" an unlicensed midwife.[105] Punishment for "aiding and abetting" can sever the connection between licensed midwives and those who are not licensed but who previously worked, lawfully, in collaboration with licensed midwives. That not only weakened the support network among providers but also undermined continuity of care for patients who were then unable to continue seeing the providers they previously relied on.

96 Haw. Rev. Stat. § 457J-6(b) (limiting this to "any council of kupuna convened by Papa Ola Lōkahi").
97 Haw. Rev. Stat. § 436B.
98 Haw. Rev. Stat. § 436B-27(b).
99 Haw. Rev. Stat. § 457J-13; see *also* Haw. Rev. Stat. § 436B-26.5 (regarding civil fines).
100 Haw. Rev. Stat. §§ 457J-12, 436B-19.
101 Haw. Rev. Stat. § 436B-27.
102 Haw. Rev. Stat. §§ 457J-5, J-13.
103 Haw. Rev. Stat. §§ 457J-12, 436B-19 (Under the provision of "engaging in false, fraudulent, or deceptive advertising, or making untruthful or improbable statements.").
104 Haw. Rev. Stat. § 436B-27(a).
105 Haw. Rev. Stat. §§ 457J-12, 436B-19.

Legal Challenge to the Midwifery Restriction Law

Following the law's passage, the Center for Reproductive Rights, the Native Hawaiian Legal Corporation, and Perkins Coie, filed a lawsuit (*Kahoʻohanohano v. Hawaiʻi*) on behalf of nine plaintiffs, including midwives, student midwives, pregnant women, and women planning to become pregnant. This lawsuit argued that the Midwifery Restriction law violated a host of rights, including the rights to privacy, reproductive autonomy, equality, pursuit of one's chosen profession, freedoms of speech and expression, and protection of Native Hawaiian traditional and customary practices.[106] The plaintiffs moved for a preliminary injunction on their claims that the Law violated individuals' rights to reproductive autonomy, failed to protect Native Hawaiian traditional and customary practices, and was unconstitutionally overbroad, and asked the Court to block its enforcement.[107]

After a weeklong hearing during which plaintiffs and experts presented testimony, the Court issued an order that blocked enforcement of the law against Native Hawaiians practicing, teaching, and learning traditional Native Hawaiian birthing practices.[108]

The Court recognized that "midwives trained as pale keiki can offer pregnant people a connection to Native Hawaiian birthing practices and support families to hānau [birth] at home on a family's *āina kūpuna* (ancestral lands), providing a birthing experience that offers cultural safety and concordance and heals intergenerational trauma"[109] and that the Midwifery Restriction Law "fails to reasonably protect Native Hawaiian traditional and customary rights". The Court emphasized that the requirement that anyone seeking to practice midwifery, as broadly defined under the law, coupled with the limited pathways the law introduced for midwifery licensure, was overly onerous and burdensome. It also recognized that the licensure framework "devalue[s] constitutionally protected Native Hawaiian customary practices by forcing them to assimilate and conform to western medical practices and beliefs" and that there is "a very real threat that *pale keiki*, *hoʻohānau*, and *hānau* customary practices will be 'impermissibly regulated out of existence.'"[110] Accordingly, the Court concluded that the Law provided no practical pathway for *pale keiki* to practice their traditional, cultural birthing practices and violates the Hawaiʻi Constitution's protection for Native Hawaiian traditional and customary practices.[111]

106 Plaintiffs' Complaint for Declaratory and Injunctive Relief at ¶¶ 157-80, Kahoʻohanohano v. Hawaiʻi, No. 1CCV-24-0000269 (Haw. Circ. Ct. Feb. 27, 2024).
107 *Id.*
108 Kahoʻohanohano v. Hawaiʻi, No. 1CCV-24-0000269 (Haw. Circ. Ct. July 23, 2024).
109 *Id.* at ¶ 32.
110 *Id.* at ¶ 67.
111 *Id.* at ¶¶ 46-68.

The Court's order highlighted challenges imposed by the Law that are relevant to the maternal health and rights of communities throughout the state, including the threatened loss of tradition and culture; limited pathways to licensure; diminished access to care, in particular for Indigenous people and other people of color; and damage to individuals' health, safety, and well-being.[112] The Court, however, concluded that the Law did *not* violate individuals' right to reproductive autonomy.[113] The Court construed that right as a right to an "unlicensed midwife," rather than the right to decide where, how, and with whom they birth, and akin to decisions about whether to continue a pregnancy and who to form a family with.[114] Based on the Court's failure to fully understand the rights at stake, the Court did not block enforcement of the Law broadly.[115]

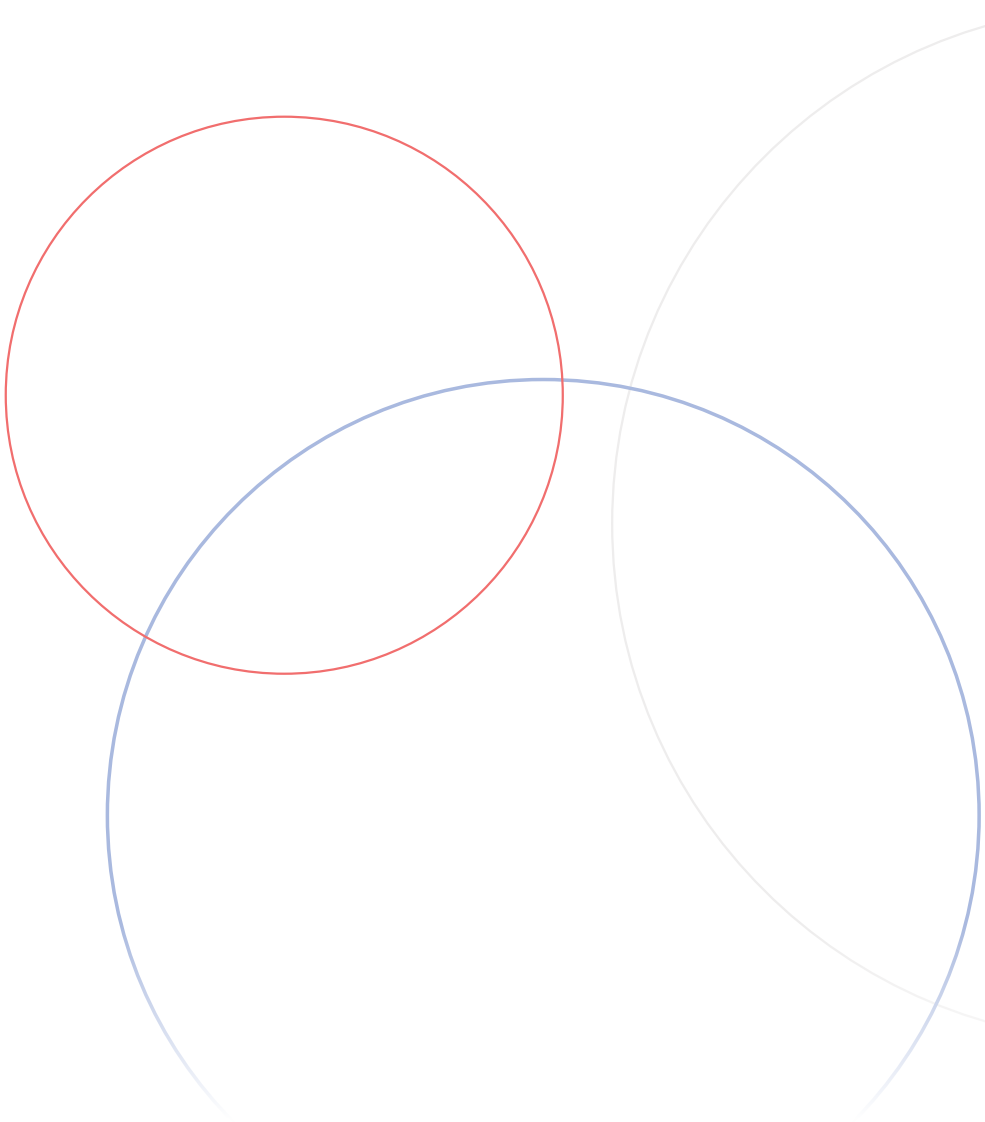
New Legislation

In 2025, the Hawai'i legislature passed a bill to replace the Midwifery Restriction Law. The newly enacted law addresses several concerns raised in *Kaho'ohanohano v. Hawai'i*, including the overbroad definition of midwifery, arbitrary eligibility requirements, unconstitutional restrictions on Native Hawaiian cultural practices, and the criminalization of unlicensed individuals providing information, care, or advice to pregnant or birthing people. First, the new midwifery law contains a more tailored definition of the conduct to be regulated, which is less likely to chill support from family members, doulas, and other birth workers. Second, it expands pathways to licensure, allowing all Certified Professional Midwives to apply for a license, including those who gain skills and competencies through the Portfolio Evaluation Process and obtain a midwifery bridge certificate after 2020. Third, protections for Native Hawaiian cultural practitioners engaged in traditional and customary practices have been strengthened by language that more clearly exempts cultural practitioners and does not require them to engage with processes that do not work or exist in practice. Finally, the new law rejects criminal penalties and states that "It shall not be a violation of this chapter for a person invited by a patient to be present at a birth occurring at a location other than a birth facility; provided that the person shall not use the title "midwife", "licensed midwife", or engage in the practice of midwifery, unless otherwise licensed under this chapter."[116] Civil penalties continue to apply to anyone practicing midwifery or calling themselves a "midwife" without a license.[117]

112 *Id.* at ¶¶ 56-59, 83.
113 *Id.* at ¶¶ 20-30.
114 *Id.* at ¶ 11.
115 *Id.* at ¶¶ 87-89.
116 H.B. 1194, H.D. 2, S.D. 3, 33rd Leg., Reg. Sess. (2025) § 457J-J(6)(b).
117 *E.g.*, H.B. 1194, H.D. 2, S.D. 3, 33rd Leg., Reg. Sess. (2025) § 457J-F(b).

Conclusion

Traditional midwifery and Native Hawaiian childbirth traditions hold deep cultural, spiritual, and communal significance. These practices offer holistic, community-centered approaches to childbirth that foster continuity of care, support culturally grounded care, and restore dignity and autonomy to the birth experience. Despite this, traditional midwifery has been restricted and marginalized at multiple points in history, including, most recently, through the 2019 Midwifery Restriction law. While this law aimed to regulate midwifery, it ultimately marginalized traditional Native Hawaiian birthing practices and restricted access to culturally competent care. It also imposed burdens on community-based midwives and aspiring practitioners, worsening already persistent challenges pregnant people face finding providers who meet their needs. The replacement bill, passed in 2025, marks a critical step toward restoring reproductive autonomy, supporting Indigenous knowledge systems, and expanding pathways to safe, community-rooted care. By addressing some of the law's most harmful provisions and recognizing the legitimacy of traditional practices, the new law moves closer to a maternal health system that honors both cultural heritage and individual choice. Nonetheless, the new law continues to leave some behind and there remains more work to do.



INDIA

Regulating Midwifery: The Legal & Policy Framework of India

SNAPSHOT OF MIDWIFERY IN INDIA

- **Types of midwives:** In 2018, India's Midwifery Services Initiative introduced a new cadre of midwives with the title Nurse Practitioner in Midwifery (NPM). Other skilled birth attendants use the term "midwife" but do not necessarily align with ICM standards on midwifery training and competencies. In some contexts, there are "traditional midwives" or "traditional birth attendants," called *dais*, but this practice is unregulated and relatively uncommon.
- **Routes of entry:** To enter the 18-month NPM program, individuals must first obtain a General Nursing and Midwifery Diploma (3.5 years) or become a registered nurse and registered midwife (4 years), and complete at least two years of field experience.
- **Key challenges:**
  - » There is a conflation of midwifery and nursing in the National Nursing and Midwifery Commission Act, which undermines implementation of the midwifery model of care.
  - » Although the Midwifery Services Initiative aims to promote NPMs' autonomy and full scope of practice, aspects of the initiative undermine evidence-based practices around midwifery and prevent midwives from acting autonomously.

Background

In the past 25 years, India's maternal mortality ratio has decreased considerably from 393 maternal deaths per 100,000 live births to 80 maternal deaths per 100,000 live births (2023).[118] Notably, this progress has not been uniform, as there are significant disparities in maternal mortality, as women of low economic status, uneducated women, rural women, and women of lower caste

118 World Bank Group, *Maternal mortality ratio (modeled estimate, per 100,000 live births) – India* (2025), https://data.worldbank.org/indicator/SH.STA.MMRT?contextual=default&locations=IN.

status have higher rates of maternal deaths[119] and nearly two-thirds of maternal deaths occur in the least developed states in India.[120]

The Janani Suraksha Yojana (JSY) program has been a hallmark of India's efforts to reduce maternal mortality and morbidity. This program is the largest conditional cash transfer scheme in the world[121] and was designed to promote institutional deliveries in high-focus states with poor maternal health outcomes by providing a stipend to women after they delivered in either a government facility or an accredited private facility.[122] The program also provides funding for Accredited Social Health Activists (ASHAs) to facilitate antenatal care, counsel women on the benefits of institutional delivery, ensure newborn immunization, and provide postnatal care.[123] This considerably increased the proportion of institutional deliveries in India from around 40% in 2005-2006 to 89% in 2019-2021.[124] Skilled birth attendance has also increased, rising exponentially by 81% from 2005-2006 to 2015-2016.[125] Since then, the central government approved a novel tax-financed initiative called the National Health Protection Scheme (PM-JAY). This program seeks to provide health coverage for the lowest two income quintiles, comprising roughly 40% of the population, to continue improving access to maternal healthcare.[126]

Despite increasing investment by the Indian government into maternal healthcare, there are great disparities in accessing care. Although the average rate of skilled birth attendance is 89%,[127] the rate varies significantly across regions, socioeconomic status, and caste. Only 64% of women from the lowest wealth quintile use a skilled birth attendant (SBA), whereas the rate is 96% among women from the highest wealth quintile.[128] Regionally, the southern states of India have consistently high rates of SBA (over 80%), whereas there are far lower rates in northern and eastern India, with some regions falling below 40%.[129] Women in urban areas are more likely to

119 Mukesh Hamal et al., *Social determinants of maternal health: a scoping review of factors influencing maternal mortality and maternal health service use in India*, 41 Pub Health Rev 13 (2020), https://doi.org/10.1186/s40985-020-00125-6.

120 C Meh et al., *Trends in maternal mortality in India over two decades in nationally representative surveys*, 129 British J Obstet Gynecol 550 (2021), https://doi.org/10.1111/1471-0528.16888.

121 Arabinda Ghosh & Rohini Ghosh, *Maternal health care in India: A reflection of 10 years of National Health Mission on the Indian maternal health scenario*, 25 Sexual Reprod Healthcare 100530 (2020), https://doi.org/10.1016/j.srhc.2020.100530.

122 Sanjeev K. Gupta et al., *Impact of Janani Suraksha Yojana on Institutional Delivery Rate and Maternal Morbidity and Mortality: An Observational Study in India*, 30 J Health Pop Nutr 464 (2012), https://doi.org/10.3329/jhpn.v30i4.13416.

123 Tesfaye Alemayehu Gebremedhin, Itismita Mohanty, & Theo Niyonsenga, *Public health insurance and maternal health care utilization in India: evidence from the 2005–2012 mothers' cohort data*, 22 BMC Preg Childbirth 155 (2022), https://doi.org/10.1186/s12884-022-04441-4; Pooja Paswan, *Mitigating Maternal Mortality and Child Mortality: The Transformative Impact of Janani Suraksha Yojana in India*, PA Times, Oct. 18, 2024, https://patimes.org/mitigating-maternal-mortality-and-child-mortality-the-transformative-impact-of-janani-suraksha-yojana-in-india/.

124 Sanjeev K. Gupta et al., *Impact of Janani Suraksha Yojana on Institutional Delivery Rate and Maternal Morbidity and Mortality: An Observational Study in India*, 30 J Health Pop Nutr 464 (2012), https://doi.org/10.3329/jhpn.v30i4.13416; Ministry of Health and Family Welfare [India], *National Family Health Survey (NFHS-5), 2019-21* (2022), at 264, https://ruralindiaonline.org/en/library/resource/national-family-health-survey-nfhs-5-2019-21-india/.

125 Md Akhtarul Islam et al., *Prevalence and determinants of utilizing skilled birth attendance during home delivery of pregnant women in India: Evidence from the Indian Demographic and Health Survey 2015–16*, 19 PLoS One e0295389 (2024), https://doi.org/10.1371/journal.pone.0295389.

126 The Commonwealth Fund, *International Health Care System Profiles: India* (June 5, 2020), https://www.commonwealthfund.org/international-health-policy-center/countries/india.

127 World Bank Group, *Births attended by skilled health staff (% of total) – India*, https://data.worldbank.org/indicator/SH.STA.BRTC.ZS?locations=IN (accessed May 14, 2025).

128 Prem Shankar Mishra et al., *Spatial inequalities in skilled birth attendance in India: a spatial-regional model approach*, 22 BMC Pub Health 79 (2022), https://doi.org/10.1186/s12889-021-12436-7.

129 Prem Shankar Mishra et al., *Spatial inequalities in skilled birth attendance in India: a spatial-regional model approach*, 22 BMC Pub Health 79 (2022), https://doi.org/10.1186/s12889-021-12436-7.

have a skilled birth attendant (94%) than women in rural areas (88%).[130] Additionally, even as institutional delivery rates are increasing across the country, they remain financially burdensome for most women. A 2025 study found that two-thirds of women incur out-of-pocket expenses for their institutional deliveries and that 23% of women in India have financed childbirth through the selling of jewelry, property, or borrowings from friends.[131]

Furthermore, there is considerable variation in the quality of maternal care available to women, and there is concerning evidence on the overmedicalization of birth and disrespect and abuse in birthing settings. A 2020 meta-analysis documented the prevalence of disrespect and abuse across different states and hospital settings as ranging from 20% to 100%, with an overall prevalence of 71%.[132] A 2021 systematic review on the prevalence of obstetric violence in India corroborated these findings, identifying widespread instances of failure to meet professional standards of care, including the use of force, involuntary post-partum contraception, lack of informed consent before clinical procedures, unnecessary and/or unanesthetized episiotomies, and a lack of privacy.[133] The review concluded that verbal abuse, physical abuse, and dehumanizing behaviors were the three most common forms of obstetric violence women experienced.[134] There is also evidence that birth is overmedicalized in certain settings, with the 2021 National Family Health Survey finding a 47.5% C-section rate in private facilities; this is a stark contrast from the 14.3% C-section rate in public facilities.[135]

In 2018, India introduced the Midwifery Services Initiative to develop a new cadre of Nurse Practitioners in Midwifery (NPM) in order to ensure high-quality, dignified, and respectful maternal healthcare.[136] This new midwife cadre is educated to the International Confederation of Midwives (ICM) standards, and to date, seven national midwifery training institutes have been established.[137] Importantly, in establishing this initiative, the Indian government explicitly recognized that the overmedicalization of pregnancy and birth in urban areas and the lack of skilled providers in rural areas are two principal drivers of poor maternal health outcomes and persistent maternal mortality.[138] This case study on midwifery in India will largely focus on the Midwifery Services Initiative and NPMs.

