I'm not a robot

When a woman has access to trusted emotional, psychological and practical support during labour and childbirth, evidence shows that both her experience of childbirth and her health outcomes can improve. In Companion of choice during labour and childbirth for improved quality of care, WHO and HRP present updated information on the benefits of labour companionship for women and their newborns, and how it can be implemented as part of efforts to improve quality of maternity care. The current COVID-19 pandemic is no exception. WHO Clinical management of COVID-19: interim guidance strongly recommends that all pregnant women, including those with suspected, probable or confirmed COVID-19, have access to a companion of choice during labour and childbirth.The importance of a chosen companion during labour and childbirth – latest evidence Again and again, research shows that women greatly value and benefit from the presence of someone they trust during labour and childbirth. A companion of choice can give support in practical and emotional ways. They can bridge communication gaps between a woman in labour and the healthcare workers around her, offer massage or hand-holding to help relieve pain, and provide reassurance to help her feel in control. As an advocate, a labour companion can witness and safeguard against mistreatment or neglect. The benefits of labour companionship can also include shorter length of time in labour, decreased caesearean section and more positive health indicators for babies in the first five minutes after birth. Implementing labour companionship as part of respectful maternal and newborn care WHO is committed to improving women's and newborns' experience of care as an integral component of better maternal and newborn health, and to helping countries put evidence-based global guidance into practice. Support for labour companionship is presented in four different WHO guidelines: intrapartum care for a positive childbirth experience, health promotion interventions for maternal and newborn health, augmentation of labour, and clinical management of COVID-19. The new Companion of choice updates a 2016 version with an expanded section on implementing companionship during labour and childbirth. It includes a logic model to support the integration of labour companions into maternal care programmes, and case studies from Egypt, Lebanon and the Syrian Arab Republic showing design and implementation in practice. "From global actors to professional organizations, healthcare providers to community networks and womens' groups, everyone has a role to play in advocating for labour companions – and for ensuring every women has a right to a companion of her choice to support her during labour and childbirth. Our experience from implementation research shows that women, communities, health workers and management can be engaged to transform health services and find labour companionship solutions," said Annie Portela, Technical Officer in the WHO Department of Maternal, Newborn, Child and Adolescent Health and Ageing. The way forward Many countries do not yet have policies in favour of labour companionship, and many healthcare facilities do not allow women to have a companion. Raising awareness, engaging in discussion, and providing physical infrastructure such as curtains for privacy and a chair for the companion, are all important steps for ensuring every woman can have a chosen birth companion if she wants one. Global efforts to improve maternal health – such as the emphasis on increasing facility-based childbirth – do not end with the reduction of maternal mortality and morbidity. Women's preferences during childbirth must be known and must be supported. COVID-19 and labour companionship Most health systems around the world are facing challenges of increased demand for care of people COVID-19, compounded by fear, misinformation and limitations on movement that disrupt access to care. As countries identify ways to address COVID-19, integrating human rights protections and guarantees is not only a moral imperative, it is essential to successfully addressing public health concerns. "Pregnancy is not put on pause in a pandemic, and neither are fundamental human rights. A woman's experience of childbirth is as important as her clinical care," said Dr Özge Tunçalp, scientist at WHO/HRP. "In the 'new normal' of COVID-19, WHO strongly recommends that the emotional, practical and health benefits of having a chosen labour companion are respected and accommodated. The pandemic must not disrupt every woman's right to high-quality, respectful maternity care." Information is essential for change, but in settings where information is not readily available, epidemiological research becomes one of the most powerful sources of information for change. A supplement by BJOG: An International Journal of Obstetrics and Gynaecology titled "Application of maternal near-miss approach to audits of severe maternal complications in a low-resource country" reinforces this message.Spotlight on NigeriaClose to 200 million people inhabit Nigeria, considered Africa's most populous country. Nigeria is also the country where nearly 20% of all global maternal deaths happen. Between 2005 and 2015, it is estimated that over 600 000 maternal deaths and no less than 900 000 maternal near-miss cases occurred in the country. In 2015, Nigeria's estimated maternal mortality ratio was over 800 maternal deaths per 100 000 live births, with approximately 58 000 maternal deaths during that year. By comparison, the total number of maternal deaths in 2015 in the 46 most developed countries was 1700, resulting in a maternal mortality