

THE STATE OF THE
World's Midwifery
2021

How to use the
SoWMy 2021
country profile

SoWMy 2021: How to use the country profile

The *State of the World's Midwifery 2021* (SoWMy 2021) country profiles are designed to prompt and inform policy discussions on how the education, composition, deployment and working environment of the sexual, reproductive, maternal, newborn and adolescent health (SRMNAH) workforce impacts on the delivery of SRMNAH services for all women, newborns and adolescents.

The country profiles are an innovative mix of the data submitted to the various data sources and projections for the period leading to 2030. The projections aim to inform policy dialogue and decision-making within countries. They are, of course, sensitive to the data and assumptions that inform them and are limited in their context-specificity by the use of standard, evidence-based parameters (details in [Webappendix 3](#)). They should therefore be treated, not as fact sheets, but as **a tool to review and improve data quality**, and to inform discussions of the potential impact of different workforce planning strategies. They may also enable the identification of future analysis and research needed at national and sub-national levels. **Yellow highlighting indicates issues to consider when reviewing a country profile.**

The estimates shown in the country profile were those available in mid-2020. More recent updates to these data sources are not captured in the SoWMy country profiles.

The code “nr” stands for “not reported”, i.e. the cited data source includes no estimate for that country.

1. Key SRMNAH indicators (page 1, top section)

The country's map is displayed on the left.¹

The right-hand side of this section illustrates the country context using key SRMNAH indicators. Table A7.1 shows the data sources used for these indicators. Some countries prefer to use national data sources for these indicators, but global sources have been used to ensure that comparable methods were applied for all countries.

¹ The designations employed and the presentation of the maps do not imply the expression of any opinion whatsoever on the part of the United Nations Populations Fund (UNFPA), World Health Organization (WHO) and International Confederation of Midwives (ICM) concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement. Terminology used to refer to countries, territories and areas as well as representation of countries, territories and areas, including delimitation of frontiers or boundaries, and any direct or indirect attribution of status in this publication follow exclusively the institutional style and practice of UNFPA as lead publishing organization; may be at variance with those used by WHO; and should not be regarded as direct or indirect recognition by WHO of the legal status of any country, territory, city or area or of its authorities, or of the delimitation of its frontiers or boundaries.

Table A7.1: Data sources used for key SRMNAH indicators

Indicator(s)	Data source
Estimated population; women of reproductive age; adolescents, total fertility rate; live births	UN Department of Economic and Social Affairs (DESA) World Population Prospects 2019 revision
Pregnancies	Live births as above, with a multiplier to account for stillbirths, spontaneous abortions and induced abortions based on estimates made by the Guttmacher Institute (1) and used in Tatem et al. 2014
Adolescent birth rate; coverage for 4+ antenatal care visits	WHO Global Health Observatory data repository
Maternal mortality ratio	WHO, UNICEF, UNFPA, World Bank Group and UN Population Division, 2019
Neonatal mortality rate; stillbirth rate	UN Inter-Agency Group for Child Mortality estimation, 2020
Births attended by skilled health personnel	SDG indicator database
Modern contraceptive prevalence rate; unmet need for family planning	UN DESA estimates and projections of family planning indicators, 2020
Caesarean section rate	Boerma et al. 2018

Note: The estimates shown in the country profiles were current when they were prepared in late 2020, but several of these sources have been updated since then.

2. Full SRMNAH workforce availability (page 1, middle section)

The first two columns in this table in the country profile show the validated data submitted by the national focal point to the WHO National Health Workforce Accounts (NHWA) (as at December 2020; if more recent data have since been entered in NHWA, these are not shown) for occupation groups considered to be part of the SRMNAH workforce. The occupation groups are defined in Table A7.2.