130 Ministry of Health and Family Welfare [India], *National Family Health Survey (NFHS-5), 2019-21* (2022), at 267, https://ruralindiaonline.org/en/library/resource/national-family-health-survey-nfhs-5-2019-21-india/.

131 R. Lusome, Ambady Sivan, & M. Arun Kumar, *Out of Pocket Expenditure on Institutional Deliveries in India*, 29 Mat Child Health J 386 (2025), https://doi.org/10.1007/s10995-025-04060-3.

132 H. Ansari & R. Yeravdekar, *Respectful maternity care during childbirth in India: A systematic review and meta-analysis*, 66 J Postgrad Med 133 (2020), https://doi.org/10.4103/jpgmJPGM_648_19.

133 Abid Faheem, *The nature of obstetric violence and the organisational context of its manifestation in India: a systematic review*, 29 Sex Reprod Health Matters (2021), https://doi.org/10.1080/26410397.2021.2004634.

134 Abid Faheem, *The nature of obstetric violence and the organisational context of its manifestation in India: a systematic review*, 29 Sex Reprod Health Matters (2021), https://doi.org/10.1080/26410397.2021.2004634.

135 Ministry of Health and Family Welfare [India], *National Family Health Survey (NFHS-5), 2019-21* (2022), at 300, https://ruralindiaonline.org/en/library/resource/national-family-health-survey-nfhs-5-2019-21-india/.

136 Ani Grace Kalaimathi, *Professional Midwife-Led Care in India*, International Confederation of Midwives [ICM] (Jan. 4, 2024), https://internationalmidwives.org/professional-midwife-led-care-in-india/.

137 Ministry of Health and Family Welfare [India], *Scope of Practice for Midwifery Educator & Nurse Practitioner Midwife* (2021), at 4, https://nhm.gov.in/New_Updates_2018/Scope%20of%20Practice%20Document%20.pdf.

138 Ministry of Health and Family Welfare [India], *Guidelines on Midwifery Services in India* (2018), at 1, 2, https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCHA/MH/Guidelines/Guidelines_on_Midwifery_Services_in_India.pdf.

There have previously been attempts to develop cadres of professional midwives in India, including through foreign aid programs. These were only partially successful for a host of reasons, including a lack of role clarity for integrated midwives, inadequate training, a lack of career opportunities for midwives, and lack of sustained resourcing.[139] Perhaps most critically, there was no legal and regulatory framework to facilitate the integration of midwives into the healthcare system. As the Guidelines on Midwifery Services in India state, "[o]ne of the most important and critical reason [*sic*] affecting the success of the midwifery cadre in India was the lack of [a] regulatory framework. None of the States were successful in establishing a legal framework to protect and guide midwifery programme and allow NPMs to work independently."[140] A cornerstone of the Midwifery Services Initiative is the creation of Midwife-Led Care Units (MLCUs) at public health facilities. These units are the first place where women go to receive maternal healthcare, with NPMs as the initial point of contact.[141] In these units, midwives operate under the supervision of OBGYNs and alongside Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) services, and midwifery is practiced in collaboration with obstetricians.[142]

Although there previously were several types of skilled birth attendants who were referred to as midwives or had the term "midwife" in their title, the Midwifery Services Initiative intentionally adapts ICM's standards on midwifery training and competencies to promote midwifery models of care.[143] There is also a detailed Scope of Practice for Midwifery Educator[s] and NPMs which sets forth the scope of practice, roles and responsibilities, and principles for collaborative care.[144]

When analyzing midwifery models of care in India, it is important to recognize that under India's federal structure, health is a state subject, meaning that "states or the subnational governments are the primary actors in providing healthcare services"[145] and states have "substantial authority to shape healthcare policy, manage resources, and execute programs that are specifically designed to meet local requirements".[146] However, the "Indian federal system has been influenced by a historical pattern of central planning and the consolidation of authority at the federal level"[147] and the federal government "directly exercises legislative and executive powers concerning healthcare", exerting particular influence over policy design and financing.[148] Additionally,

139 Ministry of Health and Family Welfare [India], *Guidelines on Midwifery Services in India* (2018), at 5, 6, https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCHA/MH/Guidelines/Guidelines_on_Midwifery_Services_in_India.pdf.

140 Ministry of Health and Family Welfare [India], *Guidelines on Midwifery Services in India* (2018), at 5, https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCHA/MH/Guidelines/Guidelines_on_Midwifery_Services_in_India.pdf.

141 Ani Grace Kalaimathi, *Professional Midwife-Led Care in India*, ICM (Jan. 4, 2024), https://internationalmidwives.org/professional-midwife-led-care-in-india/.

142 Ministry of Health and Family Welfare [India], *Scope of Practice for Midwifery Educator & Nurse Practitioner Midwife* (2021), at 5, https://nhm.gov.in/New_Updates_2018/Scope%20of%20Practice%20Document%20.pdf.

143 *See* Ministry of Health and Family Welfare [India], *Scope of Practice for Midwifery Educator & Nurse Practitioner Midwife* (2021), at 4, https://nhm.gov.in/New_Updates_2018/Scope%20of%20Practice%20Document%20.pdf.

144 *See* Ministry of Health and Family Welfare [India], *Scope of Practice for Midwifery Educator & Nurse Practitioner Midwife* (2021), https://nhm.gov.in/New_Updates_2018/Scope%20of%20Practice%20Document%20.pdf.

145 Niranjan Sahoo, *Health federalism in India: Changing trends*, Observer Research Foundation (Apr. 5, 2024), https://www.orfonline.org/expert-speak/health-federalism-in-india-changing-trends.

146 Prakash Singh & Shantesh Singh, *Strengthening the Fabric: Federalism, Decentralisation, and India'sHealthcare Imperative*, 9 Liberal Studies 1 (2024), at 28, https://doi.org/10.5281/zenodo.12749740.

147 Prakash Singh & Shantesh Singh, *Strengthening the Fabric: Federalism, Decentralisation, and India'sHealthcare Imperative*, 9 Liberal Studies 1 (2024), at 28, https://doi.org/10.5281/zenodo.12749740.

148 Niranjan Sahoo, *Health federalism in India: Changing trends*, Observer Research Foundation (Apr. 5, 2024), https://www.orfonline.org/expert-speak/health-federalism-in-india-changing-trends.

although over one-quarter of all institutional deliveries occurred in private facilities,[149] the new midwifery regulations focus on the public sector and do not directly impact private hospitals or health facilities.[150]

Types of Midwives

In the 2021 Scope of Practice guidelines, the Nurse Practitioner Midwife (NPM) role is defined as someone

> **"who has successfully completed the 18 months' Nurse Practitioner in Midwifery training program designed by the Indian Nursing Council (INC) based on the ICM essential competencies for basic midwifery practice and recognized in India by the Ministry of Health and Family Welfare, Government of India, and who will be registered and licensed to practice midwifery in high caseload facilities across the country under the title 'Nurse Practitioner Midwife', upon demonstrating competency in the practice of midwifery."[151]**

Under this initiative, NPMs "will be responsible for the promotion of the health of women throughout their lifecycle, with special focus on women during their childbearing years and their newborns. [They] will be responsible for providing care to women prior to pregnancy, during pregnancy, childbirth, and the postnatal period (for the mother and her newborn). The NPM will be responsible and accountable for his/her practice."[152] More recently, the National Nursing and Midwifery Commission (NNMC) Act of 2023 defined a "midwifery professional" as someone with recognized basic or advanced qualifications in midwifery who is licensed to practice by the National Nursing and Midwifery Commission.[153]

Other skilled birth attendants in India have titles that use the term "midwife," but do not necessarily align with ICM standards on midwifery training and competencies.[154] This includes auxiliary nurse midwives (ANMs), who complete a certificate course and are registered as registered auxiliary nurse midwives (Registered ANMs). General nurses and midwives (GNMs) complete a diploma course, and graduate nurses and midwives complete a bachelor's degree in nursing; both diploma and degree holders are called registered nurses and registered midwives (RNRMs). These roles undergo training that is more akin to obstetric nursing and lack formally defined scopes of practice and the full breadth of care that midwifery encompasses.[155] There are also private institutes that administer midwifery training programs, with graduates often

149 Ministry of Health and Family Welfare [India], *National Family Health Survey (NFHS-5), 2019-21* (2022), at 290, https://ruralindiaonline.org/en/library/resource/national-family-health-survey-nfhs-5-2019-21-india/.
150 See Ministry of Health and Family Welfare [India], *Guidelines on Midwifery Services in India* (2018), at 6, 10, 13, https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCHA/MH/Guidelines/Guidelines_on_Midwifery_Services_in_India.pdf.
151 Ministry of Health and Family Welfare [India], *Scope of Practice for Midwifery Educator & Nurse Practitioner Midwife* (2021), at 4, https://nhm.gov.in/New_Updates_2018/Scope%20of%20Practice%20Document%20.pdf.
152 Ministry of Health and Family Welfare [India], *Guidelines on Midwifery Services in India* (2018), at 11, https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCHA/MH/Guidelines/Guidelines_on_Midwifery_Services_in_India.pdf.
153 The National Nursing and Midwifery Commission Act, 2023, §2(f) (India).
154 Interview with Geeta Chhibber, Senior Technical Advisor for Jhpiego, India Country Office (Dec. 13, 2024).
155 Interview with Geeta Chhibber, Senior Technical Advisor for Jhpiego, India Country Office (Dec. 13, 2024).

employed in the private sector. Historically, these programs have been largely unregulated, with a wide variety in the scope of competencies and quality of training.[156] Additionally, in some contexts, there are traditional birth attendants called *dais*, though this is an unregulated practice and is far less common.[157] Therefore, for the purposes of understanding the current status of midwifery in India, this case study will primarily focus on NPMs, though it will also explore regulations impacting other types of nurse-midwives in India.

Routes of Entry

Prior to admission to the new NPM training program, individuals must first obtain either a General Nursing and Midwifery Diploma, which takes 3.5 years, or a degree to become a registered nurse and registered midwife (RNRM), which takes 4 years.[158] Then, they must have "at least two years of experience of conducting deliveries or experience of working in the concerned field," in addition to passing competency and aptitude tests.[159] Finally, the NPM training program is an additional 18-month program.[160] This means that, at a minimum, individuals will have 7 years of training and experience before becoming NPMs.

Although other individuals in India with "midwife" in their titles have more direct entry pathways, such as ANMs, GNMs, and RNRMs, these professions' training and competencies do not align with ICM standards.

REGISTRATION AND LICENSURE

Previously, the Indian Nursing Council and State Nursing Councils were responsible for registration, education, licensure, and regulation of nurses in India. The National Nursing and Midwifery Commission (NNMC) Act of 2023 replaced the Indian Nursing Council with a National Nursing and Midwifery Commission and state nursing and midwifery commissions.[161] These entities are responsible for "certification, regulation and legal protection" for NPMs.[162] The National Commission has the authority to:

- "frame policies and regulate standards for the governance of nursing and midwifery education and training,"
- "regulate nursing and midwifery institutions, researchers, professionals and associates"
- "identify and regulate any other category of nursing and midwifery profession,"

156 Interview with Geeta Chhibber, Senior Technical Advisor for Jhpiego, India Country Office (Dec. 13, 2024).
157 *See* Mira Sadgopal, *Towards recognition of traditional midwives (Dais): The Jeeva Study*, International Institute for Asian Studies (2013), https://www.iias.asia/sites/iias/files/nwl_article/2019-05/IIAS_NL65_26.pdf.
158 *See* Ministry of Health and Family Welfare [India], *Guidelines on Midwifery Services in India* (2018), at 13, https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCHA/MH/Guidelines/Guidelines_on_Midwifery_Services_in_India.pdf.
159 Ministry of Health and Family Welfare [India], *Guidelines on Midwifery Services in India* (2018), at 13, https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCHA/MH/Guidelines/Guidelines_on_Midwifery_Services_in_India.pdf.
160 Ministry of Health and Family Welfare [India], *Guidelines on Midwifery Services in India* (2018), at 10, https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCHA/MH/Guidelines/Guidelines_on_Midwifery_Services_in_India.pdf.
161 The National Nursing and Midwifery Commission Act, 2023, §3 (India).
162 Ministry of Health and Family Welfare [India], *Guidelines on Midwifery Services in India* (2018), at 11, https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCHA/MH/Guidelines/Guidelines_on_Midwifery_Services_in_India.pdf.

- regulating standards for midwifery education and "provide for a uniform mechanism for admission into the nursing and midwifery institutions at various levels,"
- establish a "mechanism, either through final year undergraduate exam or otherwise, to ensure adequate competence of the nursing and midwifery professionals for enrolment in the National Register or State Register, as the case may be, and for granting license to practice as a nursing and midwifery professional,"
- "ensure policies and codes to ensure observance of professional ethics in nursing and midwifery profession and to promote ethical conduct during the provision of care."[163]

CONFLATION OF NURSING AND MIDWIFERY PROFESSIONS AND TITLES OF MIDWIVES IN THE NATIONAL NURSING AND MIDWIFERY COMMISSION ACT

While the introduction of the NNMC Act is an important step towards recognizing the importance of midwifery as a profession, there is confusing language throughout the Act. The Act defines and uses three different categories of midwives: midwifery associate, midwifery professional, and nurse practitioner in midwifery.[164] However, these categories do not align with recognized types of midwives, as auxiliary nurse midwives (ANMs) and registered nurses and registered midwives (RNRMs) exist in addition to nurse practitioners in midwifery (NPMs). Further, the Act conflates midwifery and nursing, repeatedly referring to "nursing and midwifery professionals" without distinguishing between the two.[165] This conflation impacts how these professions are reflected in the Commission and its subsidiary bodies, which have important supervisory and adjudicatory functions, as elaborated further below. Indeed, a recent study on contextual barriers to the implementation of the MLCUs identifies the conflation of nursing and midwifery as an important barrier that undermines this model of care.[166]

LACK OF REPRESENTATION OF MIDWIVES ON THE NATIONAL COMMISSION AND AUTONOMOUS BOARDS

Although the National Nursing and Midwifery Commission is made up of 29 people (a Chairperson, sixteen ex-officio Members, and twelve Members), only 2 of them are required to be "midwifery professionals".[167] Yet, as noted previously, this term does not align with how the Ministry of Health and Family Welfare (MoHFW) defines different types of nurses and midwives, as there are nursing professionals with "midwife" in their titles who lack alignment with global midwifery standards. Therefore, it is unclear whether there is guaranteed representation of professionals who satisfy the ICM definition of a midwife.[168] Further, although the selection committee responsible for recommending members to the Commission must include "four nursing and midwifery experts,"[169] the consistent conflation of nursing and midwifery throughout the Act

163 The National Nursing and Midwifery Commission Act, 2023, §10(2) (India).
164 The National Nursing and Midwifery Commission Act, 2023, §2 (India).
165 *See, e.g.,* The National Nursing and Midwifery Commission Act, 2023 (India).
166 Malin Bogren et al., *Contextual factors influencing the implementation of midwifery-led care units in India,* 36 Women and Birth e134 (2023), https://doi.org/10.1016/j.wombi.2022.05.006.
167 The National Nursing and Midwifery Commission Act, 2023, §4(j) (India).
168 ICM, *International Definition and Scope of Practice of the Midwife* (2024), https://internationalmidwives.org/resources/international-definition-of-the-midwife/.
169 The National Nursing and Midwifery Commission Act, 2023, §5(1)(iii)(b) (India).

and the lack of requirements that any of these experts specifically be midwives also means there is no guarantee that any committee members will be midwives trained to global standards.

Three autonomous boards operate under the National Commission's supervision: the Nursing and Midwifery Undergraduate and Postgraduate Education Board, the Nursing and Midwifery Assessment and Rating Board, and the Nursing and Midwifery Ethics and Registration Board.[170] Although some specific members of these boards are "nursing and midwifery professionals," there is no guarantee that Board members will be midwives, and that midwives will be represented in decisions around midwifery education and oversight of such educational institutions. Further, the lack of guaranteed representation of midwives in the constituency of the Nursing and Midwifery Ethics and Registration Board is especially concerning given the board's broad regulatory powers, which include maintaining the National Register of nurses and midwives, including approving and rejecting applicants; regulating professional conduct, including ensuring compliance with the codes of professional and ethical conduct; serving as an appellate body for actions taken by State Commissions; and establishing mechanisms for complaints and redressing grievances.[171]

The NNMC Act also mandates the establishment of State Nursing and Midwifery Commissions within one year of the Act's commencement, whereas previously, these would have only been state nursing commissions. These bodies "enforce the professional conduct, code of ethics and etiquette to be observed by the nursing and midwifery professionals", "maintain the State Registers for registered professionals", "provide for a skill based examination to ensure adequate competence of Nursing and Midwifery Associates before enrollment in the State Register; and ensure compliance of all the directives issued by the National Commission", among other things.[172] These bodies are required to have at least three representatives from the midwifery profession.[173] Yet, due to the lack of clarity around what constitutes a midwife, it is possible that these spots will be filled by auxiliary nurse midwives (ANMs), general nurse midwives (GNMs), and bachelors nurse midwives, as opposed to nurse practitioners in midwifery (NPMs) who are trained on midwifery models of care, particularly while this cadre of NPMs is still being established. This contradicts ICM's recommendations that "nursing legislation is inadequate to regulate midwifery practice"[174] and that regulatory frameworks should recognize that midwifery is a profession that is autonomous, separate, and distinct from nursing and medicine.[175] ICM further recognizes that the regulatory body should be composed mainly of midwives and reflect the diversity of practice within the country, along with lay members representing childbearing women.[176]

170 The National Nursing and Midwifery Commission Act, 2023, §11 (India).
171 The National Nursing and Midwifery Commission Act, 2023, §20(1) (India).
172 The National Nursing and Midwifery Commission Act, 2023, §24 (India).
173 The National Nursing and Midwifery Commission Act, 2023, §23(d), (e), (f) (India).
174 ICM, *Global Standards for Midwifery Regulation* (2011), at 1, https://internationalmidwives.org/resources/global-standards-for-midwifery-regulation/.
175 ICM, *Regulation Toolkit* (2016), at 2, https://internationalmidwives.org/resources/regulation-toolkit/; ICM, *Global Standards for Midwifery Regulation* (2011) at 7, https://internationalmidwives.org/resources/global-standards-for-midwifery-regulation/.
176 ICM, *Global Standards for Midwifery Regulation* (2011), at 16, https://internationalmidwives.org/resources/global-standards-for-midwifery-regulation/.

