THE STATE OF THE WORLD'S MIDWIFERY: A CARIBBEAN RESPONSE

Small Nations, Large Impact: The Caribbean Regional Midwives Association

UNFPA

Caribbean Regional Midwives Association

USAID FROM THE AMERICAN PEOPLE

MOMENTUM A Global Partnership for Health and Resilience

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AUTHORS AND AFFILIATIONS

Karen Johnson Feltham, PhD, FACNM, RN
Consultant, MOMENTUM Country and Global Leadership

Pandora Hardtman, DNP, CNM, RN, FACNM, FAAN
Sr. Technical Advisor, MOMENTUM Country and Global Leadership/Chief Nursing and Midwifery Officer, Jhpiego

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Cover photo: Shirley Curtis/CRMA

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LIST OF ABBREVIATIONS

CARICOM	Caribbean Community and Common Market
CMO	chief midwifery officer
CNO	chief nursing officer
CPD	continuing professional development
CRMA	Caribbean Regional Midwives Association
ICM	International Confederation of Midwives
IDM	International Day of the Midwife
RN	registered nurse
SoWMy	2021 State of the World's Midwifery
SRMNAH	Sexual, reproductive, maternal, newborn, and adolescent health
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization

FORWARD

As president of the Caribbean Regional Midwives Association (CRMA), it gives me great pleasure to endorse this regional response to the State of the World Midwifery report 2021. CRMA is a nongovernmental, non-profit regional organization. We are committed to empowering our member associations to develop the capacity of their midwives to ensure quality care for the childbearing families of the Caribbean. CRMA is the premier support mechanism for midwifery associations in the Caribbean. Our mission is to promote high standards of midwifery care through capacity strengthening, advocacy, education and training, leadership, mentorship, and research.

This inaugural report highlights the sexual, reproductive, maternal, newborn, and adolescent health realities of English-speaking Caribbean countries, including Suriname (Dutch speaking). The purpose of this report is to highlight the importance of midwifery as a profession, the role of midwives, and the need for harmonization of midwifery curriculum in the region. It is hoped that the contents of this report will demonstrate that there are more similarities than differences in the region and the value of working together to move forward towards obtaining the Sustainable Development Goals 2030 that pertain to the wellbeing of women and their families. The promotion and respect for midwifery as a profession in the region will also be highlighted. This document can be used by governments and ministries of health to identify areas of priority in advancement and retention of midwives in the region. It will also be used by potential partners and donors to recognize areas of sponsorship for future work.

I would wish to thank the chief nurses, regulatory bodies and midwifery educators who provided and validated the rich information found in this document. This process was made possible by our partners, the U.S. Agency for International Development MOMENTUM Country and Global Leadership project and the United Nations Population Fund, who sponsored this dialogue and production of this document. We are eternally grateful.

Shirley E. Curtis, RN, RM, MSN, PhD
President, Caribbean Regional Midwives Association
Uniting Midwives of the Region

https://caribbeanregionalmidwivesassociation.com/

EXECUTIVE SUMMARY

The U.S. Agency for International Development (USAID) through the MOMENTUM Country and Global Leadership project seeks to improve equitable access to care and reduce maternal, newborn and child mortality and morbidity through targeted localized support and capacity building. In collaboration with the Caribbean Regional Midwives Association (CRMA) and United Nations Population Fund's (UNFPA) sub-regional office for the Caribbean, this report outlines the current status of the midwifery profession in English-speaking Caribbean countries (and Dutch-speaking) Suriname providing an overview of the status of professional organizations and midwife workforce availability in the region with recommendations for continued development and midwifery educational institutions and curricula.

Midwives are an essential component of the global health care workforce and central to strategies to reach the Sustainable Development Goals 2030 of reducing global maternal mortality, ending preventable deaths of newborns and children under 5 years of age, and ensuring access to quality sexual, reproductive, maternal, newborn, and adolescent health (SRMNAH) care. A midwifery workforce trained, educated, and regulated to international standards is central to achieving these goals.

This report contains data collected from participant countries—Antigua, The Bahamas, Barbados, Grenada, Guyana, Jamaica, Saint Lucia, St Vincent and the Grenadines, Suriname, and Trinidad and Tobago—and provides valuable data to inform next steps to shape the profession in the region. Evidence collected here indicates that although progress has been demonstrated since the initial meeting in November 2021, continued support of professional organizations is needed for midwifery to recover from the impacts of the COVID pandemic and to provide equitable access to SRMNAH services in the region.

THE APPROACH

Data collection for this report began via Zoom meetings with regional chief nursing officers in November 2021. Information pertaining to midwifery practice, education, legislation, and regulation was obtained from country nursing and midwifery leaders in small- and large-group work, interactive sessions, and via questionnaires distributed online before the initial meeting. Participants were asked to provide copies of regulatory acts and their country policies pertaining to education, workforce trends, and national, district, and regional policies that impact the midwifery profession in their countries. Challenges were encountered in the collection process as several countries' regulatory acts are currently under revision and, on occasion, participants were hesitant to share. A collection of stories to illustrate key points was encouraged. Regulatory information was gathered to enable participants to view partner country profiles and shared among participants to discuss and cross-reference regulations across the region.

KEY FINDINGS

MIDWIFERY EDUCATION

Most of the midwifery education programs in these Caribbean countries are housed within schools of nursing. Additional education and training in midwifery is required for midwifery practice. Post-nursing education certificates and diploma programs range from 1 year to 18 months (about 1.5 years); bachelor's degrees require 4 years. Of the 12 countries surveyed, three countries—Jamaica, Suriname, and Guyana—currently have a direct-entry education program for midwifery study available to students who are not nurses. Forty-three percent of responding countries report midwifery education at a diploma level, 29% at a certificate level, 14% Bachelor of Science, and 14% at Advanced Studies Certificate. Schools are accredited by varying entities in the region.

MIDWIFERY CURRICULA

Half of the 12 countries surveyed responded that midwifery curricula aligned with International Confederation of Midwives (ICM) competencies. Several respondents reported curricula that were either not aligned or were uncertain: 9% of countries were uncertain and 41% responded curriculum is not aligned with ICM competencies.

MIDWIFERY EDUCATION STANDARDS

All countries note regulations in place to ensure quality of the midwifery curriculum, although regulations governing the qualifications of midwifery educators are less consistent; Trinidad and Tobago and Belize reported no such regulation. Most countries report 100% of midwifery educators are midwives. Participants noted that when midwifery programs are within nursing schools, the principal of the school may be a nurse, but the majority of educators are midwives.

The Caribbean region maintains high standards in midwifery education, training, and regulation and SRMNAH workers with the title "midwife" are deemed competent to provide midwifery care.

MIDWIFERY WORKFORCE

AVAILABILITY

As the professions of nursing and midwifery are rarely separated in Caribbean countries, most midwives are dually registered as nurses with overlapping duties. It is therefore very difficult to disaggregate midwifery and nursing workforce numbers to accurately assess midwife availability and/or shortages. Data obtained from the State of the World's Midwifery (SoWMy) report's 21 individual country profiles estimate a total SRMNAH workforce of 29,994, of which roughly 1,659 (6%) were midwives or nurse-midwives.

MIGRATION

Formal midwifery training and education among the 12 countries surveyed in the Caribbean region has evolved to a very similar model as in the United Kingdom (U.K.) allowing for an ease of migration from many Caribbean countries to English-speaking countries, such as the U.K., Australia, and United States. The current midwife (and nurse) shortage in the U.K. and other high-income countries has an important impact to the Caribbean region's health care workforce. The global pandemic has created an urgent need in high-income countries as many nurses and midwives have left the workforce. Dialogue participants noted that Caribbean-trained midwives frequently migrate from their home countries (where they are also needed) to take attractive remuneration packages in wealthy nations. CRMA representatives reported agencies from the U.K. and Australia recruiting professionals ranging from newly graduated midwives with no work experience to seasoned professionals. There were also issues brought forth that illustrate concern with countries adherence to the World Health Organization Global Code of Practice on the International Recruitment of Health Personnel. The level of migration has serious implications on the region's ability to sustain an effective health care system and will undoubtedly affect the regions efforts to advance the 2030 agenda of the Sustainable Development Goals, to realize universal health coverage, and strengthen primary health care.

MIDWIFERY REGULATION, POLICY, AND LEADERSHIP

The midwifery profession in the region is regulated by nursing and nursing and midwifery acts that include the minimum educational requirements and conditions for practice. As midwifery is closely linked with nursing in the Caribbean region, many midwifery practice regulations share a document with nursing and occasionally nursing assistants. Countries report varying requirements for re-licensure and continued professional development.

SCOPE OF PRACTICE

Survey responses pertaining to midwives' scope of practice varied across the region. Competencies specific to labor and birth were regularly confirmed in survey responses and regulatory guidelines. However, a deficit was noted in the ICM competency domain of "ongoing care of women and newborns," specifically in *"competencies specific to the ongoing care of women and newborns,"* as many midwives in the region do not prescribe or manage family planning methods although this content is covered in midwifery curricula.