ratio of 12 maternal deaths per 100 000 live births. In fact, a Nigerian woman has a 1 in 22 lifetime risk of dying during pregnancy, childbirth or postpartum/post-abortion; whereas in the most developed countries, the lifetime risk is 1 in 4900.Inequities to health services, gaps between rich and poor remainThe World Health Organizatoin (WHO) says the high number of maternal deaths in some parts of the world reflects inequities in access to health services, and highlights the gap between rich and poor. Nearly 100% of global maternal deaths occur in developing countries with more than half of these deaths occurring in sub-Saharan Africa and almost one third happening in South Asia. More than half of maternal deaths occur in fragile and humanitarian settings. WHO adds that poor women in remote areas are the least likely to receive adequate health care. This is especially true for regions with low numbers of skilled health workers, such as sub-Saharan Africa and South Asia. Globally in 2015, births in the richest 20 per cent of households were more than twice as likely to be attended by skilled health personnel as those in the poorest 20 per cent of households (89 per cent versus 43 per cent). This means that millions of births are not assisted by a midwife, a doctor or a trained nurse.Focusing on Nigerian maternity care and health systemThe 7 papers included in the BJOG supplement shed light on some aspects of the Nigerian maternity care and health system, particularly at the tertiary level, between 2012 and 2013. They are offshoots of a landmark survey - Nigeria Near-Miss and Maternal Death Survey – which recorded close to 1000 maternal deaths in 42 tertiary hospitals spread across Nigeria. When getting there is not enough: a nationwide cross-sectional study of 998 maternal deaths and 1451 near-misses in public tertiary hospitals in a low-income country The supplement helps readers understand the reasons for the high intra-hospital deaths associated with pregnancy-related complications. Among the issues discussed in-depth include hypertensive disorders of pregnancy, postpartum haemorrhage, and unsafe abortion. An in-depth analysis of uterine rupture—a major sign of delays in managing obstructed labor–is also featured.The Nigeria Near-Miss and Maternal Death Survey revealed that intra-hospital quality of care issues, and delays in accessing the adequate level of care play a major part in the occurrence of maternal deaths. Moreover, maternity care and the underlying health system experience challenges in reducing avoidable deaths and promoting health and well-being. Next stepsTeam leaders, hospital managers and policy makers should act on the information obtained from the survey to reduce maternal deaths and morbidity in Nigeria. It is also recommended that similar initiatives be put in place where health information systems are not fully operational and unable to generate actionable information.WHO responseImproving maternal health is one of WHO's key priorities. WHO works to contribute to the reduction of maternal mortality by increasing research evidence, providing evidence-based clinical and programmatic guidance, setting global standards, and providing technical support to Member States.In addition, WHO advocates for more affordable and effective treatments, designs training materials and guidelines for health workers, and supports countries to implement policies and programmes and monitor progress.Related links10 ways to improve the quality of care in health facilities More on WHO's on maternal health Skip to main content Browse selected WHO news below. This report summarizes application of the SAFE strategy against trachoma during 2024. It includes estimates of the global population at risk of trachoma... Air pollution and climate change together worsen the health impacts of allergens like pollen and airborne biological particles, leading to increased inflammatory... There is extensive evidence on the harmful health effects of air pollution, which has guided the development of WHO's Air Quality Guidelines. These guidelines... The report on the interim Medical Countermeasures Network (i-MCM-Net) presents an overview of the network's second annual Partners Meeting, held... As more women around the world are encouraged to choose to give birth in health facilities, it is essential that their right to a positive childbirth experience remains at the heart of the care they receive. Optimal Intrapartum Care, a special supplement edited by staff at the WHO Department of Sexual and Reproductive Health and Research including HRP, presents some of the challenges emerging from the global shift towards facility-based childbirth over the last two decades. Strategies to improve the quality of care every woman receives during childbirth are central to many of the solutions. Quality of care is fundamental to WHO approach to maternity care Every pregnancy and birth is unique, meaning that the best intrapartum care for each woman and her baby is individualized as well as evidence-based.This principle of person-centred care is reflected across all WHO guidance on maternal health and enshrined in the 2016 framework for improving quality of maternal and newborn care in health facilities.The WHO 2018 recommendations on intrapartum care, 2016 recommendations on antenatal care and upcoming recommendations on postnatal care are each grounded in respectful, person-centered maternity care. Respectful intrapartum care maintains women's dignity, privacy and confidentiality, ensuring freedom from harm and mistreatment, and enabling informed choice during labour and childbirth. This WHO model of intrapartum care provides a basis for empowering all women to access and to demand the type of care that they want and need.Inequalities and challenges to quality of care for allMany of the challenges highlighted in the special supplement are related to poor quality of care. These can significantly and negatively affect women's clinical and psychological experience of childbirth. 