THE CENTRAL GOVERNMENT HAS CONSIDERABLE AUTHORITY OVER THE NATIONAL COMMISSION, THE AUTONOMOUS BOARDS, AND STATE COMMISSIONS, WHICH IN TURN MAY UNDERMINE THEIR AUTONOMY.

Although the NNMC Act gives broad authority to the National Commission, the Autonomous Boards, and State Commissions, it affords the Central Government broad oversight authority, thereby limiting the true autonomy of these entities. For example, the NNMC Act specifies that the

> **"The National Commission, the Autonomous Boards and the Nursing and Midwifery Advisory Council shall, in exercise of their powers and discharge of their functions under this Act, be bound by such directions on questions of policy as the Central Government may give in writing to them from time to time: Provided that the National Commission, the Autonomous Boards and the Advisory Council shall, as far as practicable, be given an opportunity to express their views before any direction is given under this sub-section. The decision of the Central Government whether a question is one of policy or not, shall be final."[177]**

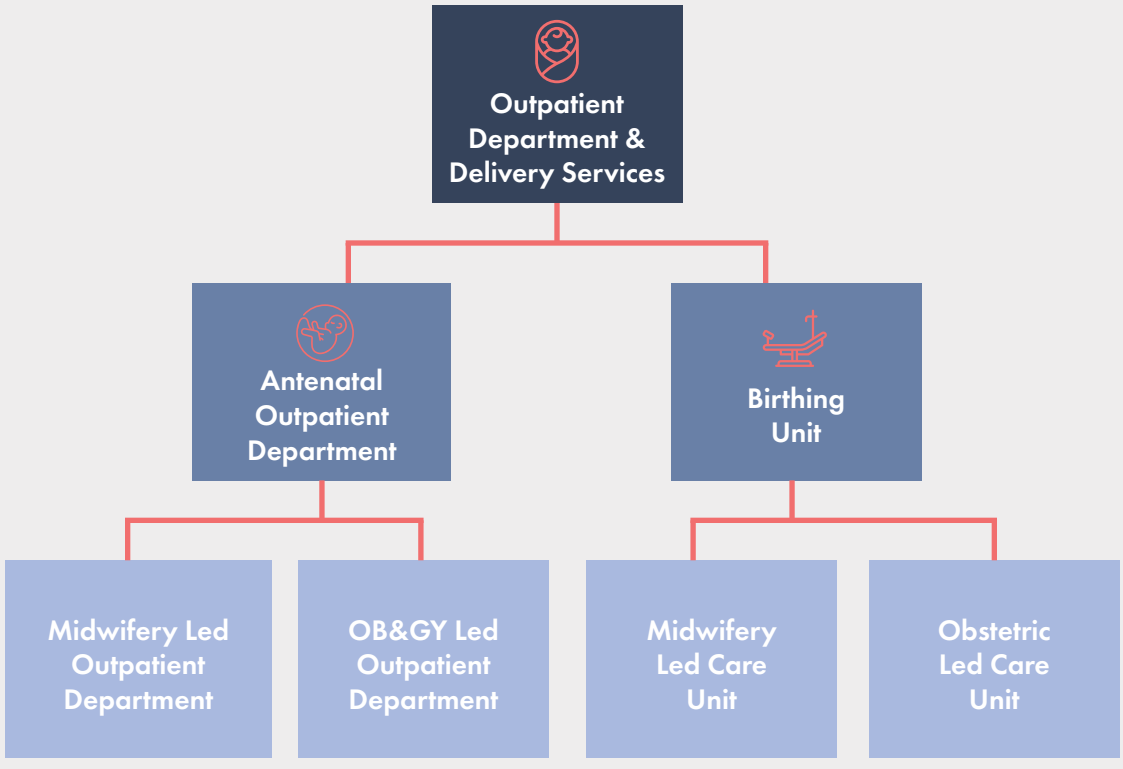
The Central Government also plays a key role in the nomination and appointment of members to the National Commission[178] and Autonomous Boards[179] and has the authority to remove members of the National Commission under certain circumstances.[180] Notably, the Central Government also has the ability to dissolve the National Commission and supersede its functions for up to six months if it believes that the Commission is unable to discharge the duties and functions or that the Commission is not complying with the Central's Governments directions in executing its mandate.[181] This undermines the autonomous nature of these bodies and could limit their independence. Notably, this is similar in nature to how the Indian Nursing Council and State Nursing Council functioned prior to the Midwifery Services Initiative, which created confusion about their respective mandates and overlaps in their areas of authority.[182]

177 The National Nursing and Midwifery Commission Act, 2023, §41 (India).
178 The National Nursing and Midwifery Commission Act, 2023, §4, 5 (India).
179 See The National Nursing and Midwifery Commission Act, 2023, § 12 (India).
180 The National Nursing and Midwifery Commission Act, 2023, §7 (India).
181 The National Nursing and Midwifery Commission Act, 2023, §50 (India). ("If, at any time, the Central Government is of the opinion that... the National Commission is unable to discharge the functions and duties imposed on it by or under the provisions of this Act... the Central Government may, by notification, supersede the National Commission for such period, not exceeding six months").
182 Kaveri Mayra, Sabu S. Padmadas, & Zoë Matthews, *Challenges and needed reforms in midwifery and nursing regulatory systems in India: Implications for education and practice,* 16 PLoS One e0251331 (2021), at 2, https://doi.org/10.1371/journal.pone.0251331 ("The Indian Nursing Council (INC) and State Nursing Councils (SNC) play key roles in the regulation of nursing and midwifery education in India. They oversee registration, licensing, inspection and examination. However, there is duplication of these roles at the national and state levels").

Autonomy/Scope of Practice

Although the Midwifery Services Initiative indicates that "the ultimate aim of regulation is to allow nurse midwives to practice autonomously and provide [the] full range of midwifery care efficiently,"[183] numerous policies undermine this aspect of the midwifery model of care. The initial introduction of NPMs has focused on improving care in the public sector through MLCUs and reducing high caseloads in public health facilities, which are predominantly tertiary-level facilities.[184] Essentially, for both antenatal care and the birthing unit, pregnant people will either receive care from the midwifery-led unit or the obstetrician-led unit (refer to the pucture below), although these two units should act in collaboration with one another as needed.[185] Over time, NPMs will be staffed in secondary and primary health care facilities and more remote and hard-to-reach locations.[186] To date, there are no guidelines on the provision of care outside of hospital settings, such as home births, independent birthing centers, or midwifery centers.

Framework for Antenatal and Delivery Services:



183 Ministry of Health and Family Welfare [India], *Guidelines on Midwifery Services in India* (2018), at 19, https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCHA/MH/Guidelines/Guidelines_on_Midwifery_Services_in_India.pdf.

184 Ministry of Health and Family Welfare [India], *Guidelines on Midwifery Services in India* (2018), at 9, 10, https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCHA/MH/Guidelines/Guidelines_on_Midwifery_Services_in_India.pdf; Interview with Geeta Chhibber, Senior Technical Advisor for Jhpiego, India Country Office (Dec. 13, 2024).

185 Ministry of Health and Family Welfare [India], *Guidelines on Midwifery Services in India* (2018), at 3, https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCHA/MH/Guidelines/Guidelines_on_Midwifery_Services_in_India.pdf

186 *See* Ministry of Health and Family Welfare [India], *Guidelines on Midwifery Services in India* (2018), at 15, https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCHA/MH/Guidelines/Guidelines_on_Midwifery_Services_in_India.pdf; Interview with Geeta Chhibber, Senior Technical Advisor for Jhpiego, India Country Office (Dec. 13, 2024).

UNDER THE MIDWIFERY SERVICES INITIATIVE, NURSE PRACTITIONER MIDWIVES WORK UNDER THE OVERSIGHT OF AN OBSTETRICIAN AND ONLY IN HOSPITAL SETTINGS.

Under this arrangement, MCLUs "operate under the overall supervision of a Medical Officer (MO)/ OB&GY Specialist."[187] However, there is no assurance that the supervising specialist will be trained to understand midwifery models of care or recognize their unique value during pregnancy and childbirth. This also reinforces the idea that midwives are not competent enough to autonomously provide care and that they must be supervised in administering care that is within their scope of practice. As noted in a recent study, this may be exacerbated by the fact that "Nurse Practitioners in Midwifery were originally nurses, who have traditionally always worked under the supervision of physicians,"[188] meaning that there may be an established power imbalance that needs to be addressed.[189] The same study recognizes the importance of NPMs being "recognized and authorized as an autonomous practitioner and allowed to provide normal birth care in their own right"[190] as being critical for reversing the overmedicalization of childbirth in India.

ELIGIBILITY FOR MIDWIFERY-LED CARE

The guidelines on operationalizing MLCUs adopt a risk-based model that delineates who can be cared for independently by a midwife and who should have more specialized care led by an obstetrician. As recognized in the midwifery services guidelines: "Only eligible women will have access to midwife-led care. Pregnant women identified with complications will be referred to a medical officer or specialists for further management."[191] Therefore, while "NPMs can also be *involved* in the care of women with high-risk pregnancies, pregnancy-related complications, and women/newborns as part of the multidisciplinary team… the overall accountability rests with the OB&GY/MOIC of the hospital/health center."[192] While the ultimate goal is a model of risk-based collaborative care and in practice, there may be deviations to balance caseloads across the two units (e.g., if one is overburdened), substantial aspects of this triage framework are not evidence-based. For example, under this directive, people who weigh over 70 kg, are less than 145 centimeters tall, under age 17, over age 40, or have had more than 5 births are excluded from midwifery-led care.[193] Furthermore, pregnant people with a previous history of prolonged labor, eclampsia, previous cesarean section, early neonatal death, or stillbirth, among other conditions, are excluded from midwifery-led care. This approach does not provide any nuance in examining

187 Ministry of Health and Family Welfare [India], *Guidelines on Midwifery Services in India* (2018), at 3, https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCHA/MH/Guidelines/Guidelines_on_Midwifery_Services_in_India.pdf ("The MLCUs will…operate under the overall supervision of Medical Officer (MO)/ OB&GY Specialist in the high caseload facilities with minimum 250 deliveries/month viz. Medical College Hospitals, District Hospitals, Sub District Hospitals, Community Health Centers/ CHC FRUs and equivalent facilities.").

188 Malin Bogren et al., *Contextual factors influencing the implementation of midwifery-led care units in India,* 36 Women and Birth e134 (2023), https://doi.org/10.1016/j.wombi.2022.05.006.

189 Malin Bogren et al., *Contextual factors influencing the implementation of midwifery-led care units in India,* 36 Women and Birth e134 (2023), https://doi.org/10.1016/j.wombi.2022.05.006.

190 Malin Bogren et al., *Contextual factors influencing the implementation of midwifery-led care units in India,* 36 Women and Birth e134 (2023), https://doi.org/10.1016/j.wombi.2022.05.006.

191 Ministry of Health and Family Welfare [India], *Guidelines on Midwifery Services in India* (2018), at 15, https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCHA/MH/Guidelines/Guidelines_on_Midwifery_Services_in_India.pdf

192 Ministry of Health and Family Welfare [India], *Guidelines on Midwifery Services in India* (2018), at 16, https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCHA/MH/Guidelines/Guidelines_on_Midwifery_Services_in_India.pdf (emphasis added).

193 Ministry of Health and Family Welfare [India], *Guidelines on Operationalization of Midwifery Units,* at 45, https://nhm.gov.in/images/pdf/programmes/maternal-health/guidelines/Operationalization-of-Midwifery-Units.pdf (accessed May 14, 2025).

the person's level of risk for the current pregnancy or considering any preventative measures that may have been taken. Such women may benefit when a midwife is included in the care provision team due to their rights-based and human-centered approach.

Additionally, many medical and antenatal problems may result from the exclusion of individuals from the MLCU, such as hypertension, diabetes, anemia, and hypo- or hyperthyroidism.[194] Such instances may benefit from collaborative care between midwives and obstetricians, as this would allow pregnant women to benefit from the midwifery model of care while also enabling NPMs to become more skilled in the identification, prevention, and management of complications. Indeed, MLCUs are designed to be co-located with Obstetric-led Care Units (OLCUs) to facilitate transfers between the two units as needed.[195] Further, particularly for pregnant people who received minimal or no prenatal care, individuals may have one or more of the outlined risk factors undetected at the time of triage. Finally, this framework does not afford pregnant people any agency in determining who will provide them with care during pregnancy, labor, and childbirth, as it does not consider the pregnant person's preferences about their maternity care.

SCOPE OF PRACTICE

The Midwifery Services Initiative and the creation of a cadre of NPMs in India mark the first time that an explicit scope of practice has been established for a specific type of healthcare worker in India, which is an incredibly notable development. As a result, there are efforts to better articulate the scope of practice for other health professionals.[196] The scope of practice clearly defines when midwives can act independently, when they should act collaboratively with a physician, and when they should refer the pregnant person to a higher level of care. It also provides significant authority to manage a range of maternal and newborn conditions either independently or in collaboration with other healthcare staff and defines prescriptive authority, recognizing their ability to prescribe a range of medications during pregnancy, delivery, and postpartum for women and newborns.[197]

However, notable discrepancies exist across guidelines related to NPMs' scope of practice. While the scope of practice guidelines for NPMs explicitly recognizes that they can administer a post-abortion intrauterine device,[198] the Reference Manual for IUCD Services specifies that after second-trimester abortions, only a trained medical doctor can do so.[199] Similarly, although the scope of practice guidelines for NPMs recognizes they can independently administer injectable

194 Ministry of Health and Family Welfare [India], *Guidelines on Operationalization of Midwifery Units*, at 45, https://nhm.gov.in/images/pdf/programmes/maternal-health/guidelines/Operationalization-of-Midwifery-Units.pdf (accessed May 14, 2025).

195 *Cf.* Ministry of Health and Family Welfare [India], *Scope of Practice for Midwifery Educator & Nurse Practitioner Midwife* (2021), at 5, https://nhm.gov.in/New_Updates_2018/Scope%20of%20Practice%20Document%20.pdf.

196 Interview with Geeta Chhibber, Senior Technical Advisor for Jhpiego, India Country Office (Dec. 13, 2024).

197 Ministry of Health and Family Welfare [India], *Scope of Practice for Midwifery Educator & Nurse Practitioner Midwife* (2021), at 10, https://nhm.gov.in/New_Updates_2018/Scope%20of%20Practice%20Document%20.pdf.

198 Ministry of Health and Family Welfare [India], *Scope of Practice for Midwifery Educator & Nurse Practitioner Midwife* (2021), at 15, https://nhm.gov.in/New_Updates_2018/Scope%20of%20Practice%20Document%20.pdf.

199 Ministry of Health and Family Welfare [India], *Guidelines on Midwifery Services in India* (2018), at 71, https://nhm.gov.in/New_Updates_2018/NHM_Components/RMNCHA/MH/Guidelines/Guidelines_on_Midwifery_Services_in_India.pdf ("It is reiterated that only doctors (MBBS and above) are allowed to insert PAIUCD after a second trimester abortion.")

contraceptives,[200] under the Reference Manual for Injectable Contraceptives, the first shot of the injection must be administered under the guidance of a trained doctor.[201]

Additionally, India's Medical Termination of Pregnancy (MTP) Act requires that abortions be performed by a "registered medical practitioner," which is defined as a doctor.[202] As a result, although midwives should be permitted to perform abortion care under international standards,[203] the scope of practice only recognizes their ability to provide options counseling and then "assist" a certified MTP provider with abortion care, including medical abortion, aspiration abortion, and treating an incomplete abortion.[204] Indeed, this requirement is a significant barrier to increasing access to safe and legal abortion services.[205]

Although the midwifery services guidelines recognize that NPMs can use ultrasound for fetal monitoring during the second stage of labor,[206] expanded use of ultrasound technology would enable midwives to better avert maternal mortality and morbidity. At a minimum, midwives should be able to use ultrasound to date a pregnancy, assess fetal size and amniotic fluid volume, determine fetal position, and check for placental position. Identifying complications early, such as a low-lying placenta, could avert morbidity and mortality by enabling referrals to a higher level of care.[207]