SUMMARY OF RECOMMENDATIONS

An important picture begins to develop of the midwifery profession in the Caribbean region. Pertinent qualitative and quantitative data and dialogue with nursing and midwifery leaders informed by State of the 2021 World's Midwifery report lead to the following report recommendations:

MIDWIFERY EDUCATION

- Standardize and accredit midwifery education programs across the region, including updating curricula to reflect ICM global standards and competency-based curriculum
- Invest in appropriate remuneration for educators, utilization of simulation in training, and clinical training that reinforces scope of practice
- Develop a regional midwifery licensing exam for all Caribbean countries

MIDWIFERY WORKFORCE

- Compile comprehensive disaggregated data, as needed, for planning workforce support strategies
- Develop a reliable repository of workforce data that includes relevant health workforce indicators such as age and area of practice (i.e., human resources for health information systems)
- Develop a comprehensive strategy to address midwife recruitment/retention, including enabling work environment and migration

MIDWIFERY REGULATION, POLICY, AND LEADERSHIP

- Increase the presence of midwives at decision-making levels, including designating a chief midwifery officer in addition to chief nursing officer when possible

INTRODUCTION

The third global State of the World's Midwifery report distributed in 2021 (SoWMy) provided an updated assessment of sexual, reproductive, maternal, newborn, and adolescent health (SRMNAH) services in 194 countries. Data collected in SoWMy supported previous findings confirming that midwives provide a sound return on investment and improved health outcomes. Fully educated and licensed midwives integrated into health care systems and supported by interdisciplinary teams can account for 90% of essential SRMNAH care, yet they comprise less than 10% of the global SRMNAH workforce.

The report identified a global shortage of 1.1 million SRMNAH workers, the largest shortage (900,000) being midwives. In response to SoWMy, the Caribbean Regional Midwives Association (CRMA), along with partners, USAID MOMENTUM Country and Global Leadership and the United Nations Population Fund (UNFPA), hosted a cost-shared three-day policy dialogue workshop to discuss SoWMy and consider a regional response. The workshop ran from 13–16 November 2022 and took place at the Marriott Hotel in Georgetown, Guyana. Guyana was chosen as it is the regional headquarters for the Caribbean Community (CARICOM) and centrally located for participating countries. Policy dialogue workshop attendees included the chief nurses and heads of regulatory councils from the following countries in the region: Antigua, The Bahamas, Barbados, Grenada, Guyana, Jamaica, Saint Lucia, St Vincent and the Grenadines, Suriname, and Trinidad and Tobago.

This landmark event brought together a variety of stakeholders to discuss midwifery as a unique profession in the region, separate from nursing and medicine. Participants discussed key issues raised in SoWMy: education and training, regulatory environment and scope of practice, and workforce and migration. The CARICOM-sponsored Regional Nursing Body meets semi-annually to address a broad agenda and specific issues pertaining to nursing (CRMA is an affiliate member within the larger Regional Nursing Body). This was the first meeting in which the sole focus was issues directly pertaining to the midwifery profession, including discussion of SoWMy and aligning the priorities of CRMA midwifery with report recommendations. **This report provides policy and country snapshots of the regional midwifery professional landscape and leadership.**

Access to antenatal care is above 86% in most Caribbean countries—with the exception of Suriname at 68%—and skilled birth attendance is high (ranging from 94% in Belize, 96% in Guyana, 98% in Suriname, and 100% coverage in Jamaica). However, inequalities are found when comparing antenatal care coverage by socio-economic characteristics within a given geographic area and when comparing one geographic coverage area to another.

Data reveal that maternal deaths occur within health facilities and are higher among low-income women and certain ethnic groups. In Suriname, the national maternal mortality rate is 96/100,000 per UNFPA/World Health Organization (WHO)/UNICEF/World Bank 2020 data; in contrast, Surinamese women of Maroon ethnicity have the highest maternal mortality ratio (184 per 100,000 live births) and the highest stillbirth rate (25 per 1,000 babies born). The majority of maternal deaths in Suriname occur in hospitals (85%); with the most important factor being substandard care and delay in diagnosis (59%) and, less frequently, patient delay (15%).

Maternal health is well reflected in regional national policies, but high levels of intimate partner violence during pregnancy, excessively high rates of cesarean sections, high levels of stillbirths, and negative childbirth experiences have been documented by Caribbean authorities These are important determinants for maternal morbidity and mortality and are factors that are believed to be influencing the increasing medicalization of birth seen in the region.

In the face of the foregoing, the Caribbean region faces the trend of international migration of health workers, inclusive of midwives, and substantial health workforce shortfalls. This impacts the delivery of quality care in several countries.

CONTEXT

The Caribbean region is a grouping of islands and countries and home to approximately 16 million people covering island states from The Bahamas in the north, to Trinidad and Tobago in the south, and Guyana and Suriname in South America. Populations and standards of living vary widely in the region with most countries designated upper middle-income by the World Bank.[1]

The midwifery profession in the Caribbean has been uniquely shaped by the indigenous peoples and colonial forces of the British, Dutch, French, and Americans. The transatlantic slave trade and an associated interest in birth outcomes necessitated trained midwives who became an important part of the local economy. Modern midwifery in English-speaking Caribbean countries is most closely linked with the British system. Placed within the nursing profession, midwifery is seen as a means of advancement to more senior positions rather than a career in and of itself. Midwifery as a profession, independent from nursing, is a more contemporary concept in the region.

The demonstrated correlation between skilled birth attendants and improved outcomes brought a renewed focus on the value of midwives. Early interest in increasing midwifery capacity came from government, nongovernmental, and development agencies. Midwifery education and training standards were initially addressed on an individual country basis, but a broader regional collaboration was encouraged and, in 2011, UNFPA, International Confederation of Midwives (ICM), and the Pan American Health Organization (PAHO), in collaboration with Family Care International, supported a regional meeting entitled *Promoting Midwifery in Latin America and the Caribbean: Strategic Planning for Achieving MDG5* with a focus on building midwifery associations and midwifery education training. CRMA has roots in earlier individual country associations, including the Jamaican Midwives Association (established 1960), and an (unsuccessful) attempt to establish a midwifery group within the Caribbean Nurses Organization. Organizers recognized the value of a unified body and, despite challenges in language and geographical distance, the CRMA was formed in April 2012 and has contributed midwifery leaders and influenced practice as vibrant members of the ICM.[2,3] The CRMA was formed with a mission to provide and promote high-quality standards of midwifery care to meet the needs of women and their families in the Caribbean through “advocacy, education, research, practice and leadership.”[4]

The newly formed CRMA developed a significant action agenda in regulation, education, and professional associations. The recent CRMA dialogue revisited the founding agenda and noted significant progress and the need for continued efforts and focus. The recommendations in this report align with those originally outlined in the CRMA strategic plan.

DIALOGUE OBJECTIVES

While the 2011 and 2014 State of the World’s Midwifery reports contributed much-needed evidence and knowledge regarding the world’s midwifery profession, there was an important deficit: these reports addressed only low- and middle-income countries and were, therefore, an incomplete global picture of the profession. For the first time, SoWMy data also included high-income countries. Given the unique position of the Caribbean regions’ diverse small island and developing nations status, alongside production of various regionally specific SoWMy reports that have resulted in the interim, the Caribbean region aspired to expand its documented profile as a tool to advance education, regulation, and association for its specific midwifery profession.

The core objectives of the policy dialogue and the pre-validation workshop were to formulate a Caribbean response to SoWMy and to develop an action plan that will guide the regulation and practice of midwifery in the region. It is anticipated that the recommendations of this dialogue will lead to an elevation of the midwifery profession and midwifery practice and, by extension, improve the care given to SRMNAH clients in the region. With this in mind, the report focuses on the following objectives:

1. Formulate an in-depth Caribbean response to SoWMy and other key reports/findings
2. Develop a regional snapshot and harmonized action plan that will give guidance to the regulation and practice of midwifery in the region
3. Provide information and develop steps to shape optimal regulatory practices in the region

The policy dialogue workshop, entitled *"State of the World's Midwifery: A Caribbean Response,"* highlighted the findings and recommendations of the three *State of the World's Midwifery* reports (2011, 2014, and 2021) and explored their impact on the Caribbean region.

This was an historic occasion as participants had been unable to meet in person for several years due to COVID-19 restrictions exacerbated by travel challenges unique to a region comprised of islands and sovereign island nations. Since the last meeting, there have been several leadership changes in both ministerial appointments and governance of relevant regulatory bodies. The shift in leadership also meant that several of the new leaders had less exposure to current midwifery practice, thus the course of the policy dialogues had the dual effect of sensitizing participants to current practice and professional issues.

Members recognized that areas of concern identified in SoWMy report were relevant in the Caribbean region and had previously validated the larger findings under the sub-headings of leadership, education, service delivery, and jobs. **Prioritization exercises completed before the face-to-face meeting highlighted education and regulation as core areas for combined regional focus.**

ADVANCE PREPARATION

The process began via meetings with chief nursing officers in November 2021 held via Zoom. Data pertaining to midwifery practice, education, legislation, and regulation was obtained from country nursing and midwifery leaders in small- and large-group work, interactive sessions, and via questionnaires distributed before the meeting. Participants were asked to provide copies of regulatory acts and their country policies pertaining to education, workforce trends, and national, district, and regional policies that impact the midwifery profession in their countries. Regulatory information was collected to enable participants to view partner country profiles and cross-reference regulations across the region.

This unique method of workshop preparation laid the foundation for new cross collaboration among CRMA members intended to establish a collaborative mindset to address midwifery professional issues as a united body. Members prepared for the workshop with preliminary readings on SoWMy reports, midwife-led care, and the ICM *Framework for Action: Strengthening Midwifery Education for Universal Coverage 2030* and the 2021 *WHO Global Code of Practice on the International Recruitment of Health Personnel* in preparation for discussions on the impact of migration on the midwifery workforce.

FINDINGS

MIDWIFERY EDUCATION

Extensive review of current CRMA member midwifery curricula revealed important cross-country comparisons (Table 1). Most Caribbean countries are aligned with the *ICM Global Standards for Midwifery Education 2021* in terms of length of study.

