

Midwives' Voices Midwives' Realities



Findings from a global consultation
on providing
quality midwifery care

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Acronyms

| | |
|--------|---|
| AIDS | Acquired immunodeficiency syndrome |
| ANC | Antenatal care |
| BEmONC | Basic emergency obstetric and newborn care |
| EmONC | Emergency obstetric and newborn care |
| ESMOE | Essential steps in managing obstetric emergency |
| HIV | Human immunodeficiency virus |
| ICM | International Confederation of Midwives |
| IUD | Intrauterine device |
| LIC | Low-income country |
| MDG | Millennium Development Goal |
| MIC | Middle-income country |
| MMR | Maternal mortality ratios |
| MoH | Ministry of Health |
| MSF | Médecins Sans Frontières |
| NGO | Nongovernmental organization |
| NICE | National Institute for Health and Care Excellence (England and Wales) |
| QoC | Quality of care |
| RCM | Royal College of Midwives |
| SANC | South African Nursing Council |
| SBA | Skilled birth attendant |
| UNFPA | United Nations Population Fund |
| USAID | United States Agency for International Development |
| WHO | World Health Organization |
| WRA | White Ribbon Alliance |

Executive summary

The largest global survey of midwifery personnel

This report documents the voices and experiences of 2,470 midwifery personnel who provide care to childbearing women and their newborns in 93 countries. The information was gathered through a multilingual participatory workshop combined with the largest global online survey of midwives to date. It highlights critical issues in the provision of quality midwifery care, describing the barriers experienced as well as solutions to improving care for women, newborns and their families.

The report was developed in collaboration with the International Confederation of Midwives (ICM) and the White Ribbon Alliance (WRA) and is part of the World Health Organization's (WHO) wider work on improving the provision of quality midwifery care to further prevent maternal and newborn deaths and disabilities.

The global maternal mortality ratio has dropped by 44% over the past 25 years, from an estimated 385 maternal deaths per 100 000 live births in 1990 to 216 per 100 000 in 2015. However, in terms of actual numbers it is estimated that 303 000 women died while giving birth in 2015; 99% of these preventable maternal deaths occur in low- and middle-income countries.¹ Similarly, the global neonatal mortality rate fell from 36 deaths per 1000 live births in 1990 to 19 in 2015, but 2.7 million neonatal deaths still occur each year.² The UN Global Strategy for Women's, Children's and Adolescents' Health³ (adopted as part of the new Sustainable Development Goals for 2016–30) highlights the urgent need for further progress to be made, and for this to be based on gender responsive, equity driven and rights based approaches with increasing emphasis on quality of care.⁴

Midwifery – “skilled, knowledgeable, compassionate care”

Why is it important to understand midwifery, and to listen to the voices of midwives and know of their realities? Midwifery is defined as “skilled, knowledgeable and compassionate care for childbearing women, newborn infants and families across the continuum from pre-pregnancy, pregnancy, birth, postpartum and the early weeks of life”.⁵ 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. Yet to date little has been documented about the perspectives of midwifery personnel (nearly all of whom were midwives in this report), or what support and systems are needed to ensure that “every woman has the right to the highest attainable standard of health, which includes the right to dignified, respectful health care”.⁶

¹ Trends in maternal mortality: 1990 to 2015 – Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division, 2015. Geneva: World Health Organization; 2015.

² Levels and trends in child mortality 2015. Estimates developed by the UN Inter-agency Group for Child Mortality Estimation. New York: UNICEF; 2015.

³ UN Global strategy for women's, children's and adolescents' health 2016–2030. Geneva: World Health Organization; 2015.

⁴ Strategies towards ending preventable maternal mortality (EPMM). Geneva: World Health Organization; 2015.

