

Letter



Letter to the Editor: Midwifery in War – Why Scientific Associations Must Lead the Response in Conflict Settings

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Dear Editor,

For a pregnant woman in a war zone, the journey to safe childbirth is fraught with peril at every turn. The cacophony of conflict replaces the calm of a delivery room; the threat of shelling overshadows the hope of a healthy newborn; and the familiar support of family is often lost amidst the chaos of displacement and destruction. War and instability have transformed pregnancy from a natural life event into a high-stakes health emergency. World Health Organization (WHO) unequivocally asserts that midwives are uniquely positioned to deliver essential care to women and newborns in these most difficult humanitarian contexts. However, this capacity is now under existential threat. Recent United Nations Population Fund (UNFPA) reporting reveals that severe funding cuts are precipitating drastic reductions in support for midwives in crisis-hit countries, directly jeopardizing access to safe maternity care for millions (1, 2).

This existential threat, in the systematic dismantling of the very maternity care systems that midwives uphold. The consequences are quantified in stark mortality figures: in conflict-affected settings, the maternal mortality ratio stands at approximately 504 deaths per 100,000 live births, more than double the global average of 211 (3). Similarly, the neonatal mortality rate in fragile states is 27 deaths per 1,000 live births, compared to 17 in non-fragile settings (4). The WHO estimates that up to 60% of these maternal deaths

are preventable with timely, accessible midwifery care. Health facilities are damaged or destroyed, referral pathways collapse, transport becomes unsafe, and essential supplies are interrupted. Women may be displaced, separated from families, exposed to gender-based violence, or forced to deliver without skilled attendance. In such settings, the absence of accessible midwifery care contributes not only to preventable maternal and newborn deaths, but also to psychological trauma and long-term reproductive health consequences.

Midwives are central to addressing this gap because they provide a comprehensive spectrum of essential sexual, reproductive, maternal, and newborn health services far beyond childbirth. This includes family planning, safe post-abortion care, screening and psychosocial support, and continuous postpartum care. UN reported that midwives can deliver up to 90% of these core services, including safe childbirth care and support for survivors of sexual violence. However, the workforce itself is under severe pressure. A global shortage of nearly one million midwives has been reported, and crisis conditions further weaken retention, safety, and service continuity. In eight crisis-hit countries alone, UNFPA will only be able to fund 47% of the midwives it intended to support in 2025, with some settings facing complete losses in midwifery support. This is not merely a financing problem; it is a survival problem for women and newborns. (1, 2)



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The role of midwifery scientific associations is therefore more important than ever, but it must be defined in concrete, verifiable actions. We propose six core actions that every association in a conflict-affected setting should prioritize: (1) Publish a context-adapted clinical guideline for maternal and newborn care within 30 days of crisis onset; (2) Establish a rapid response roster of at least 20 trained midwives ready for deployment within 72 hours; (3) Implement a 72-hour emergency training package and repeat it monthly for frontline staff; (4) Activate a telehealth or hotline service for remote triage and psychological first aid; (5) Produce weekly situation reports documenting service disruptions, maternal deaths, and security incidents for advocacy; and (6) Formally join the Health Cluster and protection working groups to ensure midwifery is represented in humanitarian coordination. These actions transform associations from passive observers to active, accountable responders (5).

These are not theoretical propositions. In recent conflicts, midwifery associations have already demonstrated tangible impact. In Gaza (2023–2024), the Palestinian Midwives Association established emergency birth preparedness teams and distributed clean delivery kits to displaced women (6). In Ukraine (2022–present), the Ukrainian Midwifery Association created a national telehealth hotline for pregnant women, providing remote triage and referral coordination even amid active shelling (7). In Sudan (2023–present), the Sudanese Midwives Association deployed mobile midwifery units to displacement camps and trained community health workers in basic obstetric first aid using locally adapted protocols (8). In Syria (2011–present), the Syrian Midwifery Society developed context-specific clinical guidelines for home births and postpartum hemorrhage management (9). Similarly, international organizations, such as UNFPA and WHO, have implemented programs to extend reproductive health services to Afghan refugee populations. In Lebanon, the Lebanese Midwives Syndicate provided perinatal mental health support to displaced pregnant women during the 2023–2024 border conflicts (10). These examples affirm that associations are operational actors on the ground. Implementing these actions, however, requires dedicated resources. Associations need: (a) Human resources at least 2–3 dedicated emergency coordination staff and a roster of 20–30 master trainers; (b) Financial resources an estimated minimum of

\$150,000–\$250,000 per country per year; (c) Technical resources offline-capable digital platforms, basic medical supplies for training kits and secure communication tools; and (d) Partnership resources formal memoranda of understanding with UNFPA, WHO, and national Red Cross/Red Crescent societies to facilitate access, logistics, and security. Without these investments, the proposed actions remain aspirational.