In the category of midwifery education program governance, all countries report educational programs conform with jurisdictional requirements of governmental oversight. Several countries noted an unknown specific budget for training of midwifery educators. All countries noted regulations in place to ensure quality of the midwifery curriculum, although regulations governing the qualifications of midwifery educators are less consistent; Trinidad and Tobago and Belize reported no such regulation.

TABLE 1. SURVEY RESULTS FOR TYPE AND LENGTH OF MIDWIFERY EDUCATION PROGRAM IN THE REGION

Country	Type of Program	Length of Study
Antigua and Barbuda	• Post-RN diploma program • Post-RN certificate program	• Diploma: 18 months • Certificate: 15 months
Saint Lucia	Post-RN diploma program	18 months
Trinidad and Tobago	• Direct-entry midwife • Post-RN certificate program • Bachelor's degree	• Direct-entry midwife/certificate: 3 years • Post-RN certificate: 18 months • Bachelor's: 4 years
Guyana	Post-RN (certificate)	1 year
Grenada	Post-RN certificate program	15 months
Belize	Post-RN midwife (certificate?)	18 months
St. Vincent and the Grenadines	Post-RN diploma program	15 months
Barbados	Post-RN diploma program	1 year
Jamaica	• Direct entry • Post-RN midwives certificate program • Bachelor's degree	• Direct entry: 4 years • Post-RN: 1 year
The Bahamas	Post-RN diploma program	18 months
Suriname	NR	NR
Additional requirements: Saint Vincent and Grenadines: requires six months of nursing experience. (Caribbean Examination Council)		

QUALITY OF MIDWIFERY EDUCATION

CRMA survey respondents report a majority of regional midwifery program educators are midwives, in keeping with ICM guidelines. Participants noted that when midwifery program are within nursing schools, the principal of the school may be a nurse, but the majority of educators are midwives. Additionally, ICM advises that clinical experiences be supervised by midwives.[5]

Low-quality midwifery education and training was noted as a significant barrier to improving SRMNAH access in the first two SoWMy reports. High-quality SRMNAH care can be attained with an educated and trained midwifery workforce that has completed high-quality programs. The quality of midwifery education and training programs must be evaluated and held to international standards as set by ICM. Without consistent evaluation of educational programs, it is impossible to measure quality and ascertain if ICM standards are being met. As reported, program length of study in the region has been identified, but program quality is unknown.

"Hands-on" clinical experiences with a qualified mentor is an essential component of midwifery education. According to the ICM document, *Guidance for Meeting the ICM Global Standards for Midwifery Education (2021): Practical/Clinical Experience,* a midwifery curriculum should include both theory and practice, with a minimum of 50% of practice in clinical settings, including access to a variety of learning experiences that address all aspects of midwifery scope of practice and competencies. Additionally, the quality of care that students participate in shapes their clinical practice. ICM notes the following, "Student learning is enhanced when they witness quality care in clinical sites and are rewarded for establishing positive relationships and providing respectful, safe and effective care."[6] The curriculum content and the environment in which students engage in clinical practice must be assessed. It should be noted that student learners (nursing, midwifery, and medicine) will engage in modeling behavior by watching what mentors say and do. Clinical sites that demonstrate respectful maternity care are essential to quality midwifery education.

The midwifery education discussion among dialogue participants was animated:

> "Do we have a midwifery educator who also has the administration and education competencies to head a school?"
>
> Barbados: "I believe that the midwife who heads a midwifery school should also be trained in education and administration skills."
>
> Guyana: "There is no midwifery school and so midwives are trained within a nursing school. Midwives teach the courses in the program. There should be a [midwife] coordinator, but this person is not making the decisions. Other persons who are not midwives are making decisions."

Direct-entry programs may be effective in increasing the midwifery workforce more quickly and effectively, but direct-entry programs are not the norm in the Caribbean region; most midwives complete a post-nurse certificate or diploma.

- **Trinidad and Tobago**: "Persons who are RNs as well as midwives tend to move on, tend to go to 'greener pastures' and other areas. When people are direct entry, they are there because they want to be a midwife. If that's your passion, you tend to stick with it. It is a longer program, but I find that they work well. But we have times when we have RNs (with additional midwife training) who look down on them. Regulations need to change to facilitate more direct-entry midwives."

- **Barbados**: “No direct entry, but it can be looked at. To deal with the shortage of midwives, we should look at direct entry. Concerns now that we have a Bachelor of Science in Nursing, the length of time it takes to get a person to be a midwife in a four-year program (you could basically do a masters and start a PhD) has serious implications. All the post-basic programs are affected.”
- **Trinidad and Tobago**: “A benefit of direct entry is that you would not be depleting your RN pool. In Trinidad, we have a great shortage of RNs. A direct-entry midwife is a specialist. Both programs would solve the problem.”
- **Guyana**: has the direct-entry program. “In other countries, you have RNs leaving for greener pastures. Another reason we have direct entry, particular to Guyana. We have a lot of hinterland regions and in those areas we have more indigenous communities. People living in the coastal area don't want to go there to take care of mothers. So what we do is we train people from there, coming directly from secondary school. Trained and stationed in those areas. Our post-basic program is not RN only, there are RNAs (nursing assistants). Post-basic programs can include both RNs and RNAs.”
- **Saint Vincent and the Grenadines**: question regarding promotion. “In most cases, the person who gets promoted has to be an RN and midwifery trained. Because we are small, where would they go after that?”
- **Barbados**: What is the professional progression for midwives? “Lack of career advancement for direct entries in Barbados. In countries with direct entry, what avenues do we have to progress? In the ward setting, community midwives. In Jamaica, that was a concern, so they started a university-based program where they can go and get degrees in midwifery. They should be able to progress with that midwifery degree.”

Betty Ann Pilgrim, National Administrator Nursing Services Trinidad and Tobago at Ministry of Health, Ministry of Health, Trinidad and Tobago.

I completed my nursing training in 1987 and always wanted to be a midwife, but at the time, Trinidad and Tobago had stopped midwifery training. In the ‘70s and ‘80s midwives were trained in batches—when 60 to 75 persons finished their nursing training, there would be a batch to begin midwifery training. Unable to begin right away in Trinidad and Tobago, I went to the U.K. in 1988 to pursue midwifery training. Midwifery practice was so autonomous there—I managed women in the antenatal period from as early as six weeks’ gestation, through birth and postpartum. I loved it! I returned to Trinidad and Tobago 20 years later still passionate about midwifery. I came into the CNO’s role and have faced many challenges. We are fighting to make changes—the culture in the midwifery units needs to be addressed—to introduce research to replace outdated practice such as cord care, episiotomy repair (by midwives), induction of labor (by midwives), encouraging movement in labor, and using a variety of positions. We are, however, facing few challenges, as follows:

1) Resistance to change from both midwives and doctors
2) Midwives resistance to embrace the extended role of the midwife. This may cause too much added stress in light of the current shortage
3) Fear of litigation
4) Dominance of obstetrics by doctors, which impacts the midwives’ practice.

Proper dialogue is needed to address these challenges. We looked closely at recommendations from SoWMy but response has been slow. Several meetings have been held with ministry and regional health authority personnel since January 2022. We discussed ideas for midwifery and looked at the Trinidad and Tobago’s response. Recommendations included more education and training and so on. And apart from that, recommended task shifting to meet the needs of midwifery and to include direct-entry training, not just training of registered nurses.

EDUCATION PRIORITIES

- Research
- Channel for professional growth
- Training facilities
- Simulation labs—how equipped? Hi-fi mannikins?
- Library
- Change in curriculum: standardized, CRMA advocating to harmonize curriculum across the Caribbean; pulling together a regional midwifery exam o make sure when you say midwife you know the standard to which they were assessed
- Standardized
- Increase program to Master of Science
- Ownership of midwifery program
- Increase salaries for midwives
- Respect for midwives
- Continuing education for educators continuing professional development (CPD) tie-in
- ICM competency based
- Preceptor training—have rolled out quite a few; how to evaluate students based on competencies
- Recruitment of educators—increase number of faculty, encourage midwives to go on with their training

RE-LICENSURE AND CONTINUING PROFESSIONAL DEVELOPMENT

Re-licensure is a requirement for midwives in all countries surveyed with the exception of The Bahamas. Most countries that ask for continuing education hours for licensure do not separate nursing from midwifery hours. Time frames for re-licensure range from annually to every three years. CPD differs among CRMA countries varying in requirement from 10-60 hours biennially.

FIGURE 1. GUYANA PRACTICE ACT:

> (4) In order to be re-registered by the Council, any nursing personnel who has been out of practice for at least three years shall complete clinical re-orientation under supervision at a recognised institution for a period stipulated by the Council.