⁵ Renfrew MJ, McFadden A, Bastos MH, Campbell J, Channon AA, Cheung NF et al. Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care. *The Lancet*. 2014 Sept 20;384(9948):1129–1145. [http://dx.doi.org/10.1016/S0140-6736\(14\)60789-3](http://dx.doi.org/10.1016/S0140-6736(14)60789-3)

⁶ WHO Statement on the prevention and elimination of disrespect and abuse during facility-based childbirth. Geneva: World Health Organization; 2015.

Address hierarchies of power, transform gender dynamics

The themes that emerged from both the workshop and the global online survey show that midwives are deeply committed to providing the best quality of care for women, newborns and their families. But they are also deeply frustrated by the realities they experience that constrain their efforts. Importantly, they express how they are hindered through a lack of voice in creating the change and delivering the creative solutions they know are so badly needed. These experiences are universal across the information collected regardless of whether midwives care for women and newborns in high-, middle- or low-income countries. This report highlights that it is not just about fixing financial resources or health systems, but about redressing complex hierarchies of power and transforming gender dynamics. Respondents highlighted that “power, agency and status” is important for midwifery personnel if progress is to be made in delivering quality care.

Experiences of disrespect, subordination and gender discrimination

The themes in the report provide striking first-hand examples of the experiences of the 2,470 midwives. There are descriptions of being disrespected at work and in the community, with 36% of respondents noting a lack of respect by senior medical staff and 32% saying they would value “being listened to” (this rose to 53% among African midwives). Lack of status and “subordination by the medical profession” were frequently quoted issues together with limited legal and regulatory support. Between 20–30% of all respondents said that they are treated badly because of discrimination against women and gender inequality.

Socio-cultural barriers: harassment, unsafe accommodation, social isolation

The barriers described by participants in this consultation align well with an analytical framework developed by WHO’s systematic mapping of social, economic and professional barriers that prevent quality care and a systematic review of interventions that help overcome these difficulties.

From a perspective of social barriers, 37% of all the midwives in the survey have experienced harassment at work, with many describing a lack of security and fear of violence. A significant number of respondents, particularly in Africa, say that disrespect in the workplace “extends to harassment – verbal bullying and, at times, physical and sexual abuse”. This affects their “feelings of self-worth and their ability to provide quality care”. Other barriers to providing quality care include living in inadequate and unsafe accommodation leading to isolation from family support, and difficulties in managing paid employment with domestic and childbearing responsibilities.

Economic barriers: salaries not comparable, not enough for basic needs

Economically, the midwives reported low salaries that are not comparable with similar professions and are sometimes not enough to live on. One fifth of those who participated depend on another source of income to survive, which adds to the pressure and exhaustion that they experience. Yet many still place ethical values of care above salary levels, for example the midwives in one country “aim to get fully trained and gain experience in public sector hospitals even though we know that the salaries are much lower than the private sector”. Others felt that because midwifery does not come high on the political agenda there is inadequate resourcing of midwifery services and that “the vital role of midwifery is not recognized, and therefore funding is not sufficient”.

Professional barriers: lack of opportunity for leadership is disempowering

Professionally, 89% of respondents reported that a clear understanding of what midwifery involves is critical for change to take place. Concerns were also expressed over the perceived devaluing of midwifery combined with the increasing medicalization of birth. Others felt that the lack of leadership opportunities for senior midwifery staff disempowered the profession, particularly when midwifery is subsumed within nursing structures. There was a strong recommendation for strengthened midwifery education to overcome these barriers, with increased access to higher education and professional development, supported by well-resourced midwifery associations.

Midwifery personnel have the solutions

Participants gave many other insights into how to overcome barriers and create positive change. These include ensuring that (as in some countries already) midwifery is “a profession separate from nursing with regulations specifically for midwives” and that midwives should “be policy-makers”. It was also seen as essential that “education planners and researchers have enough knowledge of the profession and the scope of practice of midwives” before making decisions on providing quality care. Participants described the need for the inclusion of rights, gender, ethics and equality into pre-service training across the health system, and a system for peer support.