Table A7.2: Occupation group definitions

Occupation	Definition
Midwifery professionals	Midwifery professionals plan, manage and provide midwifery care services before, during and after pregnancy and childbirth. They provide delivery care to reduce health risks to women and newborn children according to the practice and standards of modern midwifery, working autonomously or in teams with other health-care providers. They may conduct research on midwifery practices and procedures, and implement midwifery education activities in clinical and community settings.
Midwifery associate professionals	Midwifery associate professionals provide basic health care and advice before, during and after pregnancy and childbirth. They provide advice to women, families and communities on birth and emergency plans, breastfeeding, infant care, family planning and related topics; monitor health status during pregnancy and childbirth; and implement care, treatment and referral plans usually established by medical, midwifery and other health professionals.
Midwives not further defined	Midwives are counted here if the country did not specify whether they were professionals or associates.
Nursing professionals	Nursing professionals provide treatment, support and care services for people in need of nursing care due to the effects of ageing, injury, illness or other physical or mental impairment, or potential risks to health, according to the practice and standards of modern nursing. They assume responsibility for the planning and management of patient care, including the supervision of other health-care workers, working autonomously or in

Occupation	Definition
	teams with medical doctors and others in the practical application of preventive and curative measures in clinical and community settings.
Nursing professionals with midwifery training	Nursing professionals who have successfully completed a midwifery education programme and have the requisite qualifications to be registered and/or licensed to practise midwifery. Usually this is achieved by qualifying as a nursing professional and then acquiring a further qualification in midwifery.
Nursing associate professionals	Nursing associate professionals provide basic nursing and personal care for people needing such care due to effects of ageing, illness, injury or other physical or mental impairment. They provide health advice to patients and families, monitor patients' conditions, and implement care, treatment and referral plans usually established by medical, nursing and other health professionals.
Nursing associate professionals with midwifery training	Nursing associate professionals who have also successfully completed formal education to provide basic health care and advice before, during and after pregnancy and childbirth. They provide advice to women, families and communities on birth and emergency plans, breastfeeding, infant care, family planning and related topics; monitor health status during pregnancy and childbirth; and implement care, treatment and referral plans usually established by medical, midwifery and other health professionals.
Nurses not further defined	Nurses are counted here if the country did not specify whether they were professionals or associates.
Community health workers	Community health workers provide health education, referral and follow-up, case management, and basic preventive health care and home visiting services to specific communities. They support and assist individuals and families in navigating the health and social services systems.
Paramedical practitioners	Paramedical practitioners provide advisory, diagnostic, curative and preventive medical services more limited in scope and complexity than those carried out by medical doctors. They work autonomously or with limited supervision by medical doctors, and perform clinical, therapeutic and surgical procedures to treat and prevent diseases, injuries and other physical or mental impairments common to specific communities.
Medical assistants	Medical assistants perform basic clinical and administrative tasks to support patient care under the direct supervision of a medical practitioner or other health professional. They perform routine tasks and procedures such as measuring patients' vital signs, administering medications and injections, recording information in medical record-keeping systems, preparing and handling medical instruments and supplies, and collecting and preparing specimens of bodily fluids and tissues for laboratory testing.
General medical practitioners	General medical practitioners (including family and primary-care doctors) diagnose, treat and prevent illness, disease, injury and other physical and mental impairments, and maintain general health in humans by applying the principles and procedures of modern medicine. They plan, supervise and evaluate the implementation of care and treatment plans by other health-care providers. They do not limit their practice to particular disease categories or methods of treatment, and may assume responsibility for providing continuing and comprehensive medical care to individuals, families and communities.
Obstetricians & gynaecologists	Doctors in obstetric and gynaecological specialties and related branches focusing on the care of women's reproductive systems including before, during and after pregnancy and childbirth.
Paediatricians	Doctors in paediatrics and related specialties focusing on the prevention, diagnosis and treatment of health problems in infants, children and adolescents.

Individual countries may have other occupation groups working in SRMNAH. The country profile does not take these other occupations into account, and the analysis should be interpreted with this in mind.

For each occupation group, the headcount and the year to which the headcount applies are shown. If a country provided headcount data for more than one year, only the most recent year is shown. The code "nr" means that the country has reported no data to NHWA for that occupation group

since the SoWMy 2014 report. It is important to establish whether this is because the occupation group does not exist in that country, or because no headcount data were available. If the latter, plans should be made to improve data availability for NHWA.