MIDWIFERY TRAINING AND EDUCATION RECOMMENDATIONS

- Standardize and accredit midwifery education programs across the region, including updating curricula to reflect ICM global standards and competency-based curriculum
- Invest in appropriate remuneration for educators
- Use simulation in training and clinical training that reinforces scope of practice
- Prioritize facilities, simulation labs, and simulation opportunities and continuing education for educators
- Mandatory CPD to keep up educational standards

MIDWIFERY WORKFORCE

AVAILABILITY OF MIDWIVES

Data obtained from SoWMy individual country profiles in the CRMA region estimate a total SRMNAH workforce of 29,994, of which roughly 1,659 (6%) are midwives or nurse-midwives (Table 2). There is variation in professional training and scope of practice in the region. Most countries require a nursing degree before additional training in midwifery. According to the International Confederation of Midwifery Global Standards Education 2021, a nursing degree is not necessary for midwifery training.[7] Of the countries surveyed, only Jamaica has a path to midwifery practice that does not include first becoming a nurse. However, responsibilities do not always align with Caribbean midwives' competencies. According to the Suriname *Maternal and Newborn Health Strategy, 2021-2025,* for example, much of antenatal care is provided by medical doctors, although the data appears somewhat uncertain. Of note in SoWMy, midwives in Suriname, "can still play a key role in the provision of family planning, prenatal, and follow-up postnatal care for mother and newborn, including home visits and health promotion/ community health interventions."[8]

A dedicated midwifery workforce database exists in just five of the countries surveyed: Antigua and Barbuda, Guyana, Belize, Barbados, and The Bahamas. All are maintained by nursing or nursing and midwifery councils. With the data gap, leaders are unable to disaggregate midwifery and nursing workforce numbers to accurately assess shortages. Additionally, region representatives report that many midwives maintain both nursing and midwifery licenses but work primarily as nurses. In this case, the number of midwifery licenses issued is not indicative of the available midwifery workforce. Countries with a dedicated workforce database report a concerning midwifery workforce shortage ranging from 20%–95%. Comprehensive disaggregated data are needed for planning strategies that support the workforce. Members recommend developing a reliable repository of workforce data that includes relevant health workforce indicators such as age and area of practice.

TABLE 2. SRMNAH WORKFORCE[9]

	Total SRMNAH workforce	Midwives/ nurse-midwives	Density per 10,000 population
Antigua and Barbuda	931	272	28
The Bahamas	2,028	195	5
Barbados	1,036	146	5.1
Dominica	440	NR	NR
Grenada	704	NR	NR
Guyana	823	79	1
Haiti (?)	4,424	197	0.2
Jamaica	4,767	398	1.3
St. Kitts and Nevis	224	NR	NR
Saint Lucia	596	95	5.2
St. Vincent and the Grenadines	781	NR	NR
Suriname	2,681	111	1.9
Trinidad and Tobago	10,559	236	1.7
Total	29,994	1,729	NR

Source: SoWMy country profile 2021, accessed January 2023. Original: National Health Workforce Accounts data platform, accessed December 2020
NR=no response

RETENTION AND GLOBAL MIGRATION

The relationship between midwives in the Caribbean and the United Kingdom (U.K.) traces back to the early years of British rule. There is record of an early 19th century plantation owner's request of the British government for better trained birth attendants/midwives to care for enslaved people in childbirth. Records show the governor of Trinidad then made an appeal to the Medical Board, resulting in the registration of women who could read and write who were then required to pass an oral exam in midwifery. After successfully passing the exam, these women were awarded a "ticket to practice midwifery."[10] Efforts to abolish midwifery in early 20th century America effectively diminished the European and apprenticeship models of becoming a midwife. Formal midwifery training and education in the Caribbean region has evolved to a model similar to the U.K., allowing for an ease of migration from the Caribbean to the U.K.

The current midwife (and nurse) shortage in the U.K. and other high-income countries contributes to the Caribbean regional workforce shortage. Recruitment packages can be quite appealing and include student loan debt repayment and salaries that exceed local in-country standards. Direct recruitment includes not just entry level clinicians, but at every level of the profession. Discussion among CRMA members revealed migration is bidirectional—midwives and nurses frequently leave one Caribbean country to work in another. In addition, four of the 11 countries reported recruiting midwives from Ghana and Cuba. Saint Lucia reported plans to recruit from Ghana and other African countries; Barbados has already done so. Ethical concerns were voiced including "poaching" midwives from other CRMA members and lower-income countries, with the result being reinforced inequities. Language barriers and practice differences were noted as well as concerns that recruited midwives receive better social support than those locally trained. A lengthy discussion on ethical recruitment followed review of the *WHO Global Code of Practice on the International Recruitment of Health Personnel* with recognition that Ghana is on the *Health Workforce Support and Safeguards List, 2020,* and is subject to safeguards as the density of midwives and nurses is below the global median.[11,12]

Health care workforce retention is a topic of global concern. Contributing factors to an international shortage of health workers have been amplified by the COVID-19 pandemic. According to the *State of the World's Nursing Report* 2020, a global shortage of nurses is influenced by several factors:[13]

- Poor working conditions and high caseloads
- Migration to high-income countries
- Low functioning education systems and shortages of qualified faculty and clinical placement sites
- A lack of funded employment positions
- An increase in chronic diseases and multiple morbidities
- Number of new midwives is not keeping pace with population growth
- Demographic changes associated with aging populations and retirement

Several of these elements are also recognized for midwifery as areas of concern in the Caribbean region, including faculty shortages and migration to high-income countries. Retention of midwives is acknowledged as an urgent workforce issue; however, no national policies or strategies exist to attract and retain midwives in any of the surveyed CRMA countries.

Captain Bobby Joe Campbell

I was born in Jamaica and trained as a direct-entry midwife, finishing in 2005. I transferred into primary care and worked as a level II midwife 2008–2015. I completed an administration program in 2013 and became a level III midwife and supervisor in an administration role representing midwives at technical meetings. I then served as vice-president of Jamaica Midwives Association.

During COVID 19 pandemic, things changed drastically for midwives in the areas where I worked and how we reached our clients. I suggested collaboration with the military [Captain Campbell is a member of the paramilitary] resulting in no break in providing sexual and reproductive health services. Midwives were asked to be involved in COVID-19 pandemic work and work as quarantine and vaccination officers.

Migratory trends are impacting a number of countries, Trinidad and Tobago, Jamaica, Barbados, Guyana: because of remuneration that they can get. The difference between country remuneration for midwives and nurses is striking. Resources might be better in high-income countries, but midwives and nurses are leaving there also. Demonstrating that maintaining a workforce is not just about salary, but also valuing staff, motivation, and the potential for upward mobility.

Regarding the process of recruitment for migration to the U.K., there are many agencies conducting recruitment drives. However, the process is very similar in that all midwives and nurses have to take the CBT [computer-based test] examination in their home country and be successful for the process to continue. On arrival to the U.K., midwives and nurses are prepared for the OSCE [observed structured clinical examination], this exam must be successfully completed within eight months of your arrival. On successful completion you receive your PIN [personal identification number] from NMC [Nursing and Midwifery Council] and your name is entered on the NMC Register.

As a Caribbean-trained midwife, working here in the U.K. is very different as it relates to practice and policies. However, Caribbean persons are equipped with very excellent adaptive skills. As a result, I have been able to adjust quite smoothly. My one month and three months evaluation keeps volume of my preceptorship period so far and the reviews shared by clients and their families who I have cared for. There is far greater autonomy in practice here for midwives than in my home country. The ladder for profession growth is far higher as well.

As a YML [Young Midwife Leader], I cannot help but to ask certain questions. So with International Day of the Midwife (IDM) coming up on May 5th, I asked the question, "What is done here for IDM?" The response received was just not settling right with me. So I boldly shared what I think it should be like. To my view, came the support of the persons in that room that day. The follow-up to that is I am now in charge of planning the function for IDM and it is going great so far: all major team members on board, planning committee formed; letters sent out; poster created for advertising.

Since the initiation of the IDM function, I have been asked if I am willing to take on one of the role as a steward for the RCM [Royal College of Midwives] for the region that I am employed by.

“We are losing the most experienced midwives; young ones won’t have relationships with experienced mentors to guide them. What will happen to the profession without guiding midwives?”
— Captain Bobby Joe Campbell

WORKFORCE RECOMMENDATIONS

The region is losing its most experienced and skilled nurses and midwives through migration to more developed countries. As such there are serious implications in the migration of nurses and midwives, which impacts the sustainability of effective health systems within the region and for efforts to advance the 2030 Agenda for Sustainable Development Goals. The progressive realization of universal health coverage,

integrated people-centered health services, and the strengthening of primary health care are also threatened by the continual outflow of this essential workforce

The COVID-19 pandemic and other natural disasters have exacerbated the gaps in availability and distribution of human resources for health. The ability for expansion, recruitment, and retention of personnel, in particular nurses and midwives and their migration, have contributed to shortages of human resources for health. There is, and will be, ongoing economic and social costs associated with the lack of robust retention policies and the potential for conflict with contrasting policies and agreements in place that bring midwives into the region from countries that can ill afford to lose their own workforce or who have language and training that does not easily match the regional norm.

Given this stark reality the following recommendations are put forth:

- ***Review and strengthen*** retention policies as a core "managed migration" strategy.
- ***Develop and review*** policy options for the monitoring and management of international recruitment agencies in line with international agreements.
- ***Review and update*** policies that facilitate opportunities for financial and service bonds for nurses and midwives who have had their training supported by the respective governments in the region.
- **Develop policies/cooperation agreements** that address the responsibility of recruiting countries in supporting the development of midwifery and nursing personnel and the strengthening of national health systems.
- ***Develop and negotiate*** with recruiting countries, financial models that facilitate the development of national health systems within Caribbean territories.

MIDWIFERY REGULATION, POLICY, AND LEADERSHIP

REGIONAL REGULATION

Overall, it was found that guiding regional regulation in both current and draft regulatory acts consistently reflects *ICM Essential Competencies for Midwifery Practice*, and the definition of the term "midwife" is generally congruous across the region.