'Optimal intrapartum care in the twenty-first century,' the first paper in the series, recalls evidence from a recent WHO-led study in four countries showing that more than one-third of women experienced mistreatment during childbirth in health facilities. This included physical and verbal abuse, stigma and discrimination, failure to meet professional standards of care, poor rapport between women and providers, and health system conditions and constraints. Poor quality of care may be a significant barrier to uptake of facility-based birth services, in particular in low and middle-income countries. For example, experience of mistreatment and poor quality care is likely to influence women's decisions about where to give birth in subsequent pregnancies.Geography can also determine the quality of care available to a woman in childbirth: the partograph, an important tool for monitoring maternal and foetal wellbeing during labour, was found to be more frequently and appropriately used in urban facilities than in rural areas. Other interventions during labour and childbirth, including companion of choice or pain relief, are not always offered to women in low resource settings and access is highly inequitable. Access to good quality medicines, including drugs for pain relief or for prevention of complication during childbirth, such as uterotonics and antibiotics, is another key global issue highlighted for improvement. Progress in maternal health is not fast enoughThe number of women choosing to give birth in health facilities has increased in past decades, driven by urgent global efforts to reduce maternal deaths.Progress has been made towards maternal and newborn targets set out in the 2030 Agenda for Sustainable Development – but it is slow, with vast inequalities worldwide."Abiding by the human rights principles of right for life, health, confidentiality, privacy, provision of information, agreeing with the woman's informed choice will help to deliver personalised respectful care and that must be the norm in any birth care setting," explained Sir Sabaratnam Arulkumaran, Past President FIGO, RCOG and the BMA. The WHO vision for maternal and newborn health globallyWHO, with Member States and international partners, is working towards a global vision where every pregnant woman and newborn receives quality care throughout pregnancy, childbirth and the postnatal period, under the umbrella of Universal Health Coverage."Increasing facility births has contributed to reducing maternal deaths, but this must not come at the price of overmedicalization of childbirth and poorer quality of care for women," said Dr Mercedes Bonet, Medical Officer at WHO/HRP."Simply surviving pregnancy and childbirth can never be the marker of successful maternity care. Addressing inequalities and promoting respectful maternity care for all women is critical to improve health equity and quality."To make this a reality, evidence-based approaches to maternal health must be adapted for different settings. The ongoing evolution and implementation of quality of care across the maternal health continuum is equally important. This means going beyond clinical requirements for a safe labour and childbirth to meet the needs of all women and their babies. What do these indicators tell us?These indicators provide information on national policies for legal entitlement to maternity protection, including leave from work during pregnancy and after birth, as well breastfeeding entitlements after return to work.Since the International Labour Organization (ILO) was founded in 1919, international labour standards have been established to provide maternity protection for women workers. The ILO Maternity Protection Convention, 2000 (No. 183) represents the minimum standards, whereas the accompanying ILO Maternity Protection Recommendation, 2000 (No. 191) encourages additional measures. Key elements of maternity protection include:Maternity leave duration: The mother's right to a period of rest in relation to childbirth is a crucial means of safeguarding health and nutrition of the mother and her child. Convention No. 183 states that maternity leave should not be less than 14 weeks, while Recommendation No. 191 suggests that maternity leave be at least 18 weeks.Amount of maternity leave cash benefits: The right to cash benefits during absence for maternity leave is intended to ensure that the woman can maintain herself and her child in proper conditions of health and with a suitable standard of living. Maternity leave cash benefits aim to replace a portion of the income lost due to the interruption of the woman's economic activities, giving practical effect to the provision for leave. Convention No. 183 states that cash benefits should not be less than two-thirds of the woman's earnings prior to taking leave, while Recommendation No. 191 encourages raising the benefits to the full amount of previous earnings.Source of maternity leave cash benefits: The source of benefits is important due to potential discrimination in the labour market if employers have to bear the full costs. Convention No. 183 stipulates that cash benefits shall be provided through compulsory social insurance or public funds, and that individual employers shall not be liable for maternity leave benefits without that employer's specific agreement.Breastfeeding