Examples of existing good practice include midwife-led units or midwife group practice, and the strengthening of midwifery associations to support better professional and regulatory needs. Respondents described how “having midwife managers and supervisors who are part of the management team allows our issues to be more visible and enables the correct decisions to be made”. Some countries described how advocacy campaigns had resulted in improvements in recognition of the midwifery profession.

We must listen to the voices of midwives to improve quality of care

Writing about the Global Maternal Newborn Health Conference held in Mexico in 2015,⁷ Richard Horton (Editor-in-Chief, *The Lancet*), notes that we need the right leaders, and to invest in more midwives. He also states that: “There are certainly successes to celebrate globally. But there are terrible failures too. Our understandable desire to prefer success over failure obscures the realities (and indignities) of life for hundreds of millions of mothers and newborns worldwide.”

The themes in this report indicate that, globally, midwifery personnel have an in-depth awareness of what is needed to improve quality of care, yet their voices are rarely heard and subsequently key issues are absent from the international, national or local policy dialogue. We hope that this report helps us to keep listening to the realities, and indignities, faced by both childbearing women and the thousands of women worldwide who provide midwifery care, to include their voices as leaders in the way forward in improving quality care, and support them together to carry on helping women, newborns and their families survive, thrive and transform.

⁷ Horton R. Offline: The Mexican Revolution. *The Lancet*. 2015 Oct 31;386(10005):1718. [http://dx.doi.org/10.1016/S0140-6736\(15\)00681-9](http://dx.doi.org/10.1016/S0140-6736(15)00681-9)

1. Introduction

The past 25 years has seen significant progress in the reduction of maternal and newborn mortality and morbidity. Although the global maternal mortality ratio has dropped by 44%, from an estimated 385 maternal deaths per 100 000 live births in 1990 to 216 per 100 000 in 2015, a staggering 303 000 women are estimated to have died while giving birth in 2015. Ninety-nine per cent of these preventable maternal deaths occur in low- and middle-income countries.⁸ Similarly, although the global neonatal mortality rate fell from 36 deaths per 1000 live births in 1990 to 19 in 2015, 2.7 million newborns continue to die each year.⁹ The UN Global Strategy for Women’s, Children’s and Adolescents’ Health¹⁰ (adopted as part of the new Sustainable Development Goals for 2016–30) highlights the urgent need for further progress to be made, and for this to be based on gender responsive, equity driven and rights based approaches.

The WHO Strategies towards Ending Preventable Maternal Mortality (EPMM) place increased emphasis on addressing quality of care.¹¹ Considerable evidence exists to demonstrate the positive impact of skilled birth attendance¹² on maternal and newborn health outcomes.¹³ A critical lesson learnt has been that it is not just the number of skilled birth attendants (SBAs) needed (i.e. how many persons with, at minimum, the competencies of a trained midwife), but also the *quality of care* that matters.¹⁴

Although the evidence indicates that midwifery has an important contribution to make to high quality maternal and newborn care and subsequent reductions in maternal and newborn mortality, the understanding of midwifery has been restricted by a failure to apply consistent definitions, resulting in a combination of professional and non-professional staff being seen as midwives.¹⁵ Midwifery is defined as “skilled, knowledgeable and compassionate care for childbearing women, newborn infants and families across the continuum from pre-pregnancy, pregnancy, birth, postpartum and the early weeks of life”. Core characteristics include “optimizing normal biological, psychological, social and cultural processes of reproduction and early life, timely prevention and management of complications, consultation with and referral to other services, respecting women’s

⁸ Trends in maternal mortality: 1990 to 2015 – Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division, 2015. Geneva: World Health Organization; 2015.

⁹ Levels and trends in child mortality 2015. Estimates developed by the UN Inter-agency Group for Child Mortality Estimation. New York: UNICEF; 2015.

¹⁰ UN Global strategy for women’s, children’s and adolescents’ health 2016–2030. Geneva: World Health Organization; 2015.