According to the ICM:

> "A midwife is a person who has successfully completed a midwifery education programme that is based on the ICM Essential Competencies for Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education and is recognized in the country where it is located; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery."[14]

The essential competencies of midwifery practice are defined within these four domains:

1. *General competencies*: relate to midwife's autonomy and accountability in all aspects of midwifery care
2. *Competencies specific to pre-pregnancy and antenatal care*: demonstrates knowledge and skill in health assessment of pregnant patient and fetus, health promotion, and recognizing complications
3. *Competencies specific to care during labor and birth*: the midwife safeguards patients during labor and birth, provides immediate care of the newborn, and recognizes and manages complications in mother or infant

4. *Competencies specific to the ongoing care of women and newborns*: ongoing care of women and newborns, including assessment, health education, breastfeeding support, and family planning management[15]

Several regulatory acts define a midwife as "an individual who has successfully completed midwifery training and education." The Barbados *Nurses Act*, which replaces the *Nurses and Midwives (Registration),* a midwife is "a person whose name appears in that part of the Register of Nurses allocated for nurses qualified to practice midwifery." Regulation guidelines offer slight reference to midwives in the revised bill other than "responsibility of midwives in emergencies."[16]

Survey responses pertaining to midwives' scope of practice varied across the region. Competencies specific to labor and birth were regularly confirmed in survey responses and regulatory guidelines. However, it was noted that in the ICM competency domain of "ongoing care of women and newborns," *most* midwives in the region do not prescribe or manage family planning methods, although the content is covered in midwifery education.

Of the countries surveyed, pre-pregnancy care was excluded in midwifery practice in Antigua and Barbuda, Saint Lucia, and Belize. Antigua and Barbuda participants noted that pre-pregnancy, newborn care, and family planning are not regularly included in midwives' practice. Antigua and Barbuda, Guyana, Trinidad and Tobago, Belize, and St. Vincent and the Grenadines responded that family planning is not included in country regulation or practice. Although intrauterine contraception device insertion and management is included in most midwifery education programs in the region, it is rarely included in midwifery practice—other professionals are responsible for placement and management. Previous research findings indicate improved health outcomes with appropriate professional autonomy and scope of practice. Workshop participants advocated for increased access to preventative care for vulnerable populations.

There are additional regulatory differences in the region. Some countries utilize a very prescriptive approach to clinical practice. For example, the *Grenada Nurses and Midwives Registration Act* precisely defines cleanliness, record keeping, handwashing, and contents of the midwives' bag.[17]

FIGURE 2. GRENADA NURSES AND MIDWIVES REGISTRATION ACT, CONTENTS OF MIDWIFERY BAG

9. Contents of midwifery bag

Every midwife shall keep and take with her on all occasions when attending a confinement, a case or bag, kept solely for the purpose and furnished with a removable lining which can be washed and boiled. At least two linings must be provided, the one in use must be clean, the other being washed immediately on removal and retained ready for use. The case or bag must at all times be ready, and be brought when requested for inspection by an authorised person. It must always contain—

(*a*) a douche-can with necessary attachments or a Higginson's syringe for giving enemas only;

(*b*) a roll-up instrument case containing—

(i) a dissecting forceps,

(ii) a pair of scissors,

(iii) rubber catheter,

(iv) clinical thermometer, (an extra roll-up case should be provided);

(*c*) rectal tube;

(*d*) a bottle of approved disinfectant;

(*e*) a glass container of approved antiseptic powder;

(*f*) a bottle of boracic solution for cleaning the child's eyelids;

(*g*) a bottle of an approved silver preparation for the disinfection of the child's eyes;

(*h*) cotton wool;

(*i*) dressing for cord such as clean lint or clean cloth which has been boiled;

(*j*) cord or tape for tying the cord;

(*k*) an enamel bowl or kidney dish;

(*l*) a graduated medicine glass;

(*m*) six tablets of ergometrine or a small bottle of liquid extract of ergot;

(*n*) a water-proof bag containing apron, soap, nail brush and towel in separate compartments.

Regional nursing and midwifery regulations are frequently covered in a single regulatory act. As in the case of *The Barbados Nursing Rules,* which includes definitions and duties of psychiatric nurse, nursing assistant, nursing auxiliaries, and midwives defining all within a single document.[18]

Midwives in the Caribbean are integrated into health care systems to varying degrees. In Suriname, there is no national health system and thus citizens need private insurance; however, the largest insurance company in the country refuses to work with midwives.

CURRENT REGIONAL REGULATORY CLIMATE

Important cross-country discussions were begun with the sharing of midwifery and nursing and midwifery acts among CRMA partners. Nursing is generally recognized as an entry point to midwifery with the exception

of Jamaica (*The Jamaica Nurses and Midwives Act* is currently under revision) and Guyana, which has direct-entry training for midwives working in the rural communities.

The nursing requirement is demonstrated in the *Grenada Nurses, Midwives* ***Registration*** *Act*:[19]

20. Qualifications of midwives

In order to be qualified as a midwife a person must successfully complete a prescribed programme of studies in the theory and practice of midwifery, and in the care of the newborn.

21. Overseas qualifications

(1) A person who satisfies the Council that he or she has completed overseas training in accordance with a scheme of training recognised by the Council—

(*a*) as a nurse generally;

(*b*) as a nurse of some special class;

(*c*) as a nursing assistant; or

(*d*) as a midwife,

and that he or she underwent the training in an institution recognised by the Council and is of good character, is, on making application in the prescribed manner and on payment of the prescribed fee, entitled to be registered in the register appearing to the Council to be appropriate to the case.

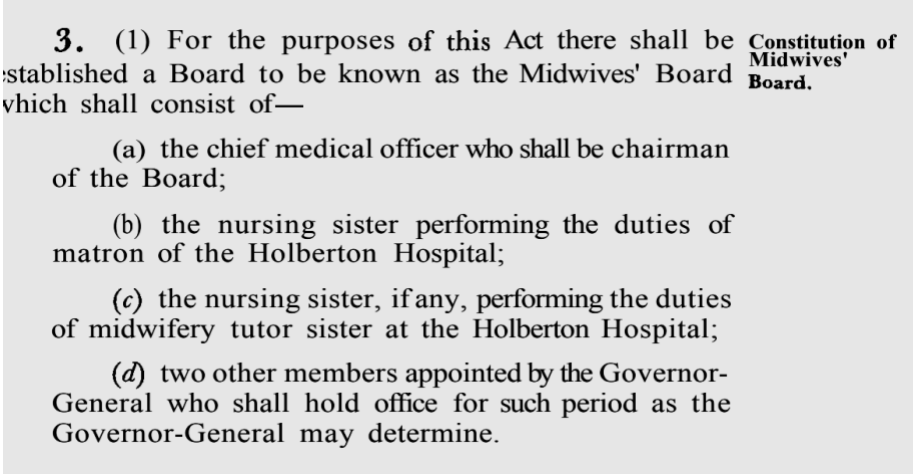
Participant discussion regarding regulatory climates:

- "In The Bahamas, you register as a nurse and as a midwife. If not registered (relicensed) as a midwife, you cannot operate as such."
- "In Trinidad, there is *a* separate license, registration, fee, etc. In other countries *the* only entry requirement is through doing nursing first, but still have to register for both if they go on to do midwifery after. For ease of movement between countries, these things and others must be addressed."
- "Guyana has direct entry (two years working in rural communities), post-basic training is one year (nurses' assistant or registered nurse [RN])."
- "It is clear that we will need to work on a standard across the countries. If not, we run the risk to take up things in our courses that don't speak to the context/model of the country."
- "Keep country policy, laws, act, in consideration as this may differ when it comes to modal for functioning of nurse/midwife."

In The Midwifery Act, Chapter 281 of the Laws of Antigua and Barbuda, a board of midwives is composed of a chief medical officer, nursing sister, and two other members appointed by the governor-general (see below). This conflicts with ICM recommendations for midwifery practice regulatory legislation defined here:[20]

- Provide the mechanism for a regulatory body that is governed by midwives with the aim of protecting the public.
- Ensure the profession is governed by midwives.

The example of Antigua and Barbuda calls into question the governing of a midwives practice without midwife representation as demonstrated in the following excerpt:



3. (1) For the purposes of this Act there shall be established a Board to be known as the Midwives' Board which shall consist of— **Constitution of Midwives' Board.**

(a) the chief medical officer who shall be chairman of the Board;

(b) the nursing sister performing the duties of matron of the Holberton Hospital;

(*c*) the nursing sister, if any, performing the duties of midwifery tutor sister at the Holberton Hospital;

(*d*) two other members appointed by the Governor-General who shall hold office for such period as the Governor-General may determine.

The current climate of midwifery regulation may change as several countries' practice acts are under construction or in review by local ministries of health (Table 3a and 3b).

TABLE 3A. STATUS OF MIDWIFERY REGULATORY ACTS AS OF NOVEMBER 2022:

Country	Regulatory Status
Trinidad and Tobago	2014—under review
St. Vincent and Grenadines	The council was reviewed in 2005, but the nurses and midwives act was completed in 1998
Jamaica	Portions the act were reviewed in 2005 and are now looking at prescriptive rights of midwives—currently under review
Grenada	In 2013, the act was sent to the legal department; it is still there waiting final review. Since then, things have changed so adjustments may be needed.
Barbados	Reviewed in 2008, currently there are some issues in review, specifically concerning specialist nurses. A look at scope of practice for midwives is needed.
Suriname	Midwives are under the medical act, which is now in state of finalization; the midwifery association was consulted.
Guyana	Act finalized in 2019, but new government administration changed, and legality was in question, so act was amended in 2022, passed in parliament, and signed off by the president. Currently drafting new regulations to go along with the revised practice act.
The Bahamas	Midwives and nurses act is tabled this year and will be discussed at the upcoming parliamentary session; currently still working under the one of 1971

TABLE 3B. REGULATORY ACTS OF THE CARIBBEAN REGION

Midwifery Act	Nurses and Midwives Act	Nurses Act	Medical Act
Antigua and Barbuda	The Bahamas	Barbados	Suriname
	Grenada		
	Guyana		
	Jamaica		
	St. Lucia		
	St. Vincent and the Grenadines*		
	Trinidad and Tobago		

*Nurses, Midwives and Nursing Assistants Act

REGULATION OF WORK ENVIRONMENT

The State of the World's Midwifery report detailed the importance of equitable working conditions, including regulations regarding maximum shift length, hours per week, salary, and social protections. The CRMA workforce survey revealed work environments are generally consistent across the region with regulated minimum wages and hours worked. Table 4 details the current regulatory environments in 13 CRMA countries.