breaks and breastfeeding facilities: The right to continue breastfeeding a child after returning to work is important since duration of leave entitlements generally is shorter than the WHO recommended duration of exclusive and continued breastfeeding. Convention No. 183 states that women shall have the right to one or more daily breaks or a daily reduction of hours of work for breastfeeding, which is to be counted as working time and remunerated accordingly. Recommendation No. 191 states that where practicable, provision should be made for the establishment of facilities for nursing under adequate hygienic conditions at or near the workplace.A composite indicator on maternity protection is included as a policy environment and capacity indicator in the core set of indicators for the Global Nutrition Monitoring Framework. It currently uses the ILO classification of compliance with Convention 183 on three key provisions (leave duration, remuneration and source of cash benefits), but an alternative method taking into account higher standards as stated in Recommendation 191 as well as breastfeeding entitlements is under development.How are they defined?The ILO periodically publishes information on the above key indicators, including an assessment of compliance with Convention No. 183, as part of the TRAVAIL Database of Conditions of Work and Employment Laws, and the NATLEX Database of National Labour, Social Security and Related Human Rights Legislation. The legislative data are collected by the ILO through periodical reviews of national labour and social security legislation, and secondary sources, such as the International Social Security Association and International Network on Leave Policies and Research, as well as consultations with ILO experts in regional and national ILO offices worldwide.Maternity protection is a composite indicator that is included in the Global Nutrition Monitoring Framework; it is currently defined as whether the country has maternity protection laws or regulations in place that are compliant with the provisions for leave duration, remuneration and source of cash benefits in Convention No. 183. However, an alternative method is under development, which may use a scale to indicate the degree of compliance. This method will also take into account the higher standards for leave duration and remuneration in Recommendation No. 191, as well as the breastfeeding entitlements within both the Convention and Recommendation. Meanwhile, the data displayed are from the 2019 WHO&UNICEF Global breastfeeding scorecard. The indicator was calculated based on three aspects of Convention No. 183 and Recommendation No. 191: length of maternity leave, amount of previous earnings paid during leave, and source of funding.What are the consequences and implications?Pregnancy and maternity are potentially vulnerable time for working women and their families. Expectant and nursing mothers require special protection to prevent any potential adverse effects for them and their infants. They need adequate time to give birth, to recover from delivery process, and to nurse their children. At the same time, they also require income security and protection to ensure that they will not suffer from income loss or lose their job because of pregnancy or maternity leave. Such protection not only ensures a woman's equal access and right to employment, it also ensures economic sustainability for the well-being of the family. Returning to work after maternity leave has been identified as a significant cause for never starting breastfeeding, early cessation of breastfeeding and lack of exclusive breastfeeding. In most low- and middle-income countries, paid maternity leave is limited to formal sector employment or is not always provided in practice. The ILO estimates that more than 800 million women lack economic security around childbirth with adverse effects on the health, nutrition and well-being of mothers and their children.Source of dataWHO, UNICEF. Increasing commitment to breastfeeding through funding and improved policies and programmes: Global breastfeeding scorecard 2019. (. ILO. Working conditions laws database. Maternity protection database (.Further readingILO. Maternity and paternity at work: law and practice across the world. Geneva: International Labour Organization; 2014 (. ILO. Maternity cash benefits for workers in the informal economy. Social protection for all issue brief. Geneva: International Labour Organization; November 2016 (. ILO. World Social Protection Report. Universal social protection to achieve the Sustainable Development Goals. Geneva: International Labour Organization; 2017 (. Rollins N, Bhandari N, Hajeebhoy N, Horton S, Lutter C, Martines J et al. Why invest, and what it will take toimprove breastfeeding practices? Lancet. 2016;387:491–504. WHO, UNICEF. Global Nutrition Monitoring Framework: operational guidance for tracking progress in meeting targets for 2025. Geneva: World Health Organization; 2017 (. WHO. Global reference list of 100 core health indicators (plus health-related SDGs). Geneva: World Health Organization; 2018 (. The World Health Organization (WHO) today released new guidance to help countries adopt and expand midwifery models of care - where midwives serve as the main care provider for women and babies throughout pregnancy, childbirth, and the postnatal period.The guidance promotes strong communication and partnership between women and midwives, and offers proven health benefits for both women and their babies. Women who received care from trusted midwives are statistically more likely to experience healthy vaginal births and report higher satisfaction with the