¹¹ Strategies towards ending preventable maternal mortality (EPMM). Geneva: World Health Organization; 2015.

¹² WHO/ICM/FIGO define an SBA as someone who has, at minimum, the competencies of a midwife as defined by the ICM: “Trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns.” Making pregnancy safer: the critical role of the skilled attendant: a joint statement by WHO, ICM and FIGO. Geneva: World Health Organization; 2004.

¹³ For example see Yakoob MY, Ali MA, Ali MU, Imdad A, Lawn JE, Van Den Broek N et al. The effect of providing skilled birth attendance and emergency obstetric care in preventing stillbirths. BMC Public Health. 2011 Apr 13;11 Suppl 3:S7. doi: 10.1186/1471-2458-11-S3-S7 PMID: 21501458

¹⁴ Strategies toward ending preventable maternal mortality (EPMM). Geneva: World Health Organization; 2015.

¹⁵ Renfrew MJ, McFadden A, Bastos MH, Campbell J, Channon AA, Cheung NF et al. Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care. The Lancet. 2014 Sept 20;384(9948):1129–1145. [http://dx.doi.org/10.1016/S0140-6736\(14\)60789-3](http://dx.doi.org/10.1016/S0140-6736(14)60789-3)

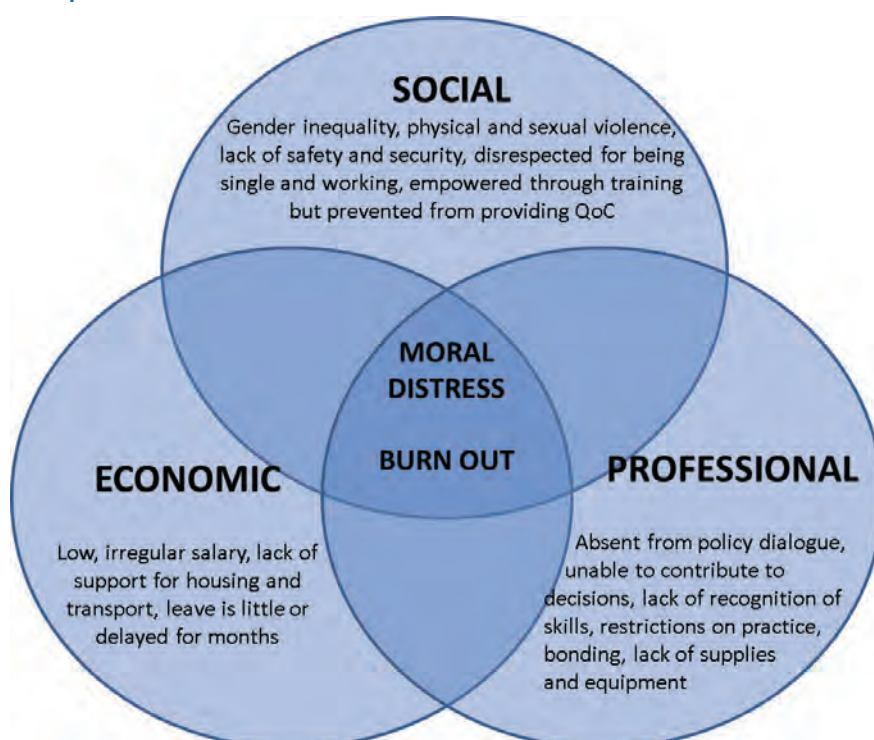
individual circumstances and views, and working in partnership with women to strengthen women's own capabilities to care for themselves and their families".¹⁶

WHO, in collaboration with the White Ribbon Alliance (WRA) and the International Confederation of Midwives (ICM), is working together with partners to improve the quality of care (as defined by WHO¹⁷) provided to women and newborns. To do this, it is critical to understand the perspectives of midwifery personnel including their views on why, in some circumstances, they feel unable to provide quality of care.