TABLE 4. REGULATION OF WORK ENVIRONMENT

Country	Workforce database	Level of midwife shortage	Re-licensure required	CPD	Number of CPD hours required	Hours worked regulated	Minimum wage	Midwifery association
Antigua and Barbuda	NR	20%	Y	Y	NR	Y	Y	NR
The Bahamas	Y	NR	N	N	NA	Y	Y	Y
Barbados	Y	95%	Y	Y	30 hours	Y	Y	Y
Belize	Y/N?	50%	Y	Y	**20 hours**	NR	NR	N
Dominica	NR	30%	Y	N	N/A	Y	Y	N
Grenada	NR	NR	NR	NR	NR	NR	NR	NR
Guyana	Y	NR	Y	Y	NR	Y	Y	Y
Jamaica	N	Approx 40%	Y	N	N/A	Y	Y	Y
St. Kitts and Nevis	NR	NR	NR	NR	NR	NR	NR	NR
Saint Lucia	N	NR	Y	Y	30 hours	Y	Y	Y
St. Vincent and the Grenadines	N	80%	Y	N	NA	Y	Y	Y
Suriname	NR	NR	NR	NR	NR	NR	NR	NR
Trinidad and Tobago	N	NR	Y	N	N/A	Y	Y	Y

CPD, continuing professional development; Yes, Y; No, N; Not Reported, NR; Not Applicable, NA

LEADERSHIP

It was noted that of the country leaders in attendance and those providing survey data, most were not midwives, but nurses, and that midwife voices are not common in high-level conversations regarding **regulation and practice**. A survey of chief nursing officers (CNOs) and chief midwifery officers (CMOs) revealed inconsistent midwifery representation. Few of the CRMA member countries are represented by midwives at higher levels of leadership, which may cause the interests of nursing and midwifery to be linked together. Although the professions are closely aligned, distinctions between the two at higher levels of leadership may foster an environment for improved midwifery advocacy.

Of the 12 countries surveyed, half reported little or no representation in regulatory decision-making and that midwifery input and responsibility for SRMNAH policies are rare. Several countries reported CNOs, nursing councils, and ministries of health driving SRMNAH policies with two (Guyana and Antigua and Barbuda) reporting participation of midwives at this decision-making level. Guidance from the ICM in the *Global Standards for Midwifery Regulation* 2011 has the following recommendation:

> "ensure the profession is governed by midwives" and "recognize the importance of separate midwifery regulation and legislation which supports and enhances the work of midwives in improving maternal, child and public health"[21]

ADVANCMENTS IN REGULATION, POLICY, AND LEADERSHIP

Midwifery association participation in regulation and decision-making has been notably inconsistent across the region. Antigua and Barbuda, Guyana, Belize, and The Bahamas reported no representative midwifery professional organizations. In the 31 January 2023 pre-validation workshop with dialogue participants, it was noted that many of the recommendations and goals set forth in November 2022 have begun to be addressed; however, program development continues and is an ongoing process. Newly created midwifery associations and midwifery representation in existing associations require continued support to maintain active participation and leadership.

Utilizing a matrix of indicators based on the global evaluation framework and the *State of the Worlds Nursing* and SoWMy theory of change, this report reveals early evidence of successful first engagement and dialogue.[22] The opening ceremonies were extensively covered by the media and press releases were written and distributed by the CRMA to CNOs and CMOs of participating countries. Dr. Pandora Hardtman, Chief Nursing and Midwifery Officer, Jhpiego, was interviewed on a local Guyanese news station reporting on the CRMA dialogue event and key issues to be addressed.

The following developments related to partnerships, new champions, and relationships with decision-makers were reported by CRMA participants at the 31 January 2023 pre-validation workshops.

- **Grenada**: Grenadian representatives met with the Grenada Nurses Association and explored ways to connect all midwives in the country, including a link in the district and hospitals, for information sharing. Participants discussed what to bring to the fore as the new government is focused on health this period. The Grenada Nurses Association has taken responsibility for formulating the midwifery group of Grenada.
- **Suriname**: Suriname Organisation of Midwives has a new interim board and is working towards organizing an election. The Ministry of Health has invited the organization chair for a meeting to talk about midwifery in Suriname.
- **Saint Lucia**: Representatives met with nursing council leaders to advocate for a title change of the regulatory act from *Nurses and Nursing Assistant Act* to *Nurses, Midwives and Nursing Assistant Act.* Two meetings were held with nursing leaders representing nurses from every institution led by the CNO. All were in agreement that there should be more recognition given to midwives and to plan activities on the

International Day of the Midwife. Recommendations include a revamp of the midwifery interest group and more recognition in the Saint Lucia's Nurses Association.

- **Guyana**: The deputy chief nurse made contact with the president of the midwives' association to determine plans for midwifery moving forward. The office of Nursing and Midwifery sees the need for a midwifery officer to streamline things for midwives. A letter was given to the chief medical officer to justify the need for a chief midwifery officer. Follow-up conversations are planned to find a suitable candidate to fill the position.
- **St. Vincent and the Grenadines**: Representatives have had successful meetings with the council for an update on the CRMA dialogue during the November 2022 meeting in Guyana and a decision to meet with key stakeholders of midwifery, including the dean (acting) for nursing education, CNO (acting) and president of St. Vincent, and the Grenadines Nurses Association. A committee was formed to develop a proposal for the Minister of Health to explore how best to move midwifery forward. During a meeting of the nurses' association, the president informed the entire body about the Guyana meeting and that midwifery should be a part of the association and be recognized.
- **Barbados**: Submitting a report highlighting action items to the permanent secretary and chief medical officer on the CRMA dialogue with associated interest. As a result of the meeting, suggestions were made to link with the planning unit of Ministry of Health to explore how to move forward (after the next budget period).
- **Trinidad and Tobago**: Reviewing curriculum and how to improve midwifery in terms of recruitment and leadership. Looking at education and practice and confirming integration of ICM competencies. Experienced COVID delays.

REGULATION, POLICY, AND LEADERSHIP RECOMMENDATIONS

CRMA members called upon their colleagues to advocate for a profession in which midwives are functioning to the full extent of their training with consistent integration of family planning and reproductive health into clinical practice.

CRMA members also call for a unified regulatory framework for midwifery as a profession separate from nursing and a pathway for leadership within midwifery. Participants noted that creating a generation of leaders is a priority and needed for the continued advancement of midwifery in the region. Discussion led to the following specific leadership recommendations:

- Be a part of organizational structure of ministries of health
- Create senior midwife positions for engagement at policy levels
- Identify persons with leadership potential and invest in training and foster a supportive environment so they can grow
- Mentor several persons simultaneously
- Recognize leadership mentorship as a long-term commitment

Discussion of training new midwifery leaders led to consideration of the potential for developing a leadership module that could be used across the region, including how to invest in leadership (it is a long-time commitment) and values clarification.

Topics for suggested leadership module:

- Skills: political advocacy, networking, and negotiation
- Interacting as a leader: have an open-door policy, less red tape, so potential future leaders can approach and learn from them
- Recognize emotional intelligence
- How to open doors and who is blocking my door?

MIDWIFE-LED IMPROVEMENTS TO CURRENT AND FUTURE SRMNAH SERVICE DELIVERY

Follow-on workshop participants in early 2023 noted the extraordinary circumstances and opportunity for new cross collaboration begun with the 2022 series of workshops and face-to-face meeting. Additional subject matter conversations that needed to be conducted were addressed via a webinar discussion, telehealth and disaster preparedness are covered below.

TELEHEALTH

Utilization of telehealth increased substantially in response to health care system disruptions during the COVID pandemic. Telehealth was employed as a means of reaching non-emergency patients when the risk of infection made contact difficult if not impossible. Telehealth use in low- and middle-income countries during the pandemic revealed a high level of acceptance for these services by both patients and health workers, although the method is not without challenges, including maintaining patient confidentiality.[23] According to the Economic Commission for Latin America and the Caribbean, telehealth is an important innovation-especially in rural communities.[24]

A unique program was developed by the midwifery lecturers at the University of The Bahamas utilizing telehealth for postpartum care. The program was piloted with midwifery students in which the student midwives evaluated postpartum patients using the messaging platform WhatsApp. An extensive process for institutional permission was obtained and guidelines developed to ensure patient consent and confidentiality. The midwife educator and students interviewed postnatal patients via WhatsApp to complete a full history on mother and newborn status since delivery. Patients' physical concerns were evaluated via video or photos with patients submitting photos of affected areas for midwife evaluation. (All photos and videos were immediately deleted.) Use of telehealth was paused when pandemic restrictions were eased, but all parties recognize the value of future use. The program is currently under review by the Ministry of Health.

CRMA members throughout the region described using telehealth to access specialists outside of the region for pediatric populations and for screening patients and monitoring medication use. Many CRMA members suggest that telehealth could be more effectively utilized. Despite the recognized value of telehealth, most countries in the Caribbean region do not have access to it.

- **Guyana**: One of the rural regions launched a telehealth pilot. The results are not yet available.