services they receive. "Expanding and investing in midwifery models of care is one of the most effective strategies to improve maternal and newborn health globally," said Dr Anshu Banerjee, Director for Maternal, Newborn, Child and Adolescent Health and Ageing at WHO. "These approaches improve outcomes, maximize resources, and can be adapted to all countries. Crucially, they also enhance women's and families' experiences of care– building trusted partnerships for health at this critical life stage."A proven, cost-effective solution Despite progress, maternal and newborn deaths remain unacceptably high—particularly in low-income and fragile settings. Recent modelling suggests that universal access to skilled midwives could prevent over 60% of these deaths, amounting to 4.3 million lives saved annually by 2035.Midwifery care models emphasize informed choice as well as communication and non-invasive techniques —such as mobility during labour, breathing guidance, varied birthing positions and emotional support— that seek to empower women, and reduce the likelihood of invasive procedures. Midwifery models of care are also an important response to the growing concern of over-medicalization in childbirth. While medical interventions such as caesarean sections, inductions, and use of forceps are essential and life-saving when clinically indicated, their routine or excessive use creates short and long-term health risks. In some countries, caesarean rates now exceed 50%, suggesting high rates of medically unnecessary procedures."Skilled midwives help women trust in their bodies, their abilities, and their care," said Ulrika Rehnstrom Loi, Midwifery expert at WHO and technical lead for the guidance. "This is why investing in midwifery models of care is so important – it not only improves health but builds a cadre of experts equipped to provide individualized, respectful care, ensuring women are consistently part of decision making and have access to the information they need as well as vital emotional support."Practical tools for implementationThe new guidance provides practical tools and real-life examples to help countries structure a transition toward midwifery models of care. As part of this process, it calls for strong political commitment, strategic planning and long-term financing for implementation -- with dedicated budget lines. It also stresses the importance of high-quality midwifery regulation and education in line with international standards, supporting autonomous, evidence-based practice.Successful implementation requires strong collaboration, the guidance notes. Midwives should be empowered to work independently while also integrated into broader healthcare teams alongside doctors and nurses. In the event of complications, midwives should be able to work in partnership with these other professionals to ensure quality multidisciplinary care for every woman and baby.A global imperativeGlobally, millions of women still give birth without a skilled health worker by their side, and one-third do not receive even four of WHO's recommended eight pregnancy checks. Progress in reducing maternal and newborn mortality has largely stagnated since 2016. "Midwifery models of care are not just smart solutions - they are a necessity," said Anna Ugglas, Chief Executive of the International Confederation of Midwives, which supported the development of the guidance. "In a world where childbirth is increasingly medicalized, they offer a person-centred, evidence-based approach that respects the physiological process of birth, restores dignity and autonomy to maternity care, and helps ensure safety for women and newborns everywhere."The guidance outlines several adaptable models of midwifery care, including:Continuity of care, where women are supported by a known midwife, or small team of midwives, throughout pregnancy, birth, and the postnatal period. Midwife-led birth centres, dedicated facilities where midwives provide intrapartum care for women at low risk of complications. They sometimes offer other services such as antenatal and postnatal care or family planning.Community-based approaches where midwives deliver services directly in communities—for example, via mobile units or local health centres. Private practice, where private midwives operate independently or through organizations. To be effective, these services must be regulated and integrated into national health systems. Skip to main content Skip to main content Midwifery is defined as "skilled, knowledgeable and compassionate care for childbearing women, newborn infants and families across the continuum from prepregnancy, pregnancy, birth, postpartum and the early weeks of life". The evidence shows us that midwifery plays a "vital" role, and when provided by educated, trained, regulated, licensed midwives, is associated with improved quality of care and rapid and sustained reductions in maternal and newborn mortality.All women and newborns have a right to a quality of care that enables a positive childbirth experience that includes respect and dignity, a companion of choice, clear communication by maternity staff, pain relief strategies, mobility in labour and birth position of choice. Midwives are essential to the provision of quality of care, in all settings, globally. Midwifery education is a key solution to the challenge of providing universal and quality maternal and newborn care to meet our Sustainable Development Goals. While improving access to care is critical, ensuring good quality of care has an even greater impact in terms of lives saved. WHO, ICM, UNFPA and UNICEF are finalising a report and action plan for strengthening quality midwifery