Within the “nursing professional” and “nursing associate professional” groups, there is a total headcount (in bold) and a breakdown of how many of these have, and do not have, midwifery training (not bold, right-justified). The headcounts for “with midwifery training” and “without midwifery training” sum to the total for that occupation group. Nurses with midwifery training are referred to as “nurse-midwives” in the rest of the analysis in the country profiles.

If there are headcounts in the “not further defined” categories for nurses and midwives, this may indicate a need within the country to better understand and report on the detailed composition of the nursing and/or midwifery workforce through NHWA.

The “total SRMNAH workforce” number at the bottom of the table is the sum of the headcounts for individual occupation groups. If headcount data are missing for one or more occupation groups, this may be because that occupation group does not exist in the country. Alternatively, it may be because headcount numbers were not provided to NHWA, in which case the total will underrepresent the size of the SRMNAH workforce.

If one or more headcounts are in dispute, or if one or more important occupation groups have no headcount data in NHWA, stakeholders are encouraged to contact the national NHWA focal point (or, if there is no NHWA focal point, advocate for one to be appointed). The WHO country office can provide support with this. Discussions can then take place with focal points on how the NHWA data collection and submission process can be improved in future. NHWA is an ongoing process and country focal points can add or amend data at any time.

The “percentage of time on SRMNAH” column shows estimates of the proportion of clinical time each occupation group spends on SRMNAH interventions (details in [Webappendix 3](#)). Within an occupation group there will be considerable variation: some individual nurses or doctors may have a specialist SRMNAH role; others may spend no time on SRMNAH. The percentage represents an average across all individuals within an occupation group. These estimates were based on expert opinion and previous surveys: they were not submitted by the country’s NHWA focal point, and may not accurately reflect the reality in every country. If the percentage is judged to be much too high or much too low in a specific country context, the projections (Sections 3 and 6 below) should be interpreted with this in mind. The code “na” (not applicable) signifies that there are no headcounts for that occupation group.

The “Dedicated SRMNAH Equivalent (DSE)” column is the result of multiplying the headcount by the % time on SRMNAH. It is similar to a “full-time equivalent” worker, and takes into account that some occupation groups do not spend all their available clinical time on SRMNAH work. This is a better indication than the headcount of the workforce’s availability for providing SRMNAH interventions.

The “graduates” columns show the number of graduates produced domestically for each occupation group, as entered in NHWA. Again, if data were provided for more than one year, only the most recent year is shown. Relatively few countries were able to provide graduate numbers for all occupation groups, despite this indicator being among the most important drivers of future workforce availability. If these data are not shown in the country profile, national stakeholders are encouraged to work with the NHWA focal points to ensure better data availability in future. Some countries provided a graduate number but no headcount for an occupation group. In such cases, the graduate numbers are still shown.

The “density per 10,000 population” column shows a ratio of the headcount to the country’s 2019 population according to the United Nations’ World Population Prospects 2019 revision. No adjustment was made if the headcount predated 2019. If the headcount in NHWA predates 2019 (as indicated in the first column) this density figure is probably inaccurate, especially if the population is growing quickly.

3. Projections to 2030, dedicated SRMNAH equivalent (DSE) workforce (page 1, bottom section)

This section compares estimates of the number of DSE workers needed with the number available. On each chart, the first pair of bars shows the baseline year, the second pair shows projections to 2025, and the third pair shows projections to 2030. Each chart represents a different group of workers:

1. midwives and nurse-midwives (professional and associate professional midwives; professional and associate professional nurse-midwives);
2. nurses (professional and associate professional nurses, **excluding nurse-midwives**);
3. SRMNAH doctors (general practitioners, ob/gyns and paediatricians); and
4. community health workers.