- **Grenada**: Used in pediatrics to access specialists.
- **St. Vincent and the Grenadines**: Used during the pandemic and the volcanic eruption. Telemedicine through the Sick Kids Initiative for pediatric consultations via Zoom and/or telephone with colleagues in the U.S. legislation is being developed to facilitate all types of health information and may include telehealth.
- **Suriname**: Medical mission in the hinterlands using telehealth when there are no midwives in the area.
- **Antigua and Barbuda:** There is a problem of maternal and child health and lack of prenatal care and sometimes postnatal care, which could allow midwives to reach people in their homes using telehealth. Would like to see how it could be used more effectively.
- **Barbados**: In the primary care centers, telephone consultations were used to some extent during the pandemic, but in recent times there was a push to return to face-to-face care.
- **The Bahamas**: Using telehealth across islands for specialists.

Countries consistently use telehealth for pediatric specialties but less in other aspects of health care. CRMA members agreed that telehealth could be more effectively utilized in the Caribbean region as many countries are composed of multiple islands and hard-to-reach rural areas.

DISASTER PREPAREDNESS AND PUBLIC HEALTH EMERGENCIES

The hurricane-prone Caribbean region is located southeast of the North American mainland, east of Central America, and north of South America between the Atlantic Ocean and the Caribbean Sea. The region experiences an average of one hurricane each season. Because of this, CRMA members report comprehensive disaster management strategies across the region. For example, in The Bahamas, SRMNAH hurricane response involves moving antepartum patients from the more remote areas of the region to the capital if there is no safe ground where they are. If a storm is anticipated, Antigua and Barbuda representatives report moving antepartum patients from Barbuda (with a population close to 1,600 people) to the mainland of Antigua. Region midwives may be used in varying capacities beyond antepartum, intrapartum, and postpartum care. Depending on the needs of the area and extent of the disaster, midwives might be reassigned to utilize their nursing skills.

Members report some nursing representation in this decision-making process but agree that midwives' potential contributions to preparedness are underutilized. The ICM position statement, *The Role of the Midwife in Disaster Preparedness* highlights the need for midwives to be prepared as essential for "the provision of maternal, newborn and child health services."[25]

The Caribbean Community Secretary General recently endorsed the launch of an early warning system in the region to improve alerts associated with natural disasters. The Secretary General noted that global warming has had an especially disruptive effect in the Caribbean region. Climate change is associated with stronger hurricanes and rising sea-levels with increased risk of flooding.[26] ICM addresses climate change and its effect on health workers in the position statement *Impact of Climate Change,* recognizing that climate change has the potential to harm both midwives and the communities they serve. ICM notes that midwives must consider climate change and ways to address global and local environmental issues.[27]

Representation at all levels of decision-making is needed to ensure appropriate focus on SRMNAH during disasters and emergencies. ICM calls for midwifery associations to contribute to disaster preparedness strategies, advocacy on behalf of women and children, and post-disaster assessments.

RECOMMENDATIONS

The data in this report and the global SoWMy was used to identify regional strengths and gaps in the current and potential SRMNAH workforce and can be used to guide future intervention and investment.

The following priorities and action agenda were put forth and confirmed by regional CRMA representatives and survey participants.

MIDWIFERY EDUCATION

- **Standardization and accreditation of midwifery education programs across the region that includes updated curricula to reflect ICM global standards and a competency-based curriculum including a regional midwifery licensing exam for all Caribbean countries.** This can best be accomplished by engaging the Regional Nursing Body of CARICOM to lead the conversation across the region. The Regional Nursing Body meets regularly with nurse administrators and regulators.
- **Appropriate remuneration for educators.** Investment in competitive renumeration for educators with a focus on utilizing best practice clinical education and pedagogy in midwifery education is needed to continue fostering a vital midwifery workforce.
- **Utilization of simulation in training and clinical training that reinforces scope of practice.** Investment in evidence-based simulation and clinical training with spending priorities on simulation labs and simulation opportunities to build and maintain competence in full scope practice.
- **Mandatory CPD for educators and midwives**. Continued opportunities for synchronous webinar and face-to-face CPD events pertaining to clinical practice and professional development is needed to support cross-country networking, leadership, and evidence-based practice.

MIDWIFERY WORKFORCE

- **Compile comprehensive disaggregated data for planning workforce supporting strategies.** Data pertaining to numbers of midwives and other SRMNAH workers are essential to determine accurate workforce availability. Funding for a comprehensive regional midwife workforce survey is needed to guide future priorities. This could be accomplished alongside revitalization of National Health Workforce account data point to delineate and define professions according to International Labor Organization categories.
- **Regional policy to address nuanced outflow and inflow migration of midwives.** Items for inclusion in policy to be considered might include increases in salary and incentives, such as tax-free vehicle purchases, expansion of career paths and bond schemes within the practice of midwifery, strengthening of adherence to recruitment codes, retention bonuses every five years, consistent training of midwives, and engaging recruiting countries with agreements for exchange programs to assist with training of midwives in country and to increase depth and breadth of experience.

MIDWIFERY REGULATION, POLICY, AND LEADERSHIP

- **Update regulation to reflect scope of practice and autonomy**. Regional midwifery curricula include the ICM essential competencies of full scope practice. Midwives functioning to the full extent of their training can meet the SRMNAH needs of a population. Strong midwifery leadership and professional organizations are needed to advocate for full scope practice authority.

- **Invest in midwifery leadership.** Identify persons with leadership potential, invest in training, foster supportive environments, and provide mentorship opportunities, including developing a leadership module for midwives interested in pursuing leadership. Identify and support for new and existing professional organizations. Engage in Young Midwifery Leaders program.
- **Increase the presence of midwives at decision-making levels including designating a chief midwifery officer in addition to chief nursing officer**. Leadership advocating for midwives and other SRMNAH workers is essential at top levels of decision-making for continued professional advocacy. Encourage professional organizations to continue to advocate for midwives at all levels of health care organizations and government.

CONCLUSION

This report was undertaken to outline the current status of the midwifery profession in English-speaking Caribbean countries (and Dutch-speaking) Suriname including an overview of the status of professional organizations, midwife workforce availability in the region, with recommendations for continued professional development and midwifery education institutions and curricula.

In general, we found that the midwifery profession is closely linked with nursing in much of the region with many midwives dually licensed as both nurse and midwife. This close association impeded data collection of midwifery as a profession distinct from nursing. Although cross-trained professionals may be a pragmatic approach, especially in countries with smaller populations, the mingling of the two professions made estimation of the midwifery workforce in the region difficult and in some countries, impossible.

Initially, we found varying levels of involvement in professional organizations with midwife representation often housed within nursing organizations. However, a recent survey of participants revealed several new cross-country partnerships and successful coalitions reflected in revived meeting events and webinar attendance.

Migration of qualified midwives is an issue of concern. Recruitment efforts from wealthy countries experiencing health care workers shortages have offered attractive renumeration packages to both experienced and newly graduated midwives.

This report, the CRMA dialogue, and the preceding and subsequent discussions were widely regarded by the participants as a galvanizing step forward. However, follow-up and support are needed to ensure that the momentum of change continues for Caribbean midwives. Research is needed with access to disaggregated data to accurately assess midwifery workforce numbers and needs. As health care systems in the region continue the post-pandemic recovery, continued prioritization of midwives' education, regulation, and deployment is needed. Newly formed midwifery associations and cross-country collaboration require support to maintain strengthening efforts.

APPENDIX A: GENERAL METHODOLOGY

The data used in this report was collected via pre-workshop surveys, in-person small group/topic discussion and reflection, webinar discussions, and polling. Additional analysis was accomplished using SoWMy report data.

METHODS

SELF-COMPLETION QUESTIONNAIRES (APPENDIX B)

Questionnaires were distributed to workshop participants-representatives of nursing and midwifery leadership prior to the in-person workshop. The questionnaire was developed by Jhpiego's chief nursing and midwifery officer and the CRMA president to reflect data collected in SoWMy. The questionnaire was created and distributed in English an online for

SECONDARY DATA COLLECTION

Published sources were utilized for data on population, demographics and health service delivery.

APPENDIX B: SURVEY

CARIBBEAN REGIONAL MIDWIVES ASSOCIATION

STATE OF THE WORLD MIDWIFERY REPORT CARIBBEAN RESPONSE SURVEY

Caribbean Regional Midwives Association would appreciate if you would take 30 minutes to complete the following Survey. We are working to mount a Regional response to the 2020 State of the World Midwifery (SoWMy) report. The information obtained will be used to guide this response and give context to future conversations. This project is supported by USAID MOMENTUM Country Global Leadership and UNFPA.

Thank you for your participation. We appreciate your time.