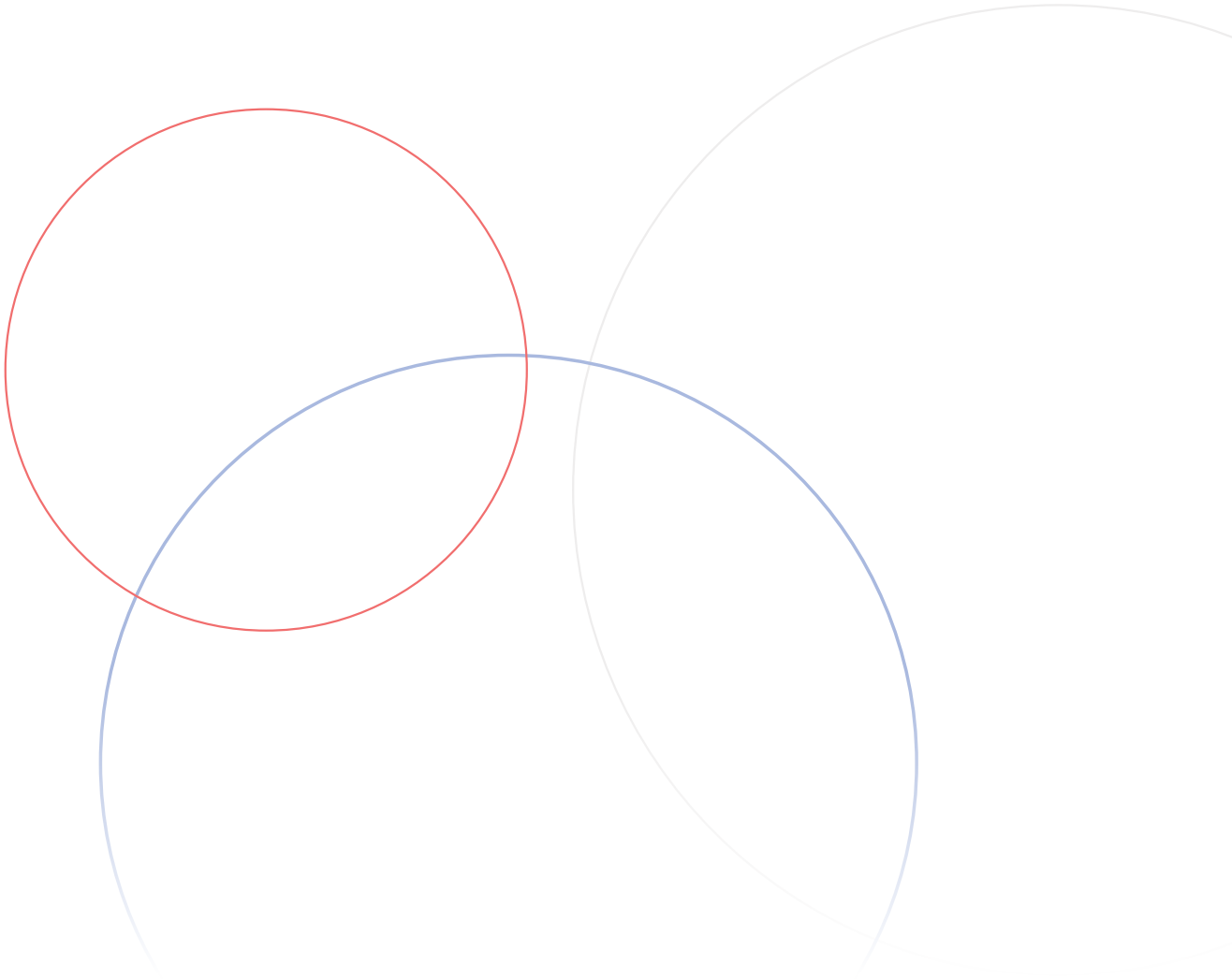
HIGHLIGHT: Alternative Birthing Positions

The Guidelines on the Operationalization of Midwifery Units recognize that "one of the essential components of respectful maternity care is [a] woman's freedom to choose birth positions of her choice."[208] The guidelines explicitly recognize that it is "important that any particular position is not forced on the woman and she is encouraged and supported to adopt any position that she finds most comfortable."[209] Notably, the guidelines provide extensive instructions on various birthing positions and how midwives should adapt their hand maneuvers depending on the birthing person's position.[210] They further recognize the importance of limiting interventions, such as intravenous fluids, that minimize physical mobility during labor and birth.[211]

200 Ministry of Health and Family Welfare [India], *Scope of Practice for Midwifery Educator & Nurse Practitioner Midwife* (2021), at 15, https://nhm.gov.in/New_Updates_2018/Scope%20of%20Practice%20Document%20.pdf.
201 Ministry of Health and Family Welfare [India], *Reference Manual for Injectable Contraceptive (DMPA)* (2016), at 37 (10.2.2), https://www.nhm.gov.in/images/pdf/programmes/family-planing/guidelines/Reference_Manual_Injectable_Contraceptives.pdf.
202 The Medical Termination of Pregnancy Act, 1971, §2(d) (India).
203 ICM, *Essential Competencies for Midwifery Practice* (2024), at 26-27, https://internationalmidwives.org/resources/essential-competencies-for-midwifery-practice/.
204 Ministry of Health and Family Welfare [India], *Guidelines on Operationalization of Midwifery Units*, at 62, https://nhm.gov.in/images/pdf/programmes/maternal-health/guidelines/Operationalization-of-Midwifery-Units.pdf (accessed May 14, 2025).
205 See Aparna Chandra et al., Legal Barriers to Accessing Safe Abortion Services in India: A Fact Finding Study, Center for Reproductive Rights (2021), at 104, https://reproductiverights.org/wp-content/uploads/2021/08/Legal-Barriers-to-Accessing-Safe-Abortion-Services-in-India_Final-for-upload.pdf.
206 Ministry of Health and Family Welfare [India], *Guidelines on Operationalization of Midwifery Units*, at 30, https://nhm.gov.in/images/pdf/programmes/maternal-health/guidelines/Operationalization-of-Midwifery-Units.pdf (accessed May 14, 2025).
207 ICM, *Essential Competencies for Midwifery Practice* (2024), at 26, 29, https://internationalmidwives.org/resources/essential-competencies-for-midwifery-practice/.
208 Ministry of Health and Family Welfare [India], *Guidelines on Operationalization of Midwifery Units*, at 24, https://nhm.gov.in/images/pdf/programmes/maternal-health/guidelines/Operationalization-of-Midwifery-Units.pdf (accessed May 14, 2025).
209 Ministry of Health and Family Welfare [India], *Guidelines on Operationalization of Midwifery Units*, at 24, https://nhm.gov.in/images/pdf/programmes/maternal-health/guidelines/Operationalization-of-Midwifery-Units.pdf (accessed May 14, 2025).
210 Ministry of Health and Family Welfare [India], *Guidelines on Operationalization of Midwifery Units*, at 26, https://nhm.gov.in/images/pdf/programmes/maternal-health/guidelines/Operationalization-of-Midwifery-Units.pdf (accessed May 14, 2025).
211 Ministry of Health and Family Welfare [India], *Guidelines on Operationalization of Midwifery Units*, at 30, https://nhm.gov.in/images/pdf/programmes/maternal-health/guidelines/Operationalization-of-Midwifery-Units.pdf (accessed May 14, 2025).

Conclusion

The Midwifery Services Initiative and the creation of a cadre of NPMs are promising developments towards the introduction, improvement, and expansion of midwifery models of care throughout India. Yet, there are areas where the legal and regulatory frameworks could be further strengthened, such as reforms to ensure that NPMs are adequately represented within the National Nursing and Midwifery Commission, expanding their autonomy and scope of practice, and ensuring an evidence-based approach to determining who could benefit from the midwifery-led care units. Further, as the cadre of NPMs is expanded, there will be important opportunities to expand their placement beyond hospitals and in primary health care centers, particularly in areas that are facing the greatest need. Such measures will enhance NPM's ability to provide quality, comprehensive care and ultimately improve maternal and newborn health outcomes and the overall experience of care for women and families throughout India.



KENYA

Regulating Midwifery: The Legal & Policy Framework of Kenya

SNAPSHOT OF MIDWIFERY IN KENYA

- **Types of midwives:** There are various recognized types of midwives and nurses with midwifery training, each with a different title and scope of practice determined by their level of education. TBAs are not recognized as midwives.
- **Routes of entry:** There are multiple routes to becoming a midwife, including direct-entry midwifery programs, post-nursing qualifications, and community or general nursing degrees that incorporate substantial midwifery training. Each pathway results in a different credential and scope of practice.
- **Key challenges:**
  - » Midwifery remains both marginalized and conflated with nursing within the Nursing Council, which is the primary regulatory body.
  - » While multiple categories of midwives are formally recognized, each with distinct scopes of practice tied to their educational background, healthcare facilities do not reflect these differences in practice. This lack of differentiation—paired with the wide range of qualifications—creates confusion about midwives' competencies among patients, healthcare teams, and human resource departments.
  - » Although midwives can theoretically obtain a license to operate a private practice under the Nurses and Midwives Act, they are required to register the facility under the name of a physician, preventing them from operating independently.
  - » Registered midwives face varying restrictions in the scope of their practice depending on the level of the healthcare facility, particularly regarding prescribing medications.

Background

After years of stagnation, Kenya has recently made significant progress in reducing its maternal mortality rate (MMR). In 2023, the MMR was 149 maternal deaths per 100,000 live births,[212] marking a notable reduction from previous years.[213] However, this figure remains more than double the Sustainable Development Goal (SDG) target of fewer than 70 maternal deaths per 100,000 live births and places Kenya as having the 50th highest MMR globally.[214] Despite improvements in the global ranking, maternal health challenges persist, including stark regional disparities. County-specific MMRs vary widely, from as low as 67 (Nyeri County) to as high as 614 (Garissa County).[215]

A critical bottleneck is the shortage of skilled birth attendants. Midwifery plays a crucial role in Kenya's healthcare system, where nurses and midwives constitute approximately 70% of the country's health workforce and influence around 80% of health indicators.[216] Yet their numbers remain insufficient: As of 2023, there were 227.3 nurses and midwives per 100,000 people, well below the WHO-recommended minimum of 356 nurses and midwives per 100,000 people and ranking Kenya 72nd for countries with the lowest healthcare workforce density globally.[217] This shortage is compounded by significant disparities in workforce distribution: urban areas like Nairobi have 97 midwives per 100,000 people, while rural counties such as Wajir have as few as 2 per 100,000.[218] These inequities are further exacerbated by systemic issues in accessibility and inadequate infrastructure of maternal health services.[219]

Despite the importance of midwifery, the profession faces significant challenges, such as the lack of recognition of its autonomy and distinct scope of practice (see Sections III and V below). In 2022, the Ministry of Health introduced the first National Nursing and Midwifery Policy, which focuses on enhancing education, workforce management, and professional development through increased investments, better remuneration, and improved healthcare delivery systems.[220] The policy specifically addresses the need for improvements to the midwifery workforce in several areas, which is important in recognizing nursing and midwifery as distinct professions.[221] Further

212 World Health Organization (WHO), *Maternal mortality ratio (per 100 000 live births)*, https://data.who.int/indicators/i/AC597B1 (accessed Apr. 22, 2025).
213 In 2010 the MMR was 210 maternal deaths per 100,000 live births. In 2020, the MMR was 184 maternal deaths per 100,000 live births, see WHO, *Maternal mortality ratio (per 100 000 live births)*, https://data.who.int/indicators/i/AC597B1 (accessed Apr. 22, 2025).
214 WHO, *Maternal mortality ratio (per 100 000 live births)*, https://data.who.int/indicators/i/AC597B1 (accessed Apr. 22, 2025).
215 Hellen M. Mwaura, Timothy K. Kamanu, & Benard W. Kulohoma, *Sub-National Disparities in Indicators of Maternal Mortality in Kenya: Insights from Demographic Health Surveys Towards Attaining SDG 3*, 7 J Women's Health Dev 29 (2024), https://www.doi.org/10.26502/fjwhd.2644-288400118.
216 Ministry of Health [Kenya], *National Nursing and Midwifery Policy 2022-2032* (2022), at 1, http://guidelines.health.go.ke:8000/media/National_Nursing_and_Midwifery_Policy_2022_-_2032.pdf.
217 WHO, *Nursing and midwifery personnel (per 10 000 population)*, https://www.who.int/data/gho/data/indicators/indicator-details/GHO/nursing-and-midwifery-personnel-(per-10-000-population) (accessed Apr. 22, 2025).
218 Ministry of Health [Kenya], *National Nursing and Midwifery Policy 2022-2032* (2022), at 6, http://guidelines.health.go.ke:8000/media/National_Nursing_and_Midwifery_Policy_2022_-_2032.pdf.
219 Ministry of Health [Kenya], *National Nursing and Midwifery Policy 2022-2032* (2022), at 2, http://guidelines.health.go.ke:8000/media/National_Nursing_and_Midwifery_Policy_2022_-_2032.pdf; Stacey Orangi et al., *Impact of free maternity policies in Kenya: an interrupted time-series analysis*, 6 BMJ Glob Health 6 (2021), https://doi.org/10.1136/bmjgh-2020-003649.
220 Ministry of Health [Kenya], *National Nursing and Midwifery Policy 2022-2032* (2022), http://guidelines.health.go.ke:8000/media/National_Nursing_and_Midwifery_Policy_2022_-_2032.pdf.
221 Ministry of Health [Kenya], *National Nursing and Midwifery Policy 2022-2032* (2022), http://guidelines.health.go.ke:8000/media/National_Nursing_and_Midwifery_Policy_2022_-_2032.pdf.

recent developments include the launch of a specialized Bachelor of Science in Midwifery program in 2018 with a broader scope of practice (see Sections III and V.2. below). Additionally, the Midwifery Association of Kenya, recently established in 2016,[222] serves as a key platform for advocating for a stronger and more autonomous midwifery profession.[223]

Recognition and Regulation

A. WHO IS FORMALLY RECOGNIZED AS A MIDWIFE?

The Nurses and Midwives Act (1983, revised 2022) defines a "midwife" as:

> **a person who has successfully completed midwifery education programme based on the essential competences for basic midwifery practice according to global standards of midwifery education and is recognized and licensed in the country of origin.[224]**

However, Kenya does not have a sole category of midwives with a unified title and scope of practice. Rather, there are various recognized types of midwives and nurses with midwifery training, each with a different title and scope of practice determined by their level of education (see Sections III and V.2. below).

As Kenya's regulatory framework requires formal education and licensure to use the title of midwife,[225] this excludes traditional birth attendants (TBAs) from formal recognition. TBAs are still active throughout the country and assist at least 6% of births.[226] The formal healthcare sector discourages reliance on TBAs due to concerns over unsafe practices, and there are no pathways for TBAs to become licensed midwives or other recognized health personnel without formal education.[227] One government initiative seeks to transition TBAs into the role of Community Health Promoters (CHPs).[228] Leveraging the trust TBAs hold within their communities, CHPs are intended to refer pregnant individuals to healthcare facilities for childbirth.[229] However, the policy requires CHPs to be literate,[230] which excludes many TBAs from qualifying for this role. In some counties, NGOs incentivize TBAs with small stipends or other commodities to encourage

222 Amos Getanda, *Re-Orienting the Midwifery Profession in Kenya, in* 1 Contemporary Issues for Midwifery in Kenya 1, 9 (Numid, 2017), https://www.researchgate.net/publication/348778811_Re-Orienting_the_Midwifery_Profession_in_Kenya.
223 Midwives Association of Kenya, *About MAK*, https://www.midwiveskenya.org/about (accessed Apr. 22, 2025).
224 Nurses and Midwives Act (1983, rev. 2022), S. 2 [Kenya].
225 Nurses and Midwives Act (1983, rev. 2022), S. 19 (1) [Kenya].
226 Kenya National Bureau of Statistics, *Kenya Demographic and Health Survey 2022* (2023), https://www.knbs.or.ke/wp-content/uploads/2023/08/Kenya-Demographic-and-Health-Survey-2022-Main-Report-Volume-1.pdf.
227 *Cf.* Nurses and Midwives Act (1983, rev. 2022), S. 13 [Kenya]; Ministry of Health [Kenya], *National Nursing and Midwifery Policy 2022-2032* (2022), http://guidelines.health.go.ke:8000/media/National_Nursing_and_Midwifery_Policy_2022_-_2032.pdf; Interview with Eunice Atsali, National Secretary, Midwives Association of Kenya (Dec. 5, 2024).
228 Interview with Eunice Atsali, National Secretary, Midwives Association of Kenya (Dec. 5, 2024).
229 Peter Muiruri, *'Agents of change': Kenya's traditional midwives help cut deaths of mothers*, The Guardian, Aug. 23, 2023, https://www.theguardian.com/global-development/2023/aug/23/agents-of-change-kenyas-traditional-midwives-help-cut-deaths-of-mothers?CMP=share_btn_url, Esther L. Anono et al., *Community perceptions towards the new role of traditional birth attendants as birth companions and nutrition advocates in Kakamega County, Kenya*, 14 Mat Child Nutr e12578 (2018), https://doi.org/10.1111/mcn.12578.
230 Primary Health Care Act (2023), S. 9(2)(f) [Kenya].

them to bring birthing people to formal healthcare facilities.[231] Other efforts have involved training TBAs in basic sanitation and safety practices, but these trainings do not lead to any formal titles or certifications.[232] As a result, TBA practices remain not formally recognized and integrated into the healthcare system, though prosecution is uncommon in Kenya.[233]

B. REGULATORY BODY

The Nurses and Midwives Act of 1983 establishes the Nursing Council of Kenya, which oversees both nursing and midwifery by establishing and improving standards, developing and overseeing training and education, conducting registration and enrollment examinations, maintaining registers and rolls, and regulating professional conduct.[234] Despite its mandate covering both professions, midwifery remains simultaneously marginalized and conflated with nursing within the Council. This marginalization can be clearly seen with the Council's title as the "Nursing Council" rather than the "Nursing and Midwifery Council," and extends further beyond that.

One key issue is representation: the Council consists of eight board members, only one of whom is a midwife, while the rest are nurses.[235] This imbalance, coupled with the conflation of nursing and midwifery throughout the Act and the Council's regulations,[236] has significant consequences for midwifery practice in Kenya. One major effect is that the curricula for midwifery education programs often closely mirror those of nursing, reflecting the priorities of the nursing-focused Council members.[237] Throughout the Nurses and Midwives Act and the Council's regulations, midwifery is frequently depicted as an "extra" specialization within nursing, rather than as an independent and autonomous profession.[238] This perception contributes to a lack of recognition for midwifery as a distinct discipline, creating confusion about midwives' autonomy, roles, and scope of practice within the healthcare system[239] affecting both healthcare providers and patients (see Sections III and V below).

Routes of Entry

Historically, midwifery was only offered as a specialization pursued after completing a nursing program in Kenya.[240] As a result, midwifery is often still perceived as a subset of nursing,[241] even though there are now several specific midwifery programs offered both as direct-entry and post-

231 John Emmanuel Kitui et al., *Traditional Birth Attendant reorientation and Motherpacks incentive's effect on health facility delivery uptake in Narok County, Kenya: An impact analysis,* 17 BMC Pregnancy Childbirth 125 (2017), https://doi.org/10.1186/s12884-017-1307-7; Angelo Tomedi, Katherine Tucker, Mutuku A. Mwanthi, *A strategy to increase the number of deliveries with skilled birth attendants in Kenya,* 120 Int J Gynaecol Obstet 152 (2013), https://doi.org/10.1016/j.ijgo.2012.09.013.