The “needed” numbers represent the number of DSEs necessary to achieve universal coverage of essential SRMNAH interventions in that year (details in [Webappendix 3](#)). This need is allocated to occupation groups according to the competencies they should have if educated and regulated according to global standards (details in [Webappendix 6](#)). Thus, a “need” estimate is shown for all four groups of workers, even if the country currently reports no headcount for one or more of the groups. If a country does not recognize that occupation, it should consider how that need can be met by other occupation groups in the short term, and whether new occupation groups should be created to fill the need in the longer term.

If a country has no data for the number of women of reproductive age, number of adolescents or number of live births, it is not possible to estimate the amount of SRMNAH worker time needed. In such cases the “needed” bars are not shown on the charts.

The “actual” numbers for 2019 represent the number of DSEs currently available (see section 2 above). The DSE numbers in these charts may not exactly match the numbers in the “SRMNAH workforce availability” section because the following assumptions were made to compensate for missing or incomplete data in NHWA:

1. Midwives and nurses in the “not further defined” groups were reassigned to either the professional or the associate professional group, according to rules detailed in [Webappendix 3](#). If a country disagrees with this reassignment, the NHWA focal point should be encouraged to avoid using the “not further defined” categories in future.
2. If a country submitted headcounts to a regional SoWMy report in 2017 or 2019 but did not submit these data to NHWA, the data from the regional SoWMy report were included here (but not shown in the “SRMNAH workforce availability” section above, which only displays data submitted to NHWA).
3. If a country submitted headcounts for their entire stock of medical doctors without disaggregating by specialism, evidence-based assumptions were made about the proportion of medical doctors who were general practitioners, ob/gyns and paediatricians (details in

[Webappendix 3](#)). These assumed numbers were included here (but not in “SRMNAH workforce availability” above).

In these four figures, if the “actual” bar is smaller than the “needed” bar for the baseline year, the country may have a needs-based shortage of that occupation group. Alternatively, it might be due to missing data in NHWA, or to the need being met by other health occupations.

If the “actual” bar is the same size as or bigger than the “needed” bar, the country theoretically has sufficient SRMNAH workers in that occupation group to meet the need for the essential SRMNAH interventions which they are competent to deliver. However, in practice the need may not actually be met, e.g. if the workforce is inequitably distributed or poorly educated, or if the occupation group’s scope of practice is restricted. Furthermore, countries without a needs-based shortage may still have shortages according to other measures, such as demand for SRMNAH care.

The “forecast” numbers for 2025 and 2030 are estimates based on the current age structure of the workforce (if provided in NHWA: otherwise regional averages were applied) and the rate of domestic production (details in [Webappendix 3](#): again estimates were used if no graduate numbers were provided). If the “forecast” bar is smaller than the “needed” bar, the country is projected to have a needs-based shortage in that year.

For midwives, nurses and doctors, the differently coloured sections of the bars show how many DSEs of each type are needed within the overall total. It is important to look at these individual sections as well as the overall height of each bar. If any individual segment of the “actual” or “forecast” bar is smaller than the corresponding segment of the “needed” bar, this may indicate an inappropriate or inefficient skill mix within the SRMNAH workforce.

For community health workers, the “actual” and “forecast” bars are empty if the country did not submit headcounts in NHWA.

4. Wider midwifery workforce demography (page 2, top section)

These two charts illustrate the age and gender distribution of the country’s wider midwifery workforce (professional and associate professional midwives and nurse-midwives) according to the data submitted to NHWA. If the bar for those aged 55+ is larger than the bar for those aged <35, the midwifery workforce is ageing and there is a risk of shortages within the next 10 years if production does not keep pace with retirements.

A midwifery workforce which is mostly female is not necessarily a problem, because many women prefer to receive care from a female midwife. However, a workforce which is 100% female may indicate unnecessarily restrictive recruitment policies and/or practices. If a large proportion of midwifery workers are male, consideration should be given to whether the gender balance is appropriate.

The code “nr” means that the country did not provide age- and gender-disaggregated headcounts for midwifery workers.