education to be released at the World Health Assembly, 20-28 May 2019. WHO is working hard to provide a solution is to transform midwifery education through the first global, in-service, evidence based interprofessional Midwifery Education Tool kit. This tool kit brings together maternal, newborn, sexual, reproductive and mental health for life-long learning in compassionate midwifery care, including during pandemics and for use in fragile and humanitarian settings. Focused on a midwifery model of continuity of care, putting women, newborns and their families at the center, this toolkit provides midwives with all the training required to care for healthy women and their newborns, prevent unnecessary interventions, while ensuring lifesaving actions and enable health professionals to work effectively in a multi-disciplinary team.Midwifery education is designed to address three strategic priorities:All midwives should be educated to high standards and enabled to practise to their full scopeMidwives should be involved in education policy at the highest levelEducation processes should be coordinated and aligned A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery. (ICM 2005) outcomes were found to be improved through midwifery practice and philosophy of care of services can be provided by midwives, when educated to international standards Find out more of all maternal deaths, stillbirth and newborn deaths could be averted with quality midwifery care Find out more of reproductive age have their need for family planning met with a modern method Find out more of pregnant women (in 75 countries with data since 2009) had at least 4 antenatal care visits Find out more women who died of maternal causes in 2020 Find out more within the scope of midwifery show the importance of optimizing the normal processes of childbirth Find out more of nurses and midwives comprise nearly 50% of the world's health workforce occur in low and lower middle-income countries Find out more approximately, die every day from preventable causes related to pregnancy and childbirth Find out more Skilled health personnel, as referenced by SDG indicator 3.1.2, are competent maternal and newborn health (MNH) professionals educated, trained and regulated to national and international standards. They are competent to: (i) provide and promote evidence-based, human-rights based, quality, socioculturally sensitive and dignified care to women and newborns; (ii) facilitate physiological processes during labour and delivery to ensure a clean and positive childbirth experience; and (iii) identify and manage or refer women and/or newborns with complications. In addition, as part of an integrated team of MNH professionals (including midwives, nurses, obstetricians, paediatricians and anaesthetists), they perform all signal functions of emergency maternal and newborn care to optimize the health and well-being of women and newborns. Within an enabling environment, midwives trained to International Confederation of Midwives (ICM) standards can provide nearly all of the essential care needed for women and newborns. (In different countries, these competencies are held by professionals with varying occupational titles.) Reference: WHO, UNFPA, UNICEF, ICM, ICN, FIGO and IPA 2018 When midwives are educated to international standards, and midwifery includes the provision of family planning, it could avert more than 80% of all maternal deaths, stillbirths and neonatal deaths. Achieving this impact also requires that midwives are licensed, regulated, fully integrated into health systems and working in interprofessional teams.Beyond preventing maternal and newborn deaths, quality midwifery care improves over 50 other health-related outcomes, including in sexual and reproductive health, immunization, breastfeeding, tobacco cessation in pregnancy, malaria, TB, HIV and obesity in pregnancy, early childhood development and postpartum depression. Midwives are uniquely able to provide essential services to women and newborns in even the most difficult humanitarian, fragile and conflict-affected settings. This means that midwives will make a significant contribution to delivering on the commitments made in the Astana Declaration on Primary Health Care and the Global Action Plan on Healthy Lives and Well-Being.Educating midwives to international standards is a cost-effective investment as it saves resources by reducing costly and unnecessary interventionsYet there is a startling lack of investment in quality midwifery education, despite the evidence of impact. Now is the time to take collective action. Midwives can provide about 90% of the SRMNAH care needed, but they account for less than 10% of the global SRMNAH workforce. The world needs 900,000 more midwives. By 2030, the midwife shortage will be smaller (750,000), but there will still be a major gap between the number required and the workforce available in midwifery.The gap between low-income countries and high- and middle-income countries is projected to widen by 2030, increasing inequality. To close the gap by 2030, 1.3 million new DSE worker posts (mostly midwives and mostly in Africa) need to be created in the next 10 years.WHO is working on each of the 4 priority areas to strengthen the quality and quantity of midwives globally. The most recent resolution, WHA 64.7, gives WHO the mandate to develop and strengthen strategies such as: capacity of nursing and midwifery workforce through the provision of support to Member States on developing targets, action plans and forging strong interdisciplinary health teams as well as strengthening the dataset on nursing and midwifery. The goal of this guide is to support