232 Interview with Eunice Atsali, National Secretary, Midwives Association of Kenya (Dec. 5, 2024).

233 Interview with Eunice Atsali, National Secretary, Midwives Association of Kenya (Dec. 5, 2024).

234 Nurses and Midwives Act (1983, rev. 2022), S. 9 (1) [Kenya].

235 Nurses and Midwives Act (1983, rev. 2022), S. 4 [Kenya]; Interview with Eunice Atsali, National Secretary, Midwives Association of Kenya (Dec. 5, 2024) (regarding the current composition).

236 *See, e.g.,* Nurses and Midwives Act (1983, rev. 2022), S. 18A, 18B [Kenya] (only referring to "nurse" while meaning nurse or midwife).

237 Interview with Eunice Atsali, National Secretary, Midwives Association of Kenya (Dec. 5, 2024).

238 Interview with Eunice Atsali, National Secretary, Midwives Association of Kenya (Dec. 5, 2024).

239 Interview with Eunice Atsali, National Secretary, Midwives Association of Kenya (Dec. 5, 2024).

240 Amos Getanda, *Re-Orienting the Midwifery Profession in Kenya, in* 1 Contemporary Issues for Midwifery in Kenya 1, 2 (Numid, 2017), https://www.researchgate.net/publication/348778811_Re-Orienting_the_Midwifery_Profession_in_Kenya.

241 Amos Getanda, *Re-Orienting the Midwifery Profession in Kenya, in* 1 Contemporary Issues for Midwifery in Kenya 1, 2 (Numid, 2017), https://www.researchgate.net/publication/348778811_Re-Orienting_the_Midwifery_Profession_in_Kenya.

registration pathways.[242] The midwifery programs approved by the Nursing Council and their corresponding professional titles are as follows:[243]

- **Registered Midwife (KRM):** 3-year basic program in midwifery at the **diploma** level, either as a direct entry program or post-enrollment with 2 years of experience.[244]
- **Registered Midwife at Degree Level (BScM):** Program in nursing, midwifery, reproductive, community, and public health at the **degree** level, either as a 2.5-year post-registration program with 2 years of experience,[245] or as a 3-year direct entry program with higher secondary education requirements.[246]
- **Registered Nurse-Midwife (KRN/M):** 3-year basic program in nursing and midwifery at the **diploma** level.[247]

There are also nursing programs with substantial midwifery training components:[248]

- **Registered Community Health Nurse (KRCHN):** 3-year basic program or 2-year post-enrollment program in nursing, midwifery, psychiatry, and community health programs at the **diploma** level.[249]
- **Registered Nurse at Degree Level (BScN):** Program in nursing, midwifery, psychiatry, and community health at **degree** level, either as a 2.5-year post-registration program with 2 years of experience,[250] or as a 3-year direct entry program with higher secondary education requirements.[251]

Although some universities additionally offer master's and doctoral degrees,[252] these advanced qualifications do not extend the title or scope of practice beyond that of registered midwives with

242 Nursing Council of Kenya, *Scope of Practice for Entry-Level Programmes* (2020), at 2, https://nckenya.com/wp-content/uploads/2020/08/Scope_of-Practice_For_Entry_Level_Programmes_17.08.2020.pdf.

243 Previously, Kenya offered a 2.5-year certificate-level midwifery program that qualified graduates as Enrolled Midwives. While this program conferred the title of midwife, it did not classify graduates as "skilled healthcare professionals" under Kenyan law, limiting their scope of practice. This program has been discontinued for decades and the remaining Enrolled Midwives are nearing retirement. Interview with Eunice Atsali, National Secretary, Midwives Association of Kenya (Dec. 5, 2024).

244 Nursing Council of Kenya, Student Indexing, https://nckenya.com/indexing/ (accessed Apr. 22, 2025); Nursing Council of Kenya, *Scope of Practice for Entry-Level Programmes* (2020), at 2, https://nckenya.com/wp-content/uploads/2020/08/Scope_of-Practice_For_Entry_Level_Programmes_17.08.2020.pdf.

245 *See, e.g.*, The Aga Khan University, *Frequently Asked Questions*, https://www.aku.edu/admissions/Pages/faqs-sonam-ke.aspx (accessed Apr. 22, 2025).

246 *See, e.g.*, Meru University of Science and Technology, *Bachelor of Science in Midwifery*, https://son.must.ac.ke/bachelor-of-science-in-midwifery/ (accessed Apr. 22, 2025).

247 *See e.g.*, Kenya Medical Training College, *Programmes & Courses* (2020), https://kmtc.ac.ke/wp-content/uploads/2020/02/KMTC-Programmes-Courses-Feb-2020.pdf.

248 The content in these curricula is normally named as Midwifery 1, 2, and 3 and covers the essential competencies of midwifery, but has a shorter duration compared to the full midwifery programs listed above.

249 *See e.g.*, Kenya Medical Training College, *Programmes & Courses* (2020), https://kmtc.ac.ke/wp-content/uploads/2020/02/KMTC-Programmes-Courses-Feb-2020.pdf.

250 *See, e.g.*, The Aga Khan University, *Frequently Asked Questions*, https://www.aku.edu/admissions/Pages/faqs-sonam-ke.aspx (accessed Apr. 22, 2025).

251 *See, e.g.*, Kenya Methodist University, *Bachelor of Science in Nursing*, https://www.kemu.ac.ke/wp-content/uploads/assets/brochures/school%20of%20medicine%20and%20health%20sciences/degree/Bachelor%20of%20Science%20in%20Nursing.pdf (accessed Apr. 22, 2025).

252 Nursing Council of Kenya, *Scope of Practice for Entry-Level Programmes* (2020), https://nckenya.com/wp-content/uploads/2020/08/Scope_of-Practice_For_Entry_Level_Programmes_17.08.2020.pdf. *See, e.g.*, The Aga Khan University, *Frequently Asked Questions*, https://www.aku.edu/admissions/Pages/faqs-sonam-ke.aspx (accessed Apr. 22, 2025).

a bachelor's degree (BScM).[253] As a result, graduate- and PhD-qualified nurses and midwives often transition into management and education roles due to limited opportunities for advancement in clinical practice.[254]

The Ministry of Health's National Nursing and Midwifery Policy also highlights that there is a significant shortage of midwifery training institutions,[255] with currently only three schools offering the KRM program,[256] another three offering the upgraded BScM degree,[257] and ten offering the combined KRNM program.[258] Further, the Nursing Council's licensing process lacks standardized minimum entry grades and training hours for foreign-trained nurses, allowing some underqualified practitioners to enter the workforce.[259]

HIGHLIGHT: Workforce Composition and Blurred Roles

According to a local midwifery expert, only KRM, BScM, and KRN/M qualifications technically qualify individuals as "midwives."[260] However, KRCHN and BScN professionals, with their significant midwifery training, are authorized to perform several midwifery tasks[261] and often function as midwives in practice.[262] The workforce composition reflects this overlap: KRCHN professionals form the majority of the midwifery workforce, followed by BScN, KRM, KRN/M, and finally BScM professionals.[263]

Importantly, healthcare facilities do not distinguish between these different titles and qualifications in practice. Instead, all nurses and midwives are hired as "Nursing Officers,"[264] with their salaries varying based on education and years of experience. This lack of differentiation, combined with the variety of qualifications, leads to confusion at multiple levels:

253 *Cf.* Nursing Council of Kenya, *Scope of Practice for Entry-Level Programmes* (2020), https://nckenya.com/wp-content/uploads/2020/08/Scope_of-Practice_For_Entry_Level_Programmes_17.08.2020.pdf.

254 Eunice Ndirangu-Mugo et al., *Scopes of practice for advanced practice nursing and advanced practice midwifery in Kenya: A gap analysis*, 71 Int Nursing Rev 276 (2024), https://doi.org/10.1111/inr.12947.

255 Ministry of Health [Kenya], *National Nursing and Midwifery Policy 2022-2032* (2022), at 5, http://guidelines.health.go.ke:8000/media/National_Nursing_and_Midwifery_Policy_2022_-_2032.pdf. Currently, only three universities offer KRM, another three offer the upgraded BScM program, and ten universities offer KRNM.

256 Catherine McAuley Nursing School, Pumwani Maternity College of Nursing and Midwifery, Nairobi KMTC.

257 Aga Khan University, AMREF University, Masinde Muliro University.

258 E-mail Eunice Atsali, National Secretary, Midwives Association of Kenya to Lilian Winter, Global Legal Fellow, Center for Reproductive Rights (Jan. 26, 2025) (on file with author).

259 Ministry of Health [Kenya], *National Nursing and Midwifery Policy 2022-2032* (2022), at 5, http://guidelines.health.go.ke:8000/media/National_Nursing_and_Midwifery_Policy_2022_-_2032.pdf.

260 Interview with Eunice Atsali, National Secretary, Midwives Association of Kenya (Dec. 5, 2024).

261 *Cf.* Nursing Council of Kenya, *Scope of Practice for Entry-Level Programmes* (2020), https://nckenya.com/wp-content/uploads/2020/08/Scope_of-Practice_For_Entry_Level_Programmes_17.08.2020.pdf. For an overview of courses for the Bachelor of Science in Nursing, *See, e.g.* Kenya Methodist University, *Bachelor of Science in Nursing*, https://www.kemu.ac.ke/wp-content/uploads/assets/brochures/school%20of%20medicine%20and%20health%20sciences/degree/Bachelor%20of%20Science%20in%20Nursing.pdf (accessed Apr. 22, 2025).

262 Interview with Eunice Atsali, National Secretary, Midwives Association of Kenya (Dec. 5, 2024).

263 According to data from the Nursing Council of Kenya, the registered (not active) midwifery workforce currently consists of: 95,374 KRCHN Basic and 1,115 KRCHN Post-Basic; 11,243 BScN; 5,587 KRM (note that this number does not distinguish between basic and post-basic, meaning it may include many post-nursing graduates, which would make them KRNM); 630 KRNM Basic; and 75 BScM. Information obtained from the Nursing Council of Kenya through e-mail correspondence with Eunice Atsali, National Secretary, Midwives Association of Kenya to Katy Mayall, Director of Strategic Initiatives, Center for Reproductive Rights (Jan 21, 2025) (on file with author).

264 Public Service commission [Kenya], *Revised Scheme of Service for Nursing Personnel* (2014), https://knun.or.ke/echoopsy/2020/09/scheme-of-service-for-nursing-personnel.pdf.

1. **Patient Understanding:** Patients often struggle to understand the distinctions among different providers and their scopes of practice.[265]
2. **Healthcare Team Dynamics:** Other healthcare workers, particularly physicians, may not fully recognize midwives' distinct qualifications and independent scope of practice, perceiving them all to be nurses.[266]
3. **Human Resource Management:** At the county level, staffing needs are usually framed generically by requiring nurses and not specifying midwives.[267] This leads administrators to favor hiring broadly qualified nurses over specialized midwives, who are both more narrowly focused and more expensive to employ (if they pursued a post-nursing degree or a BScM).[268]

Licensure/Certification and Registration

To practice as a midwife, registration and licensure with the Nursing Council are required,[269] with the Registrar maintaining separate records for nurses, midwives, and community health nurses.[270] After completing the education requirements, applicants must pass a national licensure exam, demonstrate good character, and pay a registration fee to receive a practice license and registration certificate.[271] A license is valid for two years and is renewed biannually with a fee.[272] Although Continuing Professional Development (CPD) is not mandatory, the Nursing and Midwives Act implies a duty to maintain skills, and disregarding Council standards or offering opinions without sufficient information is considered professional misconduct.[273]

Under the Nurses and Midwives Act, it is an offense for individuals who are not eligible for registration, enrollment, or licensing to use "any title appropriate to a person so registered, enrolled or licensed" or to otherwise misrepresent themselves as such.[274] Additionally, it is an offense for those who are ineligible for registration, enrollment, or licensure to practice as nurses or midwives.[275] Violations may result in fines, imprisonment, or both.[276] This implies that TBAs,[277]

265 Interview with Eunice Atsali, National Secretary, Midwives Association of Kenya (Dec. 5, 2024).
266 Interview with Eunice Atsali, National Secretary, Midwives Association of Kenya (Dec. 5, 2024).
267 Interview with Eunice Atsali, National Secretary, Midwives Association of Kenya (Dec. 5, 2024).
268 *Cf.* Public Service commission [Kenya], *Revised Scheme of Service for Nursing Personnel* (2014), https://knun.or.ke/echoopsy/2020/09/scheme-of-service-for-nursing-personnel.pdf; Interview with Eunice Atsali, National Secretary, Midwives Association of Kenya (Dec. 5, 2024).
269 Nurses and Midwives Act (1983, rev. 2022), S. 19, 12, 14 [Kenya]. For "enrolled midwives," enrollment (which is distinct from registration) was required, see Nurses and Midwives Act (1983, rev. 2022), S. 13, 15 [Kenya].
270 Nurses and Midwives Act (1983, rev. 2022), S. 14, 16 [Kenya].
271 Nurses and Midwives Act (1983, rev. 2022), S. 13, 15 [Kenya]. Nurses and Midwives Act - Nurses (Licensing) Regulations (1985, rev. 2022), S. 2 [Kenya]; Nursing Council of Kenya, *Registration and Licensing*, https://nckenya.com/registration/ (accessed Apr. 22, 2025).
272 Nurses and Midwives Act - Nurses (Licensing) Regulations (1985 rev. 2022), S. 6 [Kenya].
273 Nurses and Midwives Act - Nurses (Licensing) Regulations (1985 rev. 2022), S. 18 [Kenya].
274 Nurses and Midwives Act (1983, rev. 2022), S. 19 (1) [Kenya].
275 There are two exceptions to this provision: (1) where specifically authorized by a Cabinet Secretary regulation for that region, or (2) if they are serving the government or an approved institution under the supervision of a medical practitioner or a registered, enrolled, or licensed nurse or midwife.
276 Nurses and Midwives Act (1983, rev. 2022), S. 19 [Kenya].
277 TBAs are not mentioned in the Nurses and Midwives Act or the Nursing Policy, and the Ministry of Health has explicitly stated that they are not recognized as "providers of skilled care", *see* Ministry of Health [Kenya], *National Reproductive Health Policy: Enhancing Reproductive Health for all Kenyans* (2007), at 10, 12, https://healtheducationresources.unesco.org/sites/default/files/resources/kenya_National_Reproductive_Health_Policy_booklet_2007.pdf.

who assist with a significant number of childbirths in Kenya,[278] could theoretically be criminalized if they practice midwifery without the supervision of a licensed medical professional or if they misrepresent themselves as nurses or midwives. However, according to a local midwifery expert, while the government discourages reliance on TBAs, prosecution is not common in Kenya.[279]

In addition to the general practicing license, which permits midwives to work in health institutions within their licensed title and scope of practice, midwives can apply for a license to operate a private practice. This requires meeting the criteria outlined in Section 17 of the Nurses and Midwives Act, including holding a valid practice license and having at least three years of post-qualification experience.[280]

Autonomy and Authority (Scope of Practice)

A. AUTONOMY

The Nursing Council states that "Nursing/Midwifery is an autonomous and self-regulating profession."[281] Nurses and midwives are tasked with assessing, diagnosing, treating, and managing both acute and chronic illnesses and addressing clients' health needs across the health continuum, including promotive, curative, preventive, rehabilitative, and palliative care.[282] The Council further recognizes that "Nursing/Midwifery practice is based on the application of appropriate nursing care models/frameworks in the provision of patient/client care," emphasizing that nurses and midwives should "function as members of the multidisciplinary healthcare team to protect the interests and rights of the client/patient."[283]

While these principles align to some extent with the midwifery models of care to some extent, they continue to conflate nursing and midwifery. Additionally, while acknowledging the vital role nurses and midwives play in Kenya, such as delivering most healthcare services,[284] the regulatory framework does not explicitly stipulate that midwives should operate autonomously and independently as primary care providers throughout the childbearing continuum. As explained by a local midwifery expert and representative from the Midwifery Association, while midwives can theoretically obtain a license to operate a private practice under the Nurses and Midwives Act, in practice, they are required to register the facility under the name of a physician, preventing them from operating independently.[285].

278 According to the Kenya Demographic and Health Survey from 2022, 6% of births were attended by TBAs. Kenya National Bureau of Statistics, *Kenya Demographic and Health Survey 2022* (2023), at p. 251, https://www.knbs.or.ke/wp-content/uploads/2023/08/Kenya-Demographic-and-Health-Survey-2022-Main-Report-Volume-1.pdf.

279 Interview with Eunice Atsali, National Secretary, Midwives Association of Kenya (Dec. 5, 2024).

280 Nurses and Midwives Act (1983, rev. 2022), S. 17(1), (2) [Kenya].

281 Nursing Council of Kenya, *Scope of Practice for Entry Level Nurses and Midwives in Kenya* (2020), at 10, https://nckenya.com/wp-content/uploads/2020/08/Scope_of-Practice_For_Entry_Level_Programmes_17.08.2020.pdf.

282 Nursing Council of Kenya, *Scope of Practice for Entry Level Nurses and Midwives in Kenya* (2020), at 10f, https://nckenya.com/wp-content/uploads/2020/08/Scope_of-Practice_For_Entry_Level_Programmes_17.08.2020.pdf.

283 Nursing Council of Kenya, *Scope of Practice for Entry Level Nurses and Midwives in Kenya* (2020), at 11, https://nckenya.com/wp-content/uploads/2020/08/Scope_of-Practice_For_Entry_Level_Programmes_17.08.2020.pdf.

284 Nursing Council of Kenya, *Overview*, https://nckenya.com/company-overview/ (accessed Apr. 22, 2025).

285 While not explicitly required by law, this is standard practice and expected of midwives, according to a local expert, Interview with Eunice Atsali, National Secretary, Midwives Association of Kenya (Dec. 5, 2024).