5. Enabling environment (page 2, left-hand section)

The data in this section come from the 2020 ICM member association survey and the 2018–2019 WHO SRMNCAH policy survey

The code “nr” denotes one of three things: (1) the country did not complete the survey, (2) the survey was completed but this question was not answered, or (3) the survey was completed but the data were not validated by the competent authority in the country. In the last case, the unvalidated data can be viewed at the [ICM Global Midwives’ Hub](#).

The code “na” means that this indicator is not applicable. For example, for a country without a direct-entry midwifery education programme, the question about the duration of the direct-entry programme is not applicable. The code “dk” means “don’t know”, i.e. those responsible for completing and validating the survey did not know the answer to that question.

Policy environment

The first indicator in this section has three parts, one in each of the three columns on the right. The left-hand box shows whether there is a policy/guideline recommending midwife-led care in pregnancy, the middle box shows whether there is a policy/guideline recommending midwife-led care in childbirth, and the right-hand box whether there is a policy/guideline recommending midwife-led care in the postnatal period. For each, there are three possible answers: “mother only” (if there is a guideline but it only applies to the mother), “mother and newborn” (if the guideline applies to both) or “no” (if there is no guideline at all). Ideally a country should not have “no” or “don’t know” in any of the three boxes.

The second indicator has three numerical answers. The left-hand box shows the number of midwives in leadership roles in the national Ministry of Health, the middle box shows the number in sub-national health ministry offices, and the right-hand box the number in health worker regulatory authorities. Small numbers, especially zeroes, may be cause for concern.

Education

The first indicator has a single “yes/no” answer. Ideally the answer should be “yes”.

The second indicator has three yes/no answers. A “yes” in the left-hand box indicates that the country has at least one direct-entry midwifery education programme, a “yes” in the middle box that there is at least one post-nursing midwifery programme, under which a person graduates as a nurse (and in many cases must work for a period as a nurse) before continuing their midwifery studies. A “yes” in the right-hand box that there is at least one combined nursing and midwifery education programme, i.e. graduates qualify in both nursing and midwifery simultaneously.

The third indicator shows the duration (in months) of the available education programme(s). If the country has more than one direct-entry programme, the one with the longest duration is shown here, and details about the other programmes are given in the “explanatory notes” box on the bottom right of this page. The same applies if there is more than one post-nursing programme or more than one combined programme. The duration of the post-nursing programme does not include time spent qualifying as a nurse (usually 3-4 years) only the additional time spent on the midwifery programme. A direct-entry programme of less than 36 months’ duration or a post-nursing programme of less than 18 months’ duration may indicate the need for a curriculum review.

The fourth indicator shows the percentage of midwifery educators who are themselves qualified midwives. If this number is low, it may indicate a shortage of midwives who are competent to educate future midwives, and/or a restrictive policy about which types of health professional are competent to teach.

Regulation

The first three indicators have single “yes/no” answers. Ideally the answer should be “yes” for all three.

The fourth indicator has three “yes/no” answers. A “yes” in the left-hand box indicates that midwives must be licensed before they are permitted to practise; a “yes” in the middle box that midwives are required to renew their licence periodically; and a “yes” in the right-hand box that continuous professional development is a requirement for licence renewal. Ideally the answer should be “yes” for all three, unless the country has an alternative system or mechanism to ensure continuing competence.

Association

This indicator has two “yes/no” answers. A “yes” in the left-hand box indicates that the country has at least one professional association specifically for midwives. An association was classed as “specifically for midwives” if the association’s name includes the word “midwife” (or the equivalent term if the language does not have a word for midwife) without referring to other health occupations. A “yes” in the right-hand box indicates that there is at least one other professional association which midwives are eligible to join. A “no” in both boxes indicates that the midwifery profession may not be well represented in the country.

6. Potential to meet need and demand, 2019 and 2030 (page 2, right-hand section)

This section includes two summary measures of SRMNAH workforce availability: a needs-based estimate followed by a demand-based estimate. The methods used to produce these estimates can be found in [Webappendix 3](#).