1. Country _____
2. What is your position? _____
3. What is Total population of your country? _____
4. What is the number of births per year? _____
5. What is the percentage of births to adolescents? _____%
6. What is the most recent Maternal Mortality Rate in your country?
   _____ per 100,000 live births, _____year
7. What is the most recent Neonatal Mortality Rate in your country?
   _____per 1000 live births, _____year
8. What is the most recent Stillbirth rate in your country?
   _____ per 1000 live births, _____year
9. What is the percentage of low birth weight infants (<2500g) _____%
10. Is there a workforce database for midwives in your country? Yes _____ No _____
11. Who is responsible for the maintenance of a midwifery database? _____
12. What is the level (%) of midwifery workforce shortage in your country? _____
13. What percentage of the health budget is allocated to midwifery education? _____
14. What percentage of the health budget is allocated to training of midwifery educators? _____
15. What type of midwifery programmes do you have in your country? (tick all that apply)
    _____ Direct-entry midwives, _____ Post RN midwives _____ Integrated
    _____ Certificate programme, _____ Diploma programme _____ Bachelor's degree,
    _____ Master's degree

16. What is the duration of the midwifery programme(s) in your country?
    _____ Certificate programme _____ Diploma programme _____ Bachelor's degree,
    _____ Master's degree _____ Direct-entry midwives _____ Post RN midwives,
    _____ Integrated

17. Does the current Midwifery Regulation in your country reflect the ICM Core Competencies for Midwives?
    _____

18. Which area in the Core Competencies is **Not** included in your countries Regulations? (tick all that apply)
    _____ General _____ Pre-pregnancy _____ Antenatal
    _____ Labour _____ Delivery _____ Postnatal
    _____ Newborn care _____ Family Planning
    Explain_____
    _____

19. Is re-licensure required for the midwives in your country? Yes _____ No _____

20. If Yes, how often is re-licensure required? _____ years, Not applicable _____

21. Is Continuous Professional Development (CPD) regulated? Yes _____ No _____

22. How many CPD hours are required specifically for midwives? _____hours, Not applicable _____

23. Are there regulations that govern the quality of Midwifery curriculum? Yes _____ No _____

24. Are there regulations that govern the qualifications of midwifery educators? Yes _____ No _____

25. What percentage of midwifery educators are midwives? _____%

26. Is there a national policy /strategy in place to attract and retain midwives? Yes _____ No _____

27. Is there a midwifery model of care (midwifery-led) in in your country?
    _____ Antenatal _____ Intrapartum _____ Postnatal
    _____ Family Planning

28. Are midwives in leadership positions in your country? (tick all that apply)
    _____ National MOH level _____ Sub-national MOH level
    _____ Regulatory (Council) level

29. Is there a position for a Chief/Senior Midwifery Officer in your country? Yes _____ No _____

30. Who is responsible for driving health policies for SRMNAH in your country?
    _____

31. Is there a Midwifery Association or Midwifery Interest group in your Country? Yes _____ No _____

32. Do the Midwifery Association/Interest group participate in decision-making for regulation and practice in your country? Yes _____ No _____

APPENDIX C: JANUARY 2023 PRE-VALIDATION WORKSHOP PARTICIPANTS

Name	Affiliation	Country
Pandora Hardtman	MOMENTUM Country and Global Leadership	United States
Shirley Curtis	CRMA President	The Bahamas
Maria Francois	Guyana Midwives Association	Guyana
Cedina Forde	Guyana Nurses Association	Guyana
Nalini Dass-Sutton	CNO-MoPH	Guyana
Marita Harris	Barbados Nurses Association	Barbados
Megan Grosvenor	Deputy Registrar (acting)	Barbados
Betty Ann Pilgrim	National Administrator for Nursing Services, Ministry of Health	Trinidad and Tobago
Anoris Martin-Charles	CNO rep	Grenada
Sherrien Bhagwan	Department Manager, Ministry of Health	Grenada
Suze Holband	CMO's Land Hospital	Suriname
Gafier Jongaman	Chair of Suriname Midwives Association	Suriname
Larone Hyland	Deputy chief public health nurse CNO rep	Barbados
Margaret Smith	CNO	Antigua
Juliette Joseph	Regulation	St. Lucia
Grace Walters	Regulation	St. Vincent and the Grenadines

APPENDIX D: NOVEMBER 2022 WORKSHOP PARTICIPANTS

Name	Organization/Rep	Country
Pandora Hardtman	MOMENTUM Country and Global Leadership	United States
Judith Brielle	UNFPA (LO-Suriname)	Suriname
Debrah Lewis	UNFPA (consultant)	Trinidad
Shirley Curtis	CRMA President (facilitator)	The Bahamas
Anoris Martin-Charles	CNO rep	Grenada
Bernadine Francois	Regulation	Grenada
Suze Holband	CMO's Land Hospital	Suriname
Marjorie Vredeberg	Bachelor in Nursing Midwife Trainer	Suriname
Larone Hyland	Position Deputy chief public health nurse CNO rep	Barbados
Valarie Francis Miller	Senior Midwife, chairperson midwife group, member of the nursing council	Barbados
Adler Bynoe	UNFPA (LO-Guyana)	Guyana
Nalini Dass-Sutton	CNO-MoPH	Guyana
Margaret Smith	CNO	Antigua
Ann-Marie Brown-Issac	Regulation	Antigua
Kacey Surage-Kerthney	CNO	St. Lucia
Juliette Joseph	Regulation	St. Lucia
Patricia Ingram-Martin	CNO	Jamaica
Sheila Jones	Regulation	Jamaica
Sherry Armbrister	CNO	The Bahamas
Grace Walters	Regulation	St. Vincent and the Grenadines

APPENDIX E: OPENING CEREMONY AGENDA

Marriott Hotel
Georgetown, Guyana
November 14, 2022
8:30 am–10:00 am

Moderator:
Ms. Judith Brielle, Liaison Officer for Suriname, UNFPA

Opening Prayer:
Midwives Association of Guyana

CARICOM Song (Video)/Flag Ceremony

Welcome:
Ms. Judith Brielle, Liaison Officer for Suriname, UNFPA

REMARKS:
Caribbean Regional Midwives Association (CRMA):
Dr. Shirley Curtis, President

United Nations Population Fund (UNFPA):
Ms. Jewel Quallo-Rosberg, Officer-in-Charge, Sub-Regional Office for the Caribbean

USAID MOMENTUM Country and Global Leadership:
Dr Pandora Hardtman

United Nations Children's Fund (UNICEF):
Mr. Irfan Akhtar, Deputy Representative

Ministry of Health Guyana:
Mrs. Nalini Dass-Sutton, Chief Nursing Officer;
Narine Singh, Chief Medical Officer

Musical Selection:
Midwifery Students

PUSH for Midwives:
Video

Call to Action:
Dr. Shirley Curtis, CRMA President

Vote of Thanks:
Mrs. Debrah Lewis

APPENDIX F: WORKSHOP AGENDA

Day 1 Time	Event/Participant
08:30am-10:00am	Opening Ceremony
10:00am-10:45am	Tea Break/Reception
10:45am-11:30am	Safety briefing-UNFPA Representative Introduction: S. Curtis Expectations : D. Lewis
11:30am-1:00pm	SoWMy Report Summary: P. Hardtman Survey Report Education and SoWMy—Summary: S. Curtis UNFPA Country Profile: D. Lewis Reflections: D. Lewis
1:00pm-2:00pm	Lunch break
2:00pm-3:00pm	ICM Competencies: S. Curtis
3:00pm-4:00pm	Education and Training: S. Curtis
4:00pm-4:30pm	Reflections: D. Lewis

Day 2 Time	Event/participant
8:30am-10:00am	Opening prayer: Participant Recap: Participants Midwifery workforce: P. Hardtman Categories of SRMNAH workers Policy on retention and migration The way forward
10:30am-11:00am	Tea break
11:00am-1:00pm	Scope of practice for midwives: S. Curtis Registration and re-licensure Professional development Nurses and Midwives Act
1:00pm-2:00pm	Lunch break
2:00pm-3:30pm	Midwifery-led care: D. Lewis Senior/Chief Midwifery Officer
3:00pm-4:30pm	Emerging trends: P. Hardtman Telehealth Disaster preparedness
4:30pm-5:00pm	Reflections: D. Lewis

Day 3 Time	Event/Participant
8:30am-10:00am	Opening prayer: Participants Recap: Participants Country working groups Country response
10:00am-10:30am	Tea break
10:30am-12:00pm	Report out (15 min each)
12:00pm-1:00pm	Lunch break
1:00pm-2:30pm	Regional response Evaluation
2:30pm-4:00pm	Closing out Findings Recommendations Next Steps Vote of thanks: S. Curtis

APPENDIX G: WEBINAR AGENDA

5 DECEMBER 2022, 2:00–3:30PM EST

2:00-2:15	Introductions: S. Curtis, K. Felltham
2:15-2:40	Telehealth: COVID and Beyond-S. Curtis, K. Felltham
2:40-3:05	Disaster preparedness: The Midwife's role-participants
3:05-3:15	Regulatory Environment and Practice Autonomy: New York State, USA, case study: K. Feltham
3:15-3:45	Education and Scope of Practice: Family planning: Participants

APPENDIX H: PRESS RELEASE

Caribbean Regional Midwives Association Corner De Gannes and La Croix Streets, Couva, Trinidad
caribbeanmidwives@gmail.com

MEDIA RELEASE

The Caribbean Regional Midwives Association (CRMA) along with partners USAID MOMENTUM Country Global Leadership and UNFPA hosted a 3-day policy dialogue workshop, Nov 14- 16th, 2022 at the Marriott Hotel in Georgetown, Guyana, to discuss the *State of the World's Midwifery* (SoWMy) Report 2021 and formulate a Caribbean response. The Policy Dialogue Workshop participants included the Chief Nurses and Heads of Regulatory Councils from 10 countries in the Region: Antigua, The Bahamas, Barbados, Grenada, Guyana, Jamaica, St Lucia, St Vincent and the Grenadines, Suriname, and Trinidad and Tobago.

The third global SoWMy 2021 report provides an updated evidence base on the sexual, reproductive, maternal, newborn and adolescent health (SRMNAH) care from 194 countries. The report, produced by UNFPA, the International Confederation of Midwives (ICM), the World Health Organization (WHO) and Novametrics, shows the progress and trends and identifies the barriers and challenges to future advancement.

A formal document with the detailed Regional response to the SoWMy report 2021 will be published in the first quarter of 2023, and will be shared.

Shirley Curtis, RN, RM, MScN, PhD, President CRMA

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