B. SCOPE OF PRACTICE

The Nursing and Midwifery Policy (2022) defines "midwifery practice" as:

> **"involving giving women the necessary support, care and advice during pregnancy, labour, and the postpartum period, conducting births on the midwife's own responsibility, and providing care for the newborn based on prescribed guidelines and standards. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and newborn, the accessing of medical care or other appropriate assistance, the carrying out of emergency measures, health promotion, disease prevention, and individualized wellness education and counselling on women's health, sexual or reproductive health and childcare. A midwife may practice in any setting including the home, community, hospitals, health centres, dispensaries, or clinics."[286]**

Registered midwives (KRM, KRN/M, BScM)[287] and registered nurses with significant midwifery training (KRCHN, BScN) are authorized to independently provide various services, including antenatal care, several procedures during labor and delivery, management of basic obstetric emergencies such as hemorrhage and uncomplicated breech and twin deliveries, and family planning services such as administering hormonal implants and IUCDs.[288]

Yet, registered midwives face varying restrictions depending on the level of the healthcare facility,[289] particularly regarding prescribing medications. The official scope of practice specifies that prescribing authority is subject to varying levels of physician oversight, categorized as "restricted," "reduced restrictions," or "full practice autonomy," conditional on the context and institutional guidelines.[290] At lower healthcare facilities—including health centers, maternity centers, nursing homes (level 3), dispensaries and clinics (level 2), and community service centers (level 1)—midwives are explicitly authorized to prescribe and administer medications independently.[291] However, in higher-level facilities such as hospitals, institutional guidelines typically reserve prescribing authority for physicians.[292] This creates inconsistencies in the scope of midwifery autonomy based on facility level.

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286 Ministry of Health [Kenya], *National Nursing and Midwifery Policy 2022-2032* (2022), at p. x, http://guidelines.health.go.ke:8000/media/National_Nursing_and_Midwifery_Policy_2022_-_2032.pdf.

287 Enrolled Midwives' scope of practice is more heavily restricted, as they are not recognized as skilled healthcare providers, but this program is no longer offered as a route of entry into midwifery, *see* Nursing Council of Kenya, *Scope of Practice for Entry Level Nurses and Midwives* (2020), Annex 2, https://nckenya.com/wp-content/uploads/2020/08/Scope_of-Practice_For_Entry_Level_Programmes_17.08.2020.pdf.

288 Nursing Council of Kenya, *Scope of Practice for Entry Level Nurses and Midwives* (2020), Annex 2, https://nckenya.com/wp-content/uploads/2020/08/Scope_of-Practice_For_Entry_Level_Programmes_17.08.2020.pdf. *See also* Ministry of Health [Kenya], *National Task Sharing Guidelines 2017-2030* (2027), at 27, https://hesma.or.ke/wp-content/uploads/2017/02/Task-Sharing-Guideline-2017.pdf.

289 Kenya has six different levels of healthcare facilities: 1. Community services, 2. Dispensaries and clinics, 3. Health centers, maternity centers, and nursing homes, 4. Sub-county hospitals and medium-sized private hospitals, 5. County referral hospitals and large private hospitals, 6. National referral hospitals and large private teaching hospitals, African Health Business, *Kenya's Health Sector* (2021), https://www.ahb.co.ke/wp-content/uploads/2021/07/Country-Overview_Kenya.pdf.

290 Nursing Council of Kenya, *Scope of Practice for Entry Level Nurses and Midwives* (2020), Appendix 4, https://nckenya.com/wp-content/uploads/2020/08/Scope_of-Practice_For_Entry_Level_Programmes_17.08.2020.pdf.

291 Nursing Council of Kenya, *Scope of Practice for Entry Level Nurses and Midwives* (2020), Appendix 4, https://nckenya.com/wp-content/uploads/2020/08/Scope_of-Practice_For_Entry_Level_Programmes_17.08.2020.pdf.

292 *See* "The nurse/Midwife shall prescribe/administer prescribed drugs & vaccines in line with [...] institutional guidelines. [...] The registered nurses/midwife shall prescribe &/or administer specific drugs in: 1. Consultation with the prescribing officer [...], 6. A case where a prescription has been given by the relevant prescribing officer", Nursing Council of Kenya, *Scope of Practice for Entry Level Nurses and Midwives* (2020), Appendix 4, https://nckenya.com/wp-content/uploads/2020/08/Scope_of-Practice_For_Entry_Level_Programmes_17.08.2020.pdf.

While official regulations from the Nursing Council permit nurses and midwives to exceed their scope of practice in emergencies to save the life of the mother or baby,[293] this provision is rarely implemented in practice. A local midwifery expert recounted cases where midwives acted beyond their authorized scope during emergencies and faced legal action, even when the outcome was successful—this issue has arisen multiple times in abortion-related cases.[294] According to the expert, such complaints usually originate from physicians or hospitals, not patients, and create a significant deterrent for midwives to exceed their scope of practice, even in emergencies.[295]

The official abortion provision in Kenya's constitution authorizes a "trained health professional" to provide abortion care,[296] but in practice, midwives in Kenya avoid performing abortions due to the high risk of criminalization.[297] While abortion care is not mentioned in the scope of practice, post-abortion care is explicitly included.[298]

Although the scope of practice regulations explicitly recognize that "the roles and responsibilities of the nurse and midwife are expected to change with time",[299] this does not apply to individual midwives' scope of practice, which remains relatively inflexible. Some aspects of care may be added to the scope for KRM, KRN/M, and KCHRN following additional training, such as manual removal of the placenta, vacuum extraction, and manual vacuum aspiration.[300] Outside these specific designations outlined in the regulations, professional opportunities for midwives to expand their scope of practice are scarce.[301]

HIGHLIGHT: New Developments on Ultrasound

Historically in Kenya, only radiologists were permitted to perform ultrasound procedures, even with manual devices.[302] In a recent advancement, the Ministry of Health issued the National Obstetrics Point-of-Care Ultrasound (O-POCUS) Guidelines in 2024. These guidelines recommend that all registered midwives and other qualified clinical officers (including nurses with midwifery training) receive O-POCUS training to perform ultrasounds during obstetric and gynecological examinations.[303] This is a major step forward for both pregnant people and the midwifery profession, as midwives are explicitly recognized throughout the guidelines as qualified medical staff authorized to perform obstetric point-of-care ultrasounds across various levels of care.[304]

293 *Cf.* Nursing Council of Kenya, *Scope of Practice for Entry Level Nurses and Midwives* (2020), Appendix 4, 5, https://nckenya.com/wp-content/uploads/2020/08/Scope_of-Practice_For_Entry_Level_Programmes_17.08.2020.pdf.
294 Interview with Eunice Atsali, National Secretary, Midwives Association of Kenya (Dec. 5, 2024).
295 Interview with Eunice Atsali, National Secretary, Midwives Association of Kenya (Dec. 5, 2024).
296 Constitution art. 26(4) (2010) (Kenya).
297 Interview with Eunice Atsali, National Secretary, Midwives Association of Kenya (Dec. 5, 2024).
298 Nursing Council of Kenya, *Scope of Practice for Entry Level Nurses and Midwives* (2020), Annex 2, https://nckenya.com/wp-content/uploads/2020/08/Scope_of-Practice_For_Entry_Level_Programmes_17.08.2020.pdf.
299 Nursing Council of Kenya, *Scope of Practice for Entry Level Nurses and Midwives* (2020), at 1, https://nckenya.com/wp-content/uploads/2020/08/Scope_of-Practice_For_Entry_Level_Programmes_17.08.2020.pdf; Interview with Eunice Atsali, National Secretary, Midwives Association of Kenya (Dec. 5, 2024).
300 Nursing Council of Kenya, *Scope of Practice for Entry Level Nurses and Midwives* (2020), Annex 2, https://nckenya.com/wp-content/uploads/2020/08/Scope_of-Practice_For_Entry_Level_Programmes_17.08.2020.pdf. BScM are qualified to perform these procedures independently without additional training, as it is included in their education.
301 *Cf.* Nursing Council of Kenya, *Scope of Practice for Entry Level Nurses and Midwives* (2020), Annex 2, https://nckenya.com/wp-content/uploads/2020/08/Scope_of-Practice_For_Entry_Level_Programmes_17.08.2020.pdf; Interview with Eunice Atsali, National Secretary, Midwives Association of Kenya (Dec. 5, 2024).
302 The Radiographers Act, No. 28 (2022) Kenya Gazette Supplement.
303 Ministry of Health [Kenya], *National Obstetrics Point-of-Care Ultrasound (O-POCUS) Guidelines* (2024).
304 *Cf.* Ministry of Health [Kenya], *National Obstetrics Point-of-Care Ultrasound (O-POCUS) Guidelines* (2024); Interview with Eunice Atsali, National Secretary, Midwives Association of Kenya (Dec. 5, 2024).

Conclusion

Midwifery care plays a crucial role in addressing gaps in maternal health in Kenya, providing a key foundation for improving the quality and accessibility of maternal health services. Despite the significant contributions midwives make to the healthcare workforce, the current regulatory framework continues to present barriers to the full implementation of midwifery models of care. Our findings highlight several critical areas: the need for clearer distinction between midwifery and nursing roles and the necessity of ensuring full professional autonomy for midwives, both in their independence from physician oversight and in the extent of their scope of practice in line with international standards. While recent policy developments, such as the National Nursing and Midwifery Policy, the introduction of the BSc in Midwifery, and the inclusion of midwives in the National Obstetrics Point-of-Care Ultrasound Guidelines, signal positive progress, further reforms to the regulatory framework, alongside increased investment in midwifery education and workforce management, are essential to fully unlock the potential of midwifery care in reducing maternal mortality and improving maternal health outcomes in Kenya.

NIGERIA

Regulating Midwifery: The Legal & Policy Framework of Nigeria

SNAPSHOT OF MIDWIFERY IN NIGERIA

- **Types of midwives:** Registered Midwives & Licensed Community Midwife (only for primary healthcare facilities).
- **Routes of entry:** For Registered Midwifery, a 3-year direct entry program or an 18-month program after completing a 3-year nursing degree. Starting in 2026, these pathways will be replaced by a 4-year National Diploma/Higher National Diploma. For Licensed Community Midwifery a 2-year direct entry program.
- **Key challenges:**
  - The regulatory framework often conflates nursing and midwifery, undermining the profession's autonomy and effectiveness.
  - There are challenges with "quack" midwives and nurses—untrained and unlicensed individuals who present themselves as qualified nurses or midwives.
  - Midwives' scope of practice is not positively defined in any regulations, leading to inconsistencies in their autonomy and roles across various healthcare settings. At higher levels of care, midwives are often subject to excessive physician oversight.

Background

Nigeria has the highest maternal mortality rate (MMR) worldwide, with an alarming rate of 993 maternal deaths per 100,000 live births[305]—more than 14 times higher than the SDG target of fewer than 70 maternal deaths per 100,000 live births.[306] While there has been a modest decline in the MMR over the past two decades, progress has been inconsistent,[307] and stark regional

305 World Health Organization [WHO], *Maternal mortality ratio (per 100,000 live births)*, https://www.who.int/data/gho/data/indicators/indicator-details/GHO/maternal-mortality-ratio-(per-100-000-live-births) (accessed May 15, 2025).
306 WHO, *SDG Target 3.1 Maternal mortality*, https://www.who.int/data/gho/data/themes/topics/sdg-target-3-1-maternal-mortality (accessed May 15, 2025).
307 WHO, *Maternal mortality ratio (per 100,000 live births)*, https://data.who.int/indicators/i/AC597B1 (accessed May 15, 2025).

disparities persist. Maternal mortality is particularly high in northern and rural regions, where communities face limited access to healthcare facilities and higher levels of poverty.[308]

A central challenge to maternal health in Nigeria is the acute shortage of skilled birth attendants. According to World Health Organization (WHO) data, only 51% of births in Nigeria were attended by skilled health personnel in 2022[309]—a number that drops to just 30.6% in rural areas, as reported by the 2023 Demographic Health Survey.[310] This shortage is in part caused by the significant outflow of healthcare workers: over 30% of the country's nursing and midwifery workforce emigrated between 2017 and 2022, largely due to poor working conditions and inadequate pay.[311]

In an attempt to address these problems, the Nigerian government has implemented various initiatives to improve maternal health outcomes. One such initiative was the Midwives Service Scheme[312] (MSS), introduced in 2009 to deploy newly qualified, unemployed, and retired midwives to primary healthcare facilities, particularly in rural areas.[313] However, due to severe underfunding, inadequate infrastructure, high attrition rates, and poor remuneration[314]—with midwives under the MSS earning salaries comparable to high school graduates[315]—this initiative has been discontinued in many regions recently.[316]

These challenges reflect broader systemic issues in Nigeria's healthcare sector, including chronic underfunding and inadequate infrastructure, which continue to undermine access to quality care.[317] Government spending on public healthcare is among the lowest in Africa,[318] with nearly 70% of healthcare costs paid out-of-pocket.[319] Enrollment in the National Health Insurance Scheme remains extremely low—around 5%—and a 2023 study found that only 2% of Nigerian

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308 Chioma Judith Mba et al., *Challenges Associated with Midwifery Practice and Education in Northern Nigeria: Way Forward*, 3 Bayero Journal of Nursing and Health Care 2 (2022), https://doi.org/10.4314/bjnhc.v3i2.11; Saloko Emmanuel, *Heal Thyself: Nigeria's Worrying Healthcare Metrics*, Dataphyte (Nov. 18, 2024), https://dataphyte.com/latest-reports/health/heal-thyself-nigerias-worrying-healthcare-metrics/; World Bank Group, *Poverty & Equity Brief: Nigeria* (2023), https://databankfiles.worldbank.org/public/ddpext_download/poverty/987B9C90-CB9F-4D93-AE8C-750588BF00QA/current/Global_POVEQ_NGA.pdf.

309 WHO, *Births attended by skilled health personnel (%)*, https://www.who.int/data/gho/data/indicators/indicator-details/GHO/births-attended-by-skilled-health-personnel-(-) (accessed May 15, 2025).

310 Federal Ministry of Health and Social Welfare [Nigeria], *Demographic and Health Survey 2023-24* (2024), at 27, https://dhsprogram.com/pubs/pdf/PR157/PR157.pdf.

311 Lara Adejoro, *57,000 nurses left Nigeria in five years – NANNM*, The Punch (Nov. 14, 2022), https://punchng.com/57000-nurses-left-nigeria-in-five-years-nannm/; Hilda Ebinim, Oluwadamilare Olatunji, & Laura Hoemeke, *The Economics Behind Nigeria's Midwife Exodus*, Think Global Health (Oct. 1, 2024), https://www.thinkglobalhealth.org/article/economics-behind-nigerias-midwife-exodus.

312 Originally introduced in 2009.

313 Seye Abimbola et al., *The Midwives Service Scheme in Nigeria*, 9 PLoS med e1001211 (2012), https://doi.org/10.1371/journal.pmed.1001211.

314 Seye Abimbola et al., *The Midwives Service Scheme in Nigeria*, 9 PLoS med e1001211 (2012), https://doi.org/10.1371/journal.pmed.1001211.

315 Modupe O. Oyetunde and Chigozie A. Nkwonta, *Quality issues in midwifery: A critical analysis of midwifery in Nigeria within the context of the International Confederation Of Midwives (ICM) global standards*, 6 Int J Nursing Midwifery 40 (2014), at 40, 43, https://doi.org/10.5897/IJNM2013-0119.

316 Interview with Amina Suleiman Rajah, Midwifery Lecturer, Bayero University, Kano (Jan 27, 2025).

317 I. I. Omoleke and B. A. Taleat, *Contemporary issues and challenges of health sector in Nigeria*, 5 Res J Health Sci 4 (2017), at 210, 213, http://dx.doi.org/10.4314/rejhs.v5i4.5; Okechukwu Ignatius Eze, Alexander Iseolorunkanmi, and Davies Adeloye, *The National Health Insurance Scheme (NHIS) in Nigeria: current issues and implementation challenges*, 4 J Glob Health Econ Pol e2024002 (2024), https://doi.org/10.52872/001c.120197.

318 Alpha Chiemezie Madu and Katy Osborne, *Healthcare financing in Nigeria: A policy review*, 53 Int J Soc Determinants of Health and Health Services 434 (2023), https://doi.org/10.1177/27551938231173611.

319 Partnership for Maternal, Newborn, and Child Health [PMNCH], *Case study: Nigeria* (June 11, 2017), https://pmnch.who.int/resources/publications/m/item/case-study-nigeria; Okechukwu Ignatius Eze, Alexander Iseolorunkanmi, and Davies Adeloye, *The National Health Insurance Scheme (NHIS) in Nigeria: current issues and implementation challenges*, 4 J Glob Health Econ Pol e2024002 (2024), https://doi.org/10.52872/001c.120197.

women of reproductive age who had given birth in the past two years were insured.[320] As a result, many pregnant individuals forgo essential maternal health services or turn to unregulated providers.[321] Weak regulatory enforcement and cost-cutting measures, particularly in private healthcare facilities, have contributed to the proliferation of unskilled and unlicensed providers ("quackery"),[322] further endangering pregnant persons (see Section V).

HIGHLIGHT: Three Levels of Public Healthcare Settings in Nigeria[323]

1. **Primary Healthcare:** The first point of contact for basic health services, preventive care, and treatment of common illnesses. Managed by Local Government Areas, this includes community and rural health centers, dispensaries and clinics.
2. **Secondary Healthcare:** Provides specialized care for more complex conditions, typically through general hospitals that handle referrals from primary care. Run by state governments, these include district and regional hospitals.
3. **Tertiary Healthcare:** Focuses on advanced medical care and specialized services for complex conditions and medical education and research. Managed by the federal government, these are teaching hospitals (affiliated with universities) or national specialized hospitals.

Types of Midwives / Routes of Entry

The Nursing and Midwifery Act (NMA) defines a midwife as "a person who is registered to practice the profession in accordance with the provisions of this Act."[324] Currently, there are multiple pathways to becoming a registered midwife, including the **Basic Midwifery** program, a three-year direct-entry program after secondary education,[325] and the **Post-Basic Midwifery** program, an 18-month program for individuals who have already completed a three-year nursing degree.[326] However, both programs are being phased out and will be replaced by a new educational structure by 2026. In their place, Nigeria is introducing a four-year **National Diploma/Higher National Diploma (ND/HND)** program that integrates nursing and

320 Oluwaseun Taiwo Esan, Adeleye Abiodun Adeomi, and Olusegun Temitope Afolabi, *Health insurance coverage and access to maternal health services: Findings from Nigerian women of reproductive age*, United States Agency for International Development [USAID] (July 2023), https://dhsprogram.com/pubs/pdf/WP192/WP192.pdf.