facilitators to enable learners to implement WHO recommendations and tools for evidence-based midwifery care for… In the pursuit of providing high-quality health services to improve health and well-being for all in the context of UHC, transitioning to midwifery models… The standards for the care of small and sick newborns in health facilities define, standardize and mainstream inpatient care of small and sick newborns,… The Framework for Action to Strengthen Midwifery Education is a guide to develop high-quality, sustainable pre- and in-service midwifery education… Much progress has been made during the past two decades in coverage of births in health facilities; however, reductions in maternal and neonatal mortality… This toolkit includes 9 modules. It focuses specifically on strengthening the central role and function of the professional midwife in the provision of… The module begins with the story of Mrs X which shows how certain social, economic and cultural factors, combined with delays in seeking and obtaining… In order that students may fully understand how postpartum haemorrhage occurs, this module begins with a detailed explanation of the physiology and management… This module begins with a review of the anatomy and physiology relevant to the management of prolonged and obstructed labour. On the basis of this, the… This module begins with an explanation of the problem of puerperal sepsis. The content then covers the factors which contribute to the infection, how it… This module begins with an explanation of the conditions pre-eclampsia and eclampsia. The content then covers the factors which contribute to eclampsia,… This module begins with an explanation of abortion, including the types of abortion, the effect of abortion on maternal mortality and morbidity, the prevention… Skip to main content Skip to main content - Select language - العربية 中文 français русский español português Haemorrhage – severe heavy bleeding – and hypertensive disorders like preeclampsia are the leading causes of maternal deaths globally, according to a new study released today by the World Health Organization (WHO). These conditions were responsible for around 80 000 and 50 000 fatalities respectively in 2020 – the last year for which published estimates are available - highlighting that many women still lack access to lifesaving treatments and effective care during and after pregnancy and birth. Published in the Lancet Global Health, the study is WHO's first global update on the causes of maternal deaths since the United Nations' Sustainable Development Goals were adopted in 2015. In addition to outlining the major direct obstetric causes, it shows that other health conditions, including both infectious and chronic diseases like HIV/AIDS, malaria, anaemias, and diabetes, underpin nearly a quarter (23%) of pregnancy and childbirth-related mortality. These conditions, which often go undetected or untreated until major complications occur, exacerbate risk and complicate pregnancies for millions of women around the world."Understanding why pregnant women and mothers are dying is critical for tackling the world's lingering maternal mortality crisis and ensuring women have the best possible chances of surviving childbirth," said Dr Pascale Allotey, Director of Sexual and Reproductive Health and Research at WHO as well as the UN's Special Programme on Human Reproduction (HRP). "This is also a massive equity issue globally - women everywhere need high quality, evidence-based health care before, during and after delivery, as well as efforts to prevent and treat other underlying conditions that jeopardize their health."In 2020, there were an estimated 287 000 maternal deaths in total – equivalent to one death every two minutes. This new WHO study reports that haemorrhage - mostly occurring during or following childbirth - is responsible for nearly a third (27%) of maternal mortality, with preeclampsia and other hypertensive disorders contributing to an additional 16%. Preeclampsia is a serious condition characterized by high blood pressure that can lead to haemorrhage, strokes, organ failures and seizures if left untreated or treated too late. Other direct causes include: sepsis and infections; pulmonary embolism; complications from spontaneous and induced abortions - including miscarriage, ectopic pregnancies, and issues relating to unsafe abortions – and, anesthetic complications and injuries that occur during childbirth. The findings highlight the need to strengthen key aspects of maternity care, including antenatal services that detect risks early in pregnancy and prevent severe complications; lifesaving obstetrics that can manage critical birth-related emergencies like haemorrhage or embolism, and postnatal care. Most maternal deaths occur during or shortly after childbirth, making this a critical window to save lives. However, around a third of women – primarily in lower income countries - still do not receive essential postnatal checks in the first days after birth. At a population level, broader preventive interventions could help reduce the prevalence of underlying health conditions - like noncommunicable diseases and malnutrition - that increase women's risks."Often not just one but many interrelated factors contribute to a woman dying during or after pregnancy– preeclampsia for instance can significantly increase the likelihood of haemorrhage as well as other complications that may occur even long after childbirth," said Dr Jenny Cresswell, Scientist at WHO and an author of the paper. "A more holistic approach to maternal health has been proven to give women the best chance of a healthy pregnancy and birth, and of