Needs-based estimate (“potential met need”)

Potential met need (PMN) is defined as “the proportion of health worker time needed for universal coverage of essential SRMNAH interventions which could potentially be delivered by the current workforce, if it was educated according to global standards, equitably distributed and working within an enabling environment”. It is primarily a measure of the overall size and composition of the workforce: it does not account for workforce accessibility, acceptability or quality. If there is no PMN estimate for a country, this means either there were insufficient data in NHWA to conduct this analysis, or the country was excluded from the data source used to obtain population estimates.

The three pictures of a baby each represent a year: the one on the left-hand side shows the PMN estimate from SoWMy 2014 (or, if the country participated in a more recent regional SoWMy report, the estimate from that more recent report). This picture is labelled “nr” if the country has not participated in a SoWMy report before, or if they did participate but there was insufficient data to make a PMN estimate. The picture labelled “SoWMy 2021” shows the current PMN estimate; the one labelled “2030” shows a forecast for that year.

If the estimate is above 50%, the baby is mostly coloured green, below 50% the baby is mostly coloured grey. Ideally the 2021 and 2030 pictures should both be completely green. A small amount of grey is usually an indication of insufficient specialist doctors or insufficient midwives, because a few essential interventions (most notably caesarean sections and breastfeeding counselling) can only be delivered by them. A large amount of grey usually indicates a needs-based shortage across many or all SRMNAH occupation groups.

The 2014 and 2021 estimates are not directly comparable, because the definition of need has been expanded since SoWMy 2014, which makes it more challenging to achieve a high PMN in 2019. However, the method used to produce the 2019 estimates is almost certainly a more accurate reflection of the workforce's potential to meet the need. The changed method means that: (1) a lower % in 2021 than in 2014 does not necessarily indicate that the workforce's potential to meet the need has decreased in the last seven years, and (2) a large increase since 2014 is strong evidence that the country has significantly expanded the size or improved the composition of its SRMNAH workforce.

If a country has reported midwives or nurses "not further defined", and these have been reclassified as "associate professionals", the PMN estimate for that country will be too low. As noted above, the NHTA focal point should be discouraged from using the "not further defined" categories in future, unless there is a good reason to do so.

As noted in Section 3 above, a PMN estimate of 100% means that all of the need *could potentially* be met - it does not necessarily mean that all of the need is *actually* met. For example, there may be poor accessibility or poor quality of the available SRMNAH workers. It could also be due to the way in which need is defined: in this report it is based on the clinical time required to deliver the minimum set of essential SRMNAH interventions (see [Webappendix 5](#)). However, individual countries may use other definitions of need which are more challenging to achieve.

Demand-based estimate ("percentage met demand")

"Demand" is defined as the country's capacity to employ health workers, estimated on the basis of projected economic growth, demography and health spending by governments and individuals. By this definition, demand reflects the willingness of governments and other purchasers to pay for SRMNAH care, which in turn drives demand for employing health workers.

There are four possible categories for this demand-based projection by 2030:

1. 2030 supply severely below capacity to employ, i.e. at current rates of production, the country's supply of SRMNAH workers will be <50% of the number it could afford to employ: a severe demand-based shortage;
2. 2030 supply moderately below capacity to employ, i.e. at current rates of production, the country's supply of SRMNAH workers will be between 50% and 95% of the number it could afford to employ: a moderate demand-based shortage;
3. 2030 supply matches capacity to employ, i.e. at current rates of production, the country's supply of SRMNAH workers will be between 95% and 105% of the number it could afford to employ; and
4. 2030 supply exceeds capacity to employ, i.e. at current rates of production, the country will produce more SRMNAH workers than it can afford to employ: an oversupply.

"Demand" is defined according to a country's economic capacity to educate and employ SRMNAH workers. By this definition, demand will be low in most low- and lower middle-income countries, and therefore easier to meet. "Need" is defined according to a minimum set of essential interventions, rather than by taking into account all services provided by the SRMNAH workforce in every setting. Thus, neither individual indicator fully reflects the ideal size and composition of a country's SRMNAH workforce: it is important to consider both the needs-based *and* the demand-based analyses. It is possible for a country with a low PMN score (a needs-based shortage) to achieve a high score on the demand-based measure, and vice versa.