321 Rolle Remi Ahuru et al., *Non-utilization of primary healthcare centres for skilled pregnancy care among women in rural communities in Delta State, Southern Nigeria: perspectives from mothers, fathers and healthcare providers*, 22 J Int Women's Studies 142 (2021), https://vc.bridgew.edu/cgi/viewcontent.cgi?article=2630&context=jiws; Ogochukwu Udenigwe et al., *"We have either obsolete knowledge, obsolete equipment or obsolete skills": policy-makers and clinical managers' views on maternal health delivery in rural Nigeria*, 3 Fam Med Community Health e000994 (2021), https://doi.org/10.1136/fmch-2021-000994. *See also* Oluwaseun Taiwo Esan, Adeleye Abiodun Adeomi, and Olusegun Temitope Afolabi, *Health insurance coverage and access to maternal health services: Findings from Nigerian women of reproductive age*, United States Agency for International Development [USAID] (July 2023), https://dhsprogram.com/pubs/pdf/WP192/WP192.pdf (on the impact of insurance-coverage on likelihood to access maternal healthcare in Nigeria).

322 Taiwo Ojoye, *Arrest, prosecute quack nurses, midwives, NANNM tasks IG*, The Punch (Aug. 27, 2016), https://punchng.com/arrest-prosecute-quack-nurses-midwives-nannm-tasks-ig/; Abdullah T. Aborode, Abdulhammed O. Babatunde, and Progress Agboola, *Training and practices of quack nurses in Nigeria: A public health concern*, 36 Int J Health Plann Manage 986 (2021), https://doi.org/10.1002/hpm.3120.

323 Remi Oyedeji and Seye Abimbola, *How tertiary hospitals can strengthen primary health care in Nigeria*, 55 Nigerian Med J 519 (2014), https://doi.org/10.4103/0300-1652.144715; Francis Koce, Gurch Randhawa, Bertha Ochieng, *Understanding healthcare self-referral in Nigeria from the service users' perspective: A qualitative study of Niger state*, 19 BMC Health Serv Res 209 (2019), https://doi.org/10.1186/s12913-019-4046-9.

324 Nursing and Midwifery Act (1979, amended 2021) Cap. (143), § 26 (Nigeria).

325 *See, e.g.*, Ogun State College of Nursing Sciences, *Basic Midwifery*, https://ogcon.edu.ng/basic-midwifery/ (accessed May 19, 2025).

326 *See, e.g.*, Ogun State College of Nursing Sciences, *Post Basic Nursing*, https://ogcon.edu.ng/post-basic-nursing (accessed May 19, 2025).

midwifery education.[327] Graduates can qualify as registered nurses and specialize in either public health or midwifery during the program.[328] Those specializing in midwifery are eligible for dual registration as nurses and midwives,[329] effectively making all future midwifery graduates nurse-midwives. The **Bachelor of Nursing Science (BNSc)** follows a similar integrated model, offered as a five-year direct-entry program or a four-year program for those with a prior nursing qualification.[330] It combines general nursing education with specialization options, including midwifery and public health;[331] graduates of this program who specialize in midwifery will also be nurse-midwives.

This integration runs counter to global trends in midwifery education. As the International Confederation of Midwives (ICM) notes, "there has been a global shift toward the recognition of midwifery as a separate cadre from nursing,"[332] reflected in the widespread adoption of direct-entry midwifery programs in many high-income countries and the growing number of low- and middle-income countries following suit.[333] ICM underscores that a direct-entry, pre-service midwifery program allows students to train exclusively as midwives without a nursing prerequisite.[334] By integrating midwifery into nursing education, Nigeria's new ND/HND structure and the BScN deviate from this standard.

In addition and separate from registered midwifery, the government recently introduced a two-year **Licensed Community Midwifery (LCM)** program, designed to address staffing shortages in underserved communities, with a focus on recruiting midwives from the communities they will serve.[335] This initiative is intended as a temporary measure to reduce the maternal mortality ratio and is aimed at preparing graduates to work exclusively in Primary Healthcare Centers for uncomplicated deliveries.[336] However, according to a local midwifery expert, unofficially LCMs are now increasingly employed in secondary and tertiary facilities due to their lower cost compared to registered midwives.[337] The LCM program, with its limited scope of practice and duration of only two years, does not meet global standards for a direct-entry midwifery program.

327 Nursing & Midwifery Council of Nigeria [NMCN], *Implementation of single curriculum for basic and post-basic midwifery programmes* (May 5, 2021), https://www.nmcn.gov.ng/wp-content/uploads/2023/12/RM_Single_Curriculum_Implementation_Circular.pdf; NMCN, *Approval to run public health nursing as post basic nursing specialty programme in the Colleges of Nursing Sciences approved by Nursing and Midwifery Council of Nigeria* (July 23, 2021), https://www.nmcn.gov.ng/wp-content/uploads/2023/12/Circular_-for_PHN_in_approved_CON.pdf.

328 Lily College of Nursing Sciences, *ND/HND Nursing*, https://lilynursingcollege.com.ng/programs/nd-hnd-nursing/ (accessed May 19, 2025); A. A. Badmus, *All you need to know about ND/HND Nursing Programme in Colleges of Nursing in Nigeria*, Admission Companion (Aug. 7, 2022), https://admissioncompanion.com/all-about-nd-hnd-nursing-programme-in-colleges-of-nursing-nigeria/.

329 A. A. Badmus, *All you need to know about ND/HND Nursing Programme in Colleges of Nursing in Nigeria*, Admission Companion (Aug. 7, 2022), https://admissioncompanion.com/all-about-nd-hnd-nursing-programme-in-colleges-of-nursing-nigeria/.

330 Franco-British International University, *BNSc Nursing Science*, https://fbiu.edu.ng/bnsc-nursing-science/ (accessed May 19, 2025); National Open University of Nigeria, *B.NSc Nursing*, https://fohs.nou.edu.ng/bnsc-nursing/ (accessed May 19, 2025).

331 National Open University of Nigeria, *B.NSc Nursing*, https://fohs.nou.edu.ng/bnsc-nursing/ (accessed May 19, 2025).

332 International Confederation of Midwives [ICM], *Direct-Enry Midwifery Programme Guide* (2023), at 15, https://www.internationalmidwives.org/wp-content/uploads/en-tc_icm-direct-entry-programme-guide.pdf.

333 International Confederation of Midwives [ICM], *Direct-Enry Midwifery Programme Guide* (2023), at 15, https://www.internationalmidwives.org/wp-content/uploads/en-tc_icm-direct-entry-programme-guide.pdf.

334 International Confederation of Midwives [ICM], *Direct-Enry Midwifery Programme Guide* (2023), at 15, https://www.internationalmidwives.org/wp-content/uploads/en-tc_icm-direct-entry-programme-guide.pdf.

335 Ogun State College of Nursing Sciences, *Community Midwifery*, https://ogcon.edu.ng/community-midwifery (accessed May 19, 2025).

336 Ogun State College of Nursing Sciences, *Community Midwifery*, https://ogcon.edu.ng/community-midwifery (accessed May 19, 2025). To become a Registered Midwife, LCMs must complete an additional two-year program at a midwifery school.

337 Interview with Amina Suleiman Rajah, Midwifery Lecturer, Bayero University, Kano (Jan 27, 2025).

Under ICM standards, such direct entry programs should be at least three years[338] and should include a broader range of skills than those covered in the LCM curriculum.

Historically, male students were not permitted to enroll in Basic or Post-Basic Midwifery programs due to school policies in Nigeria.[339] However, with the introduction of the ND/HND and BScN programs, male students can now train as midwives, following a directive issued by the Nursing and Midwifery Council of Nigeria (NMCN) on January 29, 2021, encouraging greater gender diversity in nursing and midwifery education.[340]

Regulation

The NMA provides the regulatory foundation for nursing and midwifery in Nigeria. It establishes the Nursing and Midwifery Council of Nigeria (NMCN) as the regulatory authority responsible for registration, licensure, and professional oversight.[341] Section 25 of the NMA grants the Minister of Health the power to issue additional regulations, under which both the Nurses Regulations and Midwives Regulations have been enacted to govern education and practice more specifically.[342] Although the NMA has been amended periodically—the latest amendment occurring in 2021[343]—the Midwives Regulations date back to 1967 and contain outdated provisions (see Section V).

Historically, midwifery was regulated separately under a distinct Midwives Board and Midwives Decree.[344] However, with the enactment of the NMA in 1979, the Nursing Council and the Midwifery Board were merged to create the NMCN,[345] which now serves as the sole statutory body overseeing nursing and midwifery education, accreditation, registration, and practice as a parastatal of the Federal Ministry of Health.[346]

The current regulatory framework frequently conflates nursing and midwifery. Apart from the outdated Midwives Regulations, the NMA and other instruments typically refer to both professions collectively as "nurses and midwives," with no distinction between their professions and roles.[347] In some instances, midwifery is explicitly framed as a subset of nursing. For example, the Continuing Development Guidelines issued by the NMCM classify midwifery as a nursing sub-specialty:

338 ICM, *ICM Global Standards for Midwifery Education – Companion Guidelines* (2023), at 19, https://www.internationalmidwives.org/wp-content/uploads/ICM-Global-Standards-for-Midwifery-Education-%E2%80%93-Companion-Guidelines.pdf.

339 *Cf.* NMCN, *Demand for increase in the percentage of male admissions into nursing training institutions* (Jan. 29, 2021), https://nmcn.gov.ng/wp-content/uploads/2023/12/circular_on_increase_in_the_percentage_of_male_addimissions_into_nur_tra_inst.pdf.

340 NMCN, *Demand for increase in the percentage of male admissions into nursing training institutions* (Jan. 29, 2021), https://nmcn.gov.ng/wp-content/uploads/2023/12/circular_on_increase_in_the_percentage_of_male_addimissions_into_nur_tra_inst.pdf.

341 Nursing and Midwifery Act (1979, amended 2021) Cap. (143), § 1 (Nigeria).

342 Nursing and Midwifery Act (1979, amended 2021) Cap. (143), § 25 (Nigeria); *see* Midwives Regulations No. (135) (1967) (Nigeria); Nurses Regulations No. (78) (1970) (Nigeria).

343 Federal Republic of Nigeria National Assembly, *Press Statement: Senate Passes Nursing, Midwifery Act Amendment Bill, One Other* (Jan. 12, 2021), https://nass.gov.ng/news/item/1589.

344 NMCN, *Our History*, https://nmcn.gov.ng/our-history/ (accessed May 20, 2025).

345 NMCN, *Our History*, https://nmcn.gov.ng/our-history/ (accessed May 20, 2025).

346 NMCN, *Who we are – NMCN*, https://nmcn.gov.ng/who-we-are-nmcn/ (accessed May 20, 2025).

347 *See, e.g.*, Nursing and Midwifery Act (1979, amended 2021) Cap. (143), §§ 2, 12-14, 16-17, 23 (Nigeria). *Contra* Nursing and Midwifery Act (1979, amended 2021) Cap. (143), §§ 8-9 (Nigeria); these sections regulate the registration of midwives separately from the registration of nurses.

> **"Private providers are encouraged to develop CPDP for their specialties. Such sub-specialty areas include: Nursing Anaesthesia [...], Midwifery [...]."[348]**

This conflation has significant implications for how midwifery is perceived, creating confusion among healthcare providers and patients and diminishing the distinct identity and autonomy of the midwifery profession.[349] As discussed in the next section, it also impacts the representation of midwifery on decision-making bodies.

LACK OF REPRESENTATION ON NMCN BODIES

The NMCN is the authority responsible for regulating the standards of nursing and midwifery education and practice in Nigeria.[350] Its core functions include developing, implementing, and assessing educational programs, ensuring compliance with professional standards, monitoring practice, and enforcing disciplinary measures within the professions.[351] The NMCN operates through a national Council and 36 State Committees, which function under the general direction and control of the Council.[352] Despite its broad regulatory mandate, the composition of the NMCN does not guarantee adequate representation of midwives. The 22-member Council established under the NMA reserves only one seat explicitly for a midwife,[353] while the other provisions refer to "Nurse or Midwife" or solely "Nurse/Nursing."[354] For the State Committees, the NMA does not specify any composition requirements.[355] While many nurses in Nigeria also hold midwifery qualifications—currently, around half of the Council members have both nursing and midwifery degrees[356]—this is not ensured by the legal framework.[357] Moreover, it remains unclear whether members serve in their capacity as nurses or midwives, further blurring the distinction between the professions. This lack of clarity and assurance raises concerns about the consistent and meaningful representation of midwives in decisions related to midwifery education and practice.

Committees handling disciplinary actions also lack specific requirements for midwife representation: Section 16 of the NMA establishes a Nurses and Midwives Investigation Panel to investigate potential misconduct but only specifies that the Panel "shall consist of seven members, at least four of whom shall be members of the profession",[358] without distinguishing between nursing and midwifery, effectively framing them as a single profession. Section 17 establishes the Nurses and Midwives Tribunal to adjudicate cases of misconduct, stating that the Tribunal shall consist of "(i) The Chairman of the Council [...]; and (ii) Seven other members to be appointed by the Council",[359] again without prescribing the professional backgrounds of these

348 NMCN, *Guidelines for continuing education programme for private providers* (2023), at 3, https://nmcn.gov.ng/wp-content/uploads/2023/12/guidelines-for-private-providers-of-mcpdp-in-nigeria.pdf.
349 *Cf.* Modupe O. Oyetunde and Chigozie A. Nkwonta, *Quality issues in midwifery: A critical analysis of midwifery in Nigeria within the context of the International Confederation Of Midwives (ICM) global standards,* 6 Int J Nursing Midwifery 40 (2014), at 40, 43, 46, https://doi.org/10.5897/IJNM2013-0119.
350 NMCN, *Who we are – NMCN*, https://nmcn.gov.ng/who-we-are-nmcn/ (accessed May 20, 2025).
351 NMCN, *Who we are – NMCN*, https://nmcn.gov.ng/who-we-are-nmcn/ (accessed May 20, 2025).
352 Nursing and Midwifery Act (1979, amended 2021) Cap. (143), § 13 (Nigeria).
353 Nursing and Midwifery Act (1979, amended 2021) Cap. (143), § 2(1)(f) (Nigeria).
354 Nursing and Midwifery Act (1979, amended 2021) Cap. (143), § 2(1) (Nigeria).
355 Nursing and Midwifery Act (1979, amended 2021) Cap. (143), §13 (Nigeria).
356 Interview with Chizoma Ndikom, Senior Lecturer, Department of Nursing, University of Ibadan, Nigeria (Dec 17, 2024).
357 Especially as the new qualification pathway of ND/HND allows nurses to specialize in areas other than midwifery, such as public health.
358 Nursing and Midwifery Act (1979, amended 2021) Cap. (143), § 16 (Nigeria).
359 Nursing and Midwifery Act (1979, amended 2021) Cap. (143), § 17 (Nigeria).

members. The absence of a mandate for midwife representation on either the Investigation Panel or the Tribunal could have serious implications for midwives. For example, in situations where a midwife extends her scope of practice during an emergency, it is crucial that the bodies responsible for investigation and adjudication have a thorough understanding of midwifery procedures, as well as the medical expertise and context relevant to such cases. Without midwife representation, there is a risk of decisions being made without the necessary insights into and understanding of midwifery practice.[360]

The NMA's overall lack of recognition of midwifery as a distinct profession, combined with the absence of guaranteed midwife representation in the NMCN's decision-making bodies, contradicts ICM's recommendations which call for regulatory frameworks that recognize midwifery as an autonomous profession, separate from both nursing and medicine.[361]

LACK OF DISTINCT PROFESSIONAL ASSOCIATION

The professional association intended to advocate for the interests of the profession is not exclusive to midwifery but is instead a merged entity—the National Association of Nigerian Nurses and Midwives (NANNM).[362] This is contrary to ICM standards, which define a midwives' association as a professional body dedicated to midwives, serving as their voice, supporting their professionalism, and representing their interests to governments and other stakeholders.[363] By conflating midwifery with nursing, the association's focus on midwives' interests as an autonomous profession is significantly diluted.

Registration

Under the NMA, all nurses and midwives must formally register with the NMCN after completing their training and passing the national licensure examination.[364] Graduates must complete a one-year clinical posting at approved hospitals, posting at approved hospitals.[365] These requirements will remain under the new ND/HND program.[366] In 2010, the NMCN introduced the Mandatory Continuing Professional Development Programme (MCPDP),[367] requiring nurses and midwives to complete at least 60 hours of accredited continuing education courses every three years to maintain licensure.[368] While this initiative brings licensing requirements in line with ICM

360 ICM states that the regulatory body should be composed mainly of midwives, reflecting the diversity of practice within the country. ICM, *Global Standards for Midwifery Regulation* (2011), at 16, https://internationalmidwives.org/resources/global-standards-for-midwifery-regulation/.

361 ICM, *Regulation Toolkit* (2016), at 2, https://internationalmidwives.org/resources/regulation-toolkit/; ICM, *Global Standards for Midwifery Regulation* (2011), at 7, https://internationalmidwives.org/resources/global-standards-for-midwifery-regulation/.

362 NANNM, *National Association of Nigeria Nurses and Midwives*, https://nannm.com.ng (accessed May 20, 2025).

363 ICM, *Definition of a Midwives' Association* (2024), https://internationalmidwives.org/resources/definition-of-a-midwives-association/.

364 Nursing and Midwifery Act (1979, amended 2021) Cap. (143), §§ 8-9, 20, 26 (Nigeria). For Licensed Community Midwives (LCMs), the process differs—they obtain only a licensure, not full registration, due to the shorter duration and limited scope of their training. Despite the lack of registration, LCMs are recognized as skilled birth attendants, unlike TBAs.

365 Kunle Emmanuel, *What is all about this ND Nursing in Nigeria?*, Naija Nurses Forum (Apr. 27, 2023, 8:32 PM), https://www.naijanursesforum.com/viewtopic.php?t=3657; Interview with Amina Suleiman Rajah, Midwifery Lecturer, Bayero University, Kano (Jan 27, 2025).

366 Kunle Emmanuel, *What is all about this ND Nursing in Nigeria?*, Naija Nurses Forum (Apr. 27, 2023, 8:32 PM), https://www.naijanursesforum.com/viewtopic.php?t=3657; Interview with Amina Suleiman Rajah, Midwifery Lecturer, Bayero University, Kano (Jan 27, 2025).

367 NMCN, *Guidelines for continuing education programme for private providers* (2023), https://nmcn.gov.ng/wp-content/uploads/2023/12/guidelines-for-private-providers-of-mcpdp-in-nigeria.pdf.