enjoying lasting quality of life after delivery – health systems need to be able to support them across different life stages." The study draws on national data that is reported to WHO, as well as peer-reviewed studies. For some causes, data remains limited. In particular, the authors call for more data on maternal suicide, which is currently available for only 12 countries. In addition, most countries do not report on late maternal deaths (those that occur in the year following childbirth), although several conditions can lead to risks lasting much beyond the birth itself. After childbirth, many women struggle to access follow-up care, including mental health support.WHO works to strengthen access to high quality, respectful services across the continuum of pregnancy, childbirth and postnatal care, through evidence-based research and guidelines. In 2024, WHO and partners launched a global Roadmap for Postpartum Haemorrhage, which outlines key priorities for tackling this major cause of maternal death. In the same year, the World Health Assembly's 194 countries passed a Resolution committing to strengthen quality care before, during and after childbirth. To galvanize action, World Health Day 2025 – which marks five years from the Sustainable Development Goals deadline—will focus on maternal and newborn health. The campaign will call for a major intensification of efforts to ensure access to high quality, proven care for women and babies, especially in the poorest countries and crisis settings where the vast majority of deaths occur. Beyond survival, the campaign will also showcase the need for broader attention to women's health, including postnatal care and support.AboutThe study, Global and regional causes of maternal deaths 2009-2020: a WHO systematic analysis, updates a previous analysis conducted in 2014 which covered the period 2003-2009. Haemorrhage was also responsible for the largest share of deaths in the previous analysis (27%). The study is available here: 24)00560-6/fulltextData were identified via three main pathways: the WHO Mortality Database; reports published by WHO Member States (MMEIG Database); and journal articles identified via bibliographic databases. Maternal causes of death are grouped into categories aligned with the International Classification of Diseases-Maternal Mortality (ICD-MM) coding: abortion (relating to miscarriage, ectopic pregnancy and induced abortion), embolism, haemorrhage, hypertensive disorders, pregnancy-related sepsis, other direct causes, and indirect causes described above. New estimates for the total numbers of maternal deaths, including global, regional and country-level data, will be published in April 2025, covering the period 2000-2023. Skip to main content Antenatal care - regular contact with skilled health personnel during pregnancy - is a core component of maternity care, grounded in a human rights-based approach. WHO recommends that women should have eight contacts with a health provider during pregnancy to screen for potential complications and treat problems as they arise including prevention of antepartum stillbirths.Although a large proportion of women access these services at least once during their pregnancy, less than half of all women in low-resource settings received antenatal care in their first trimester. WHO works to improve access to and quality of antenatal care across every population, including adolescent girls and in hard-to-reach areas or conflict settings. Digital health interventions, such as appointment reminders, have had a positive impact and are an ongoing area of work. By focusing on a positive pregnancy experience, WHO seeks to ensure not only a healthy pregnancy for every woman and baby, but also an effective transition to positive labour and childbirth and ultimately to a positive experience of parenthood. of all maternal deaths, stillbirth and newborn deaths could be averted with quality midwifery care Find out more of services can be provided by midwives, when educated to international standards Find out more outcomes were found to be improved through midwifery practice and philosophy of care Skip to main content - Select language - العربية 中文 français русский español português This assessment tool for HIV and internally displaced persons (IDPs) is an outcom multisectoral, multi-agency assessment missions in Côte d'Ivoire,… It is impossible to address the many complex needs of respiratory virus surveillance with a single system. Therefore, multiple surveillance systems and… WHO has published guidance on adjusting public health and social measures for the next phase of the COVID-19 response. Some governments have suggested… Italy was one of the first European countries to report COVID-19 cases, at the end of January 2020. In mid-February, the country reported community-based… This report summarizes application of the SAFE strategy against trachoma during 2024. It includes estimates of the global population at risk of trachoma… Skip to main content Skip to main content Browse selected WHO publications below. This report summarizes application of the SAFE strategy against trachoma during 2024. It includes estimates of the global population at risk of trachoma... Canadian federal and provincial governments have effectively implemented policies to address greenhouse gas (GHG) emissions from the combustion of fossil... The report on the interim Medical Countermeasures Network (i-MCM-Net) presents an overview of the network's second annual Partners Meeting, held... There is extensive evidence on the harmful health effects of air pollution, which has guided the development of WHO's Air Quality Guidelines. These guidelines...