If a country is forecast to have a needs-based shortage in 2030 ($PMN < 100\%$) but no demand-based shortage (supply matches or exceeds capacity to employ) then its projected economic growth and health spending are not expected to keep pace with growing need for SRMNAH services. If supply exceeds capacity to employ, this is likely to lead to high levels of unemployment among SRMNAH workers and/or high levels of “brain drain”.

If a country is forecast to have no needs-based shortage in 2030 ($PMN = 100\%$) but a demand-based shortage (supply severely or moderately below what the country could afford) then its projected health spending is expected to keep pace with need. However, density of SRMNAH workers may be lower in 2030 than at present, which may lead to dissatisfaction among SRMNAH workers and service users.

If a country is forecast to have both a needs-based shortage in 2030 ($PMN < 100\%$) and a demand-based shortage (supply severely or moderately below what the country could afford) then greater investments will be required to boost market-based demand and supply, and to align them more closely with the population’s SRMNAH needs.

7. Explanatory notes (page 2, bottom right)

When submitting data, many countries provided additional explanatory information. Where applicable, that information is summarized here, to support understanding and interpretation of the country profiles.

Glossary of terms used in country profiles

Adolescent	A person aged between 10 and 19 years (inclusive).
Adolescent birth rate	The number of births to women aged 15-19 years per 1,000 women in that age group (2).
Caesarean section rate	The percentage of pregnant women who give birth via caesarean section.
Coverage for antenatal care	The percentage of women aged 15-49 years with a live birth in a given time who received antenatal care four or more times (3).
Dedicated SRMNAH equivalent (DSE)	Headcount adjusted for % of clinical time spent on SRMNAH care, to estimate the amount of health worker clinical time available to deliver SRMNAH interventions.
Demand for SRMNAH workers	The number of SRMNAH workers that a country's health system can support in terms of funded positions or economic demand for SRMNAH services.
Live birth	The complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy, which after such separation breathes or shows any evidence of life, such as a heartbeat, pulsation of the umbilical cord or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached (4).
Maternal mortality ratio (MMR)	The number of maternal deaths during a given time period per 100,000 live births during the same period (5).
Modern contraceptive prevalence rate	The percentage of women currently using, or whose sexual partner is currently using, at least one modern method of contraception. Modern methods include: oral contraceptive pills, implants, injectables, contraceptive patch and vaginal ring, intrauterine device, female and male condoms, female and male sterilization, vaginal barrier methods (including the diaphragm, cervical cap and spermicidal agents), lactational amenorrhoea method, emergency contraception pills, standard days method, basal body temperature method, TwoDay method and sympto-thermal method (6).
Neonatal mortality rate	Number of deaths during the first 28 completed days of life per 1,000 live births in a given year or period (7).
Percentage met demand (PMD)	The number of "dedicated SRMNAH equivalent" (DSE) workers projected in 2030 as a percentage of the number of DSE workers that a country is projected to be able to afford to employ in 2030.
Potential met need (PMN)	The percentage of health worker time needed for universal coverage of essential SRMNAH interventions that could be delivered by the current workforce if it was educated to global standards, equitably distributed and working within an enabling environment.
SRMNAH doctors	Generalist medical practitioners, obstetricians and gynaecologists, and paediatricians.
Stillbirth rate	Number of fetal deaths at 28 weeks or more of gestation per 1,000 total births (live and stillbirths) (8).
Total fertility rate	The average number of children a hypothetical cohort of women would have at the end of their reproductive period if they were subject during their whole lives to the fertility rates of a given period and if they were not subject to mortality. It is expressed as children per woman (9).
Unmet need for family planning	The percentage of women of reproductive age who have an unmet need for family planning, i.e. those wishing to stop or delay childbearing but not using any method of contraception (10).
Women of reproductive age	Women aged 15-49 years inclusive.

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