368 NMCN, *Guidelines for continuing education programme for private providers* (2023), https://nmcn.gov.ng/wp-content/uploads/2023/12/guidelines-for-private-providers-of-mcpdp-in-nigeria.pdf.

standards,[369] it has been criticized for lacking a formal mechanism to verify the up-to-date status of licenses, particularly within private healthcare facilities.[370]

Nigeria faces widespread issues of fraudulent licensing and unqualified practitioners, with individuals using fake or nonexistent licenses to work as nurses or midwives.[371] Some doctors have contributed to the problem by issuing illegitimate certifications to unqualified individuals, often under misleading titles like "Auxiliary Nurse/Midwife," which have no legal recognition under Nigerian law.[372] These untrained and unlicensed practitioners—commonly referred to as "quacks"—have caused serious harm to patients, including fatalities.[373] The issue is especially common in private hospitals, some of which seek to cut costs by employing unlicensed nurses.[374] Further compounding the problem, reports reveal the presence of unaccredited nursing and midwifery schools operating without NMCN approval.[375] These practices violate the NMA, specifically Section 20, which criminalizes practicing as a nurse or midwife without proper registration, using misleading titles, employing unregistered staff, or making false statements to obtain registration,[376] and Section 21, which criminalizes the unauthorized training of nurses or midwives.[377] Despite these legal provisions, enforcement remains weak, with significant gaps in prosecution.[378]

TRADITIONAL BIRTH ATTENDANTS

Traditional birth attendants (TBAs) remain widespread in Nigeria, with the 2018 Demographic and Health Survey (DHS) reporting that 20% of births were attended by TBAs, a figure that varies widely across states (from 0.5% to 71.8%) and is significantly higher in rural areas.[379] Whereas quack nurses/midwives are untrained providers presenting themselves as licensed professionals,

369 ICM, *Legislation to Regulate Midwifery Practice* (2024), at 3, https://www.internationalmidwives.org/wp-content/uploads/EN_Legislation-to-Regulate-Midwifery-Practice_Approved.pdf; ICM, *Global Standards for Midwifery Regulation* (2011), at 21, https://internationalmidwives.org/resources/global-standards-for-midwifery-regulation/. ICM recommends that the re-licensure process should go beyond a mere fee payment, as historically seen in some countries, and incorporate elements such as continuing education, minimum practice requirements, competency assessments, and engagement in professional activities.

370 Modupe O. Oyetunde and Chigozie A. Nkwonta, *Quality issues in midwifery: A critical analysis of midwifery in Nigeria within the context of the International Confederation Of Midwives (ICM) global standards*, 6 Int J Nursing Midwifery 40 (2014), at 40, 43, https://doi.org/10.5897/IJNM2013-0119.

371 Abdullah T. Aborode, Abdulhammed O. Babatunde, and Progress Agboola, *Training and practices of quack nurses in Nigeria: A public health concern*, 36 Int J Health Plann Manage 986 (2021), https://doi.org/10.1002/hpm.3120; Taiwo Ojoye, *Arrest, prosecute quack nurses, midwives, NANNM tasks IG*, The Punch (Aug. 27, 2016), https://punchng.com/arrest-prosecute-quack-nurses-midwives-nannm-tasks-ig/.

372 Chijioke Iremeka, *'No place for auxiliary nurses in Nigeria's healthcare system, laws'*, The Punch (Oct. 1, 2023), https://punchng.com/no-place-for-auxiliary-nurses-in-nigerias-healthcare-system-laws/.

373 Abdullah T. Aborode, Abdulhammed O. Babatunde, and Progress Agboola, *Training and practices of quack nurses in Nigeria: A public health concern*, 36 Int J Health Plann Manage 986 (2021), https://doi.org/10.1002/hpm.3120; Nelly Ikwuonu, *Quack Nurse In Trouble After Woman Loses Baby, Womb After Childbirth*, Oasis Magazine (Jul. 14, 2022), https://oasismagazine.com.ng/2022/07/uvwie-quack-nurse-in-trouble-after-woman-loses-baby-womb-after-childbirth/; Africa News, *Nigeria: Unqualified nurse is prime suspect in singer Mohbad's death-police* (Aug. 13, 2023), https://www.africanews.com/2023/10/07/nigeria-unqualified-nurse-is-prime-suspect-in-singer-mohbads-death-police/.

374 Abdullah T. Aborode, Abdulhammed O. Babatunde, and Progress Agboola, *Training and practices of quack nurses in Nigeria: A public health concern*, 36 Int J Health Plann Manage 986 (2021), https://doi.org/10.1002/hpm.3120; Chijioke Iremeka, *'No place for auxiliary nurses in Nigeria's healthcare system, laws'*, The Punch (Oct. 1, 2023), https://punchng.com/no-place-for-auxiliary-nurses-in-nigerias-healthcare-system-laws/.

375 Bankole Taiwo, *Ogun seals another illegal nursing school*, The Punch (Mar. 6, 2024), https://punchng.com/ogun-seals-another-illegal-nursing-school/.

376 Nursing and Midwifery Act (1979, amended 2021) Cap. (143), § 20 (Nigeria).

377 Nursing and Midwifery Act (1979, amended 2021) Cap. (143), § 21 (Nigeria).

378 *Cf.* Abdullah T. Aborode, Abdulhammed O. Babatunde, and Progress Agboola, *Training and practices of quack nurses in Nigeria: A public health concern*, 36 Int J Health Plann Manage 986 (2021), https://doi.org/10.1002/hpm.3120.

379 National Population Commission [Nigeria], *Nigeria Demographic and Health Survey 2018* (2019), at 178, https://www.dhsprogram.com/pubs/pdf/FR359/FR359.pdf.

TBAs are trained through apprenticeships, do not claim to be licensed professionals, and practice as traditional providers within their communities. TBAs are not formally educated or licensed, and they are not formally recognized within the regulatory framework. While Section 20 of the NMA could, in theory, criminalize TBAs who practice for profit as traditional midwives, and Section 21 could potentially criminalize the training of new TBAs (which typically occurs through informal apprenticeships within the community), there have been no reported instances of TBA prosecutions.[380] Rather, there have been efforts to integrate TBAs into the healthcare system in limited ways: In some regions, TBAs are employed in healthcare facilities to bring pregnant women in for ultrasounds.[381] Based on the ultrasound results, it is determined whether a home birth is feasible for uncomplicated pregnancies. If so, the TBA may attend the home birth and receives a small fee from the facility for each successful delivery.[382] This initiative is most commonly implemented in the northern regions,[383] where the maternal mortality rate is particularly high. It is not part of federal policy.

Scope of Practice

In Nigeria, midwives' scope of practice is not positively defined in the NMA or other regulations. Instead, it is shaped by the midwifery school curriculum,[384] which is standardized by the NMCN with minor local variations, as well as by healthcare facility protocols and internal guidelines. This results in significant inconsistencies in midwives' autonomy and responsibilities across different levels of healthcare facilities:[385]

1. **Primary Healthcare Facilities:** At the primary level, where physicians are generally absent, midwives operate with the highest degree of autonomy. They are responsible for prescribing and administering all necessary medications as well as carrying out all necessary procedures. However, midwives are not permitted to conduct ultrasounds at any healthcare level, as this is reserved to physicians in Nigeria.[386] Federal regulations permit midwives to independently establish and run birthing homes (categorized as primary healthcare facilities), provided there is prompt referral access to a physician in emergencies.[387] However, some states impose additional requirements, such as mandating formal oversight agreements with physicians for midwives to open a birthing home.[388]
2. **Secondary Healthcare Facilities (State Hospitals):** In state hospitals, a dual-room system is commonly employed. The **labor room**, designated for uncomplicated

380 Interview with Amina Suleiman Rajah, Midwifery Lecturer, Bayero University, Kano (Jan 27, 2025); Interview with Chizoma Ndikom, Senior Lecturer, Department of Nursing, University of Ibadan, Nigeria (Dec 17, 2024).
381 Aryn Baker and Lynsey Addario, *Nigeria's 'Flying Midwives' Are Helping Save Moms and Babies*, Time (Feb. 7, 2019), https://time.com/5518912/nigeria-childbirth-unicef-midwives/.
382 Interview with Amina Suleiman Rajah, Midwifery Lecturer, Bayero University, Kano (Jan 27, 2025).
383 Interview with Amina Suleiman Rajah, Midwifery Lecturer, Bayero University, Kano (Jan 27, 2025).
384 Nursing and Midwifery Act (1979, amended 2021) Cap. (143), § 23(1) (Nigeria) ("A nurse or midwife registered under this Act shall be entitled to carry out nursing or midwifery care as provided for in the training curriculum prescribed and approved by the Council.").
385 Interview with Amina Suleiman Rajah, Midwifery Lecturer, Bayero University, Kano (Jan 27, 2025).
386 *Id.*
387 Nursing and Midwifery Act (1979, amended 2021) Cap. (143), § 23(2) (Nigeria).
388 *Cf.* Nursing and Midwifery Act (1979, amended 2021) Cap. (143), § 23(2)(b) (Nigeria); Interview with Amina Suleiman Rajah, Midwifery Lecturer, Bayero University, Kano (Jan 27, 2025).

deliveries, is managed exclusively by midwives, operating independently and autonomously. The **admission room**, handling complicated deliveries, is overseen by doctors, with midwives working under their supervision. Midwives are responsible for triaging patients upon arrival, determining whether they should be directed to the labor or admission room.[389]

3. **Tertiary Healthcare Facilities (Teaching Hospitals)**: In teaching hospitals, midwives work under close supervision from doctors, with the lowest level of autonomy. For example, while they can administer medications, they are not authorized to prescribe them.[390]

Despite these established scopes of practice, neither federal nor state regulations provide an affirmative list of procedures that midwives are legally permitted to conduct. The NMA contains a single restriction on midwives' scope of practice related to pregnancy. Section 22 states:

> **"Registration under this Act shall not confer the right to assume any name, title or designation suggesting or implying that the person registered is by law entitled to take charge of cases of abnormality or disease in or relating to any pregnancy requiring medical attention."[391]**

Notably, neither the NMA nor the accompanying Nurses Regulations include similar restrictions limiting *nurses'* scope of practice for "diseases" or "abnormalities." The Midwives Regulations provide an extensive list of conditions defined as "abnormal," which are excluded from midwives' scope of practice.[392] Examples include pregnancies with a "previous adverse obstetric history," postpartum complications like "secondary postpartum hemorrhage," and conditions affecting the child, such as "inflammation of, or discharge from the eyes, however slight," and "vomiting".[393] This approach is inconsistent with international standards, which advocate for midwives as autonomous providers of comprehensive maternal and neonatal care, who work collaboratively with other professionals to ensure continuity of care for pregnant people.[394]

The Midwives Regulations also require midwives to call for a doctor and wait in cases of "threatened danger,"[395]—a term left undefined and open to interpretation. If no doctor is available, midwives must stay with the patient and provide care to the best of their ability.[396] However, the regulations also state that "a midwife shall not, except in a case of grave emergency, undertake operative work or *give treatment which is outside her province as a midwife.*"[397] In such instances,

389 Interview with Amina Suleiman Rajah, Midwifery Lecturer, Bayero University, Kano (Jan 27, 2025).
390 *Id.*; Interview with Chizoma Ndikom, Senior Lecturer, Department of Nursing, University of Ibadan, Nigeria (Dec 17, 2024); Interview with Amina Suleiman Rajah, Midwifery Lecturer, Bayero University, Kano (Jan 27, 2025).
391 Nursing and Midwifery Act (1979, amended 2021) Cap. (143), § 22 (Nigeria).
392 Midwives Regulations No. (135) (1967), § 39, 40 (Nigeria).
393 Midwives Regulations No. (135) (1967), § 40 (Nigeria).
394 ICM, *International Definition and Scope of Practice of the Midwife* (2024), at 1, https://internationalmidwives.org/resources/international-definition-of-the-midwife/; UNFPA, The State of the World's Midwifery (2021), at 7, 63, 21-038-UNFPA-SoWMy2021-Report-ENv4302_0.pdf; WHO, *Transitioning to Midwifery Models of Care: Global Position Paper* (2014), at 8, 12, https://iris.who.int/bitstream/handle/10665/379236/9789240098268-eng.pdf?sequence=1.
395 Midwives Regulations No. (135) (1967), § 27(4) (Nigeria).
396 Midwives Regulations No. (135) (1967), § 27(5), (6) (Nigeria).
397 Midwives Regulations No. (135) (1967), § 27(7) (Nigeria) [emp. add.].

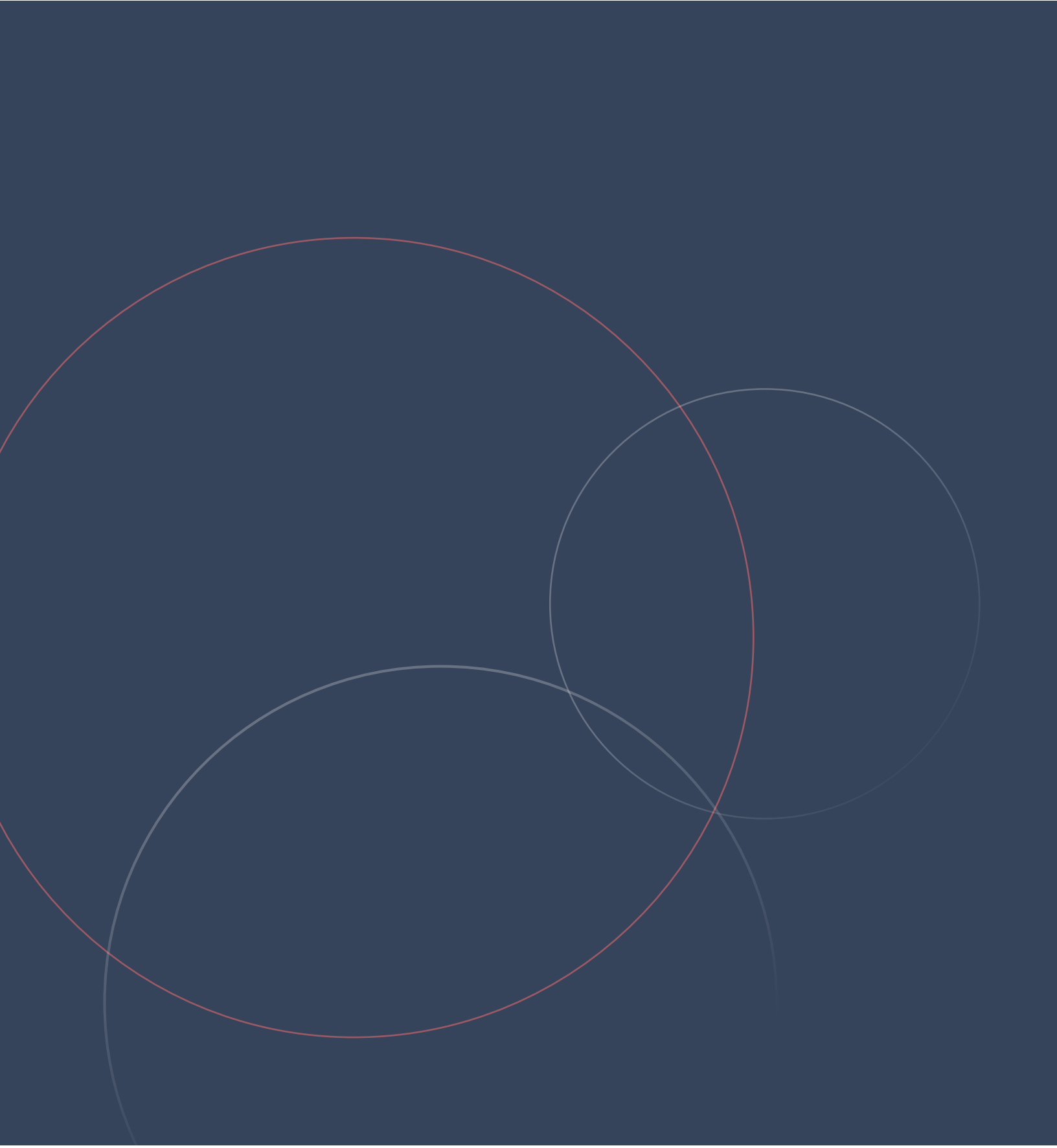
midwives must immediately notify the local supervisory authority, and their actions will be evaluated based on the specific circumstances.[398] This creates a paradox: midwives are expected to act in emergencies but are simultaneously restricted from providing treatments beyond their (not positively defined) scope of practice.

Furthermore, the Midwives Regulations still contain outdated hygiene requirements. These include specific requirements regarding midwives' personal cleanliness, appearance, clothing, and even the condition of their homes.[399] They also mandate the use of specific washable fabrics[400] (rather than modern personal protective equipment) and prescribe practices such as douching, washing with soap, and antiseptic swabbing of the patient's genitals before all examinations and labor,[401] despite current medical consensus that these practices can disrupt the natural microbiome and are not recommended as routine.[402] While these outdated requirements are reportedly no longer followed in practice, they remain part of the legislative framework.

Conclusion

Midwifery models of care are critical for addressing Nigeria's maternal health crisis, yet systemic barriers continue to limit their full potential. The conflation of midwifery and nursing and the lack of midwife representation in regulatory bodies undermine the profession's autonomy and effectiveness. Midwives often face restrictions on their scope of practice, with their ability to provide care varying significantly across different healthcare institutions and levels of the health system. In many settings, midwives are constrained by the requirement of physician oversight, which limits their capacity to independently manage pregnancies, childbirth, and postpartum care. Strengthening midwifery in Nigeria requires a regulatory framework that enhances midwifery leadership in decision-making and ensures their autonomy in clinical practice, while prioritizing investments in midwifery education and workforce retention.

398 Midwives Regulations No. (135) (1967), § 27(8), (9) (Nigeria).
399 Midwives Regulations No. (135) (1967), § 22 (Nigeria).
400 Midwives Regulations No. (135) (1967), § 22, 28 (Nigeria).
401 Midwives Regulations No. (135) (1967), § 28 (Nigeria).
402 WHO, Managing Complications in Pregnancy and Childbirth: A guide for midwives and doctors (2017), https://iris.who.int/bitstream/handle/10665/255760/9789241565493-eng.pdf?sequence=1; Louise Banga, *The microbiota of the vulva and vagina: Ways of washing to optimise the protective function of the vulvo-vaginal microbiota during pregnancy*, 57 New Zealand Coll Midwives J 34 (2021), https://doi.org/10.12784/nzcomjnl57.2021.5.34-40; Barbara Hansen Cottrell, *Vaginal Douching*, 32 J Obstet Gynecol Neonat Nursing 12 (2003), https://doi.org/10.1177/0884217502239796.



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