To initiate this work, a joint WHO-ICM-WRA session at the 2013 Women Deliver Third Global Conference in Kuala Lumpur, was convened to determine if providers of midwifery care felt "empowered, respected and safe". The presentations by delegates from Afghanistan, Nepal and Papua New Guinea, and the ensuing multi-country discussions, highlighted the stark realities of the difficult, and often dangerous, lives of women who provide midwifery care. This landmark meeting has subsequently been followed by a WHO systematic mapping of the literature on social, cultural and professional barriers; a systematic review of interventions that overcome the barriers identified, and this report on "Midwives' voices, midwives' realities".

Early findings from the Kuala Lumpur discussions and the systematic mapping revealed that the recurrent barriers to the provision of quality midwifery care in low- and middle-income settings, could be classified as **social, economic and professional**. These categories have been used to develop an analytical framework (Figure 1).

Figure 1. Analytical framework: barriers to the provision of quality care by midwifery personnel



¹⁶ Renfrew MJ, McFadden A, Bastos MH, Campbell J, Channon AA, Cheung NF et al. Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care. *The Lancet*. 2014 Sept 20;384(9948):1129–1145. [http://dx.doi.org/10.1016/S0140-6736\(14\)60789-3](http://dx.doi.org/10.1016/S0140-6736(14)60789-3)

¹⁷ Tuncalp O, Were WM, MacLenna C, Oladapo OT, Gulmezoqlu AM, Bahl R et al. Quality of care for pregnant women and newborns – the WHO vision. *BJOG*. 2015 Jul;122(8):1045–9. doi: 10.1111/1471-0528.13451

The three social, economic and professional barriers are interlinked and interdependent. Midwives experiencing difficulties within any of these areas face significant barriers that can prevent them from providing high quality care to women and newborns. When the burden of difficulty becomes too great across all three areas, midwifery personnel feel abandoned, reach burnout and are in a state of “moral distress”.¹⁸

This framework was explored further through a joint WHO-ICM-WRA workshop at the ICM Congress in Prague (June 2014), and through an accompanying global online survey. This report presents the themes arising from the consultation based on the above analytical framework. Section 2 of this report describes the qualitative participatory methodology. Section 3 presents the findings and Section 4 the discussion and conclusions. Detailed findings and qualitative tools can be found in the annexes.

¹⁸ Burnout and moral distress relate to high levels of emotional and physical exhaustion, diminishing self-esteem, low sense of personal achievement, lack of sense of purpose. See for example, Gallagher A. Moral distress and moral courage in everyday nursing practice. *Online J Issues Nurs.* 2011 Mar 21;16(2):8. PMID:22088157

2. Methodology

2.1 The findings presented in this report come from two qualitative consultation processes

- the WHO-ICM-WRA workshop attended by 42 midwives from 14 countries at the ICM Triennial Congress in Prague in June 2014;
- a global online survey in four languages (Spanish, French, English and Arabic), which resulted in 2,470 respondents from 93 countries.

The key difference between the methodologies described below and conventional methods of research lies in the location of power in the information gathering process. Qualitative participatory approaches give emphasis to local knowledge, priorities and perspectives. The information gathered is typically focused on action, rather than for knowledge per se.¹⁹

2.2 Limitations to methodology

2.2.1 Limitations to workshop methodology

- Identification and selection of participants.** The workshop was advertised widely: in the ICM Congress catalogue, through flyers, at other Congress sessions and by word of mouth. However, participation was also influenced by the efforts of the workshop facilitators to boost attendance. Participation was also encouraged by email communication before the conference with key ICM and WRA members and by a direct approach to Congress participants the day before the workshop. This approach inevitably will have led to some bias in purposeful selection and some self-selection.
- Members of the English-speaking group were very mixed** with midwifery personnel from African countries and from Europe and the Americas. This meant that the English-speaking group was not always able to reach a consensus because of the widely different circumstances in which they are working and living. What was surprising was the level of consensus that *was* reached (see Section 3).
- A fourth French-speaking group** had been prepared but at the last moment the French-speaking facilitator was unable to attend the workshop, so no French-speaking group could take place.