However, to be realistic, any strategy must also confront the internal challenges that cripple many midwifery associations in conflict zones. Most operate on precarious, short-term project funding, precluding long-term planning. The security environment itself is a formidable barrier. Midwives and association leaders operate under constant threat of arrest and harassment. Attacks on health facilities have become a tactic of war, with WHO documenting over 1,500 attacks on health care in 2023 alone. Funding shortages are compounded by the gap between pledges and actual disbursements; humanitarian health appeals are often less than 40% funded by mid-year. Many associations are excluded from formal decision-making bodies. Digital infrastructure is often fragmented internet, and mobile networks are regularly disrupted. Acknowledging these obstacles is not a sign of weakness but a prerequisite for designing resilient, context-sensitive interventions.

To translate these capabilities into measurable outcomes, associations must adopt operationally specific approaches. For training, we recommend a three-module priority package: (a) Basic Emergency Obstetric and Newborn Care adapted for austere settings; (b) Trauma-informed care for survivors of sexual violence; (c) Neonatal resuscitation without advanced equipment; and (d) Post-abortion care and family planning counseling. For delivery, associations should leverage mobile learning platforms to overcome connectivity gaps. 72-hour intensive training for frontline midwives, followed by weekly virtual mentorship sessions for three months, and monthly in-person supervision when security permits. To operationalize these recommendations, we propose a three-tier framework. Tier 1 (Preparedness pre-crisis): map the existing midwifery workforce and facilities; pre-position essential supplies and digital training content; establish coordination protocols with UN clusters and local authorities. Tier 2 (Response during active conflict): deploy the 72-hour training package; activate telehealth/hotline services; document incidents, deaths, and attacks daily; participate in all humanitarian

coordination meetings. Tier 3 (recovery and advocacy post-crisis stabilization): conduct debriefing and mental health support for midwives; analyze collected data to produce policy briefs; advocate with ministries and donors for sustained funding and legal protection. This framework ensures that actions are phased, measurable, and context-responsive. (5)

Crucially, effective action cannot occur in isolation. Midwifery associations must actively coordinate with military-civilian liaison bodies (UN OCHA's clusters) to ensure their activities are deconflicted and recognized as neutral humanitarian actions; partner with local grassroots NGOs for community engagement and trust-building; and align with the International Red Cross/Red Crescent Movement for security protocols, logistics, and access negotiation. This multi-stakeholder approach enhances protection and operational reach.

This role is especially urgent because the global response to conflict-related maternal health needs remains fragmented. While organizations, such as WHO, UNFPA, and ICM, have repeatedly emphasized the importance of protecting maternity care and midwives, implementation at the country level is often inconsistent. The International Confederation of Midwives has recently warned that health facilities and midwives must never be targets. Midwifery scientific associations can translate that global message into local action by building coalitions, supporting rapid advocacy, and keeping maternal health visible in humanitarian agendas.

The evidence is irrefutable: conflict makes pregnancy more dangerous, while funding cuts systematically dismantle the very workforce capable of mitigating this harm. We conclude with three distinct, actionable calls. To donor governments and the executive leadership of WHO and UNFPA: allocate at least 15% of humanitarian health budgets specifically to midwifery services and the protection of maternal health facilities, and establish a permanent 'Humanitarian Midwifery Fund' with a minimum annual budget of \$100 million for rapid deployment. To the editorial boards of leading public health and midwifery journals: dedicate special issues or rapid publication channels to frontline midwifery research from conflict settings. To midwifery scientific associations themselves: adopt the operational framework outlined in this letter (training modules, digital tools, coordination protocols), proactively document your experiences, and advocate for your formal inclusion in all Humanitarian Response Plan

coordination processes. The international community must protect the frontline of maternity care. Midwifery must be recognized as central to emergency response frameworks from the first hours of a crisis to long-term recovery. To fail to do so is not merely a policy failure; it is a failure of security, funding, and political will and one for which history will rightly judge us.

Statements

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