2.2.2 Limitations to the global online survey methodology

- Identification and selection of participants:** As the survey was online, the responses were more likely to come from midwifery personnel who have access to the Internet. So the sample is biased towards those in more developed areas or who have smart phones. The exception is the Arabic survey, and around 25 of the Stage 2 African questionnaires, which were completed offline and uploaded manually. The Yemen example shows that, with effort, it is possible to reach out, even to the most remote areas. In doing so, midwifery personnel can feel validated and included.

¹⁹ Social Science and Medicine Vol 41, No 12 pp 1667–1676, 1995.

- (ii) **Targeting low-income countries (LICs) and middle-income countries (MICs):** The intention was to target LICs and MICs only, however this proved to be impossible as the survey was available globally online. There was a strong response from high income countries, particularly Australia, Canada, the Netherlands, New Zealand, Spain, the United Kingdom of Great Britain and Northern Ireland and the United States of America
- (iii) **Disaggregation of data by language:** Respondents were able to choose the language in which they wished to respond (English, French, Spanish or Arabic). The results show that they did not necessarily respond in their first, or working, language. So, for example, some midwifery personnel from Iraq responded in English, and one from Spain responded in French.
- (iv) **Limitation of surveying in only four languages:** There are many midwifery personnel globally who do not speak or read any of the four languages, and who were therefore excluded from the survey.

2.3 The WHO-ICM-WRA workshop, June 2014

The ICM Triennial Congress in Prague in 2014, presented an excellent opportunity to build on the momentum of the findings already generated through the systematic mapping of the literature. A group of 42 participants from 14 countries attended the workshop including midwifery personnel, advocates, policy-makers, educators and donor representatives, though the majority were midwifery personnel. Participants were self-selected and had been informed about the workshop by ICM staff and the workshop team before and during the Congress.

Workshop objective: *To enable midwives to have their say and to share the professional, social and economic realities of your everyday, working lives.*

Following an introduction to work done-to-date, participants were split into three language groups (English, Spanish and Arabic).²⁰

Each group took part in a facilitated brainstorming exercise to explore the barriers that midwifery personnel experience in providing the care that women and newborns deserve. Questions included:

- What are your working conditions?
- What are your opportunities for education, training and professional development?
- How does being a midwife impact on your family situations?
- What are your priorities for change; for getting your rights, needs and demands met?

Participants started by brainstorming the barriers that they face in delivering quality of care and these were organized into the three areas of professional, social and economic factors (see Figure 1). They then explored the question: *What needs to be in place for you to be able to work safely and securely and have job satisfaction?* Participants identified a range of initiatives to address the barriers that they had just identified. A participatory tool (the Spokes Tool, Box 1) was used to measure to what extent the midwifery personnel felt they were making progress in addressing the barriers in their working and personal lives (see Section 3, Findings). Finally the participants voted for the initiatives that they felt were most important for progress to be achieved.

²⁰ Nine women joined the Arabic-speaking group, 16 women and one man joined the Spanish-speaking group and 16 joined the English-speaking group. Ages ranged from mid-twenties through to 70 years, and experience from seven to 47 years.

BOX 1: THE SPOKES TOOL

Spokes can be used to explore any number of different themes and topics. A preliminary discussion reveals characteristics of an issue that are recorded by using symbols or writing. These are arranged around the outside of a circle and joined to a central point by lines drawn to form a wheel. The centre represents “us”, or “now”, and the symbols around the edge of the wheel represent things we want, or need, to achieve. Participants are asked to discuss and reach a consensus on where they think they are now, in relation to the things they want to achieve, and to mark this along each spoke. It is important that participants do not try to give percentage values to the distances they are marking. The marks will show the value in spatial terms and show also the potential of one issue relative to another. If a consensus cannot be achieved on where to place the mark on a spoke, two marks may be made. Participants generally find this a very accessible tool that gives them plenty of space to think and discuss with each other, while keeping their focus on the issues under discussion.

Source: ICM Triennial Congress Workshop Guide (2014) and CR2 Participatory Tools (2005).

Analysis of findings

The qualitative data from the workshop findings were analysed as part of the Spokes methodology with the workshop participants. Each language group organized its data into the three framework areas: social, economic and professional, and identified priorities. Each group organized its data separately, and then reported back in plenary. They were assisted by the group facilitators.

2.4 The global online survey

This survey was designed to complement the participatory workshop. The 10 survey questions (see Box 2) were based on issues emerging from the WHO systematic mapping of the barriers as well as the key findings from the participatory workshop. The questions were deliberately not organized to reflect the three categories of barriers (Figure 1) to minimize influence on the respondents. WHO experts reviewed and revised the survey questions. Space for comments and open questions were provided to enable respondents to indicate what interventions might, or have, supported them to improve quality of care.

BOX 2: ONLINE SURVEY QUESTIONS (SEE ANNEX 3 FOR QUESTIONS IN FULL)

1. Which country do you currently work in?
2. What is your job title and the setting in which you work?
3. How old are you?
4. Score the following statements in terms of how often they affect you in your life as a midwife.
5. How would you say you feel on a daily basis in your job?
6. Previous research has shown that midwives are sometimes treated badly or experience poor conditions at work. Why do you think this happens? Please draw on your own experience (if relevant) and that of colleagues in your country.
7. How easy is it to combine your family life with your work as a midwife?
8. If you had the chance to make changes to your experience of being a midwife, which changes would be most important to you?
9. How do you think these changes could be encouraged?
10. Please tell us of any improvements that are being made in your country, or your part of the health service, and how these improvements have helped midwives to do their jobs better.
11. Optional: If you would like us to keep in touch with you about this research, please provide your name and email address.

The survey was undertaken in two stages. In both stages it was placed on the ICM website, with participation encouraged through the ICM Congress Newsletter and by contacting midwifery associations. Due to the language competencies of the survey team were able to carry out the survey in four languages. Stage 1 was in French, English, Spanish and Arabic in 2014. Due to the low proportion of African respondents, a Stage 2 survey was made available in February 2015. This was for African respondents only and was in English and French. This survey was targeted directly to ICM members in African countries through the ICM Secretariat and through the ICM website.

Unexpected level of response: a need to be heard

The response to the survey was around 10 times higher than anticipated with 2470 respondents. This represents the largest global survey involving midwifery personnel to date.

BOX 3: RESPONSE FROM THE YEMEN

The Yemeni Midwifery Association in Sana'a agreed to try to reach midwifery personnel working in remote governorates, and in rural as well as urban areas. To do this, the survey was printed and sent to the remote areas and completed and returned to Sana'a by service-taxi. The national consultant then added the paper-response data to the online survey. There was an overwhelming response from the midwifery personnel in Yemen – most of them living in regions afflicted by conflict, with no donor programmes and yearning to be heard. For many, this is possibly the first time they have ever been consulted. The significance of their efforts to contribute, and to get their voices heard, cannot be overstated. It is also significant that responses were received from all governorates where there are functioning branches of the Yemeni Midwifery Association, but not from Dhamar and Hodeidah.

Source: S Salloum, National Consultant

2.5 Supporting midwifery networks

A high number of respondents (1031 across all six surveys) gave their email addresses and asked to be kept in touch about the findings of the survey and the next steps. This provides an excellent opportunity to have an on-going dialogue with midwifery personnel all over the world. It could also facilitate setting up an open chat/consultation forum to discuss particular issues or topics.

3. Findings

In the following sections we summarize the key findings from the workshop, the online consultation process, and then provide a summary of the collated findings. We also highlight positive suggestions and examples from midwifery personnel on how to tackle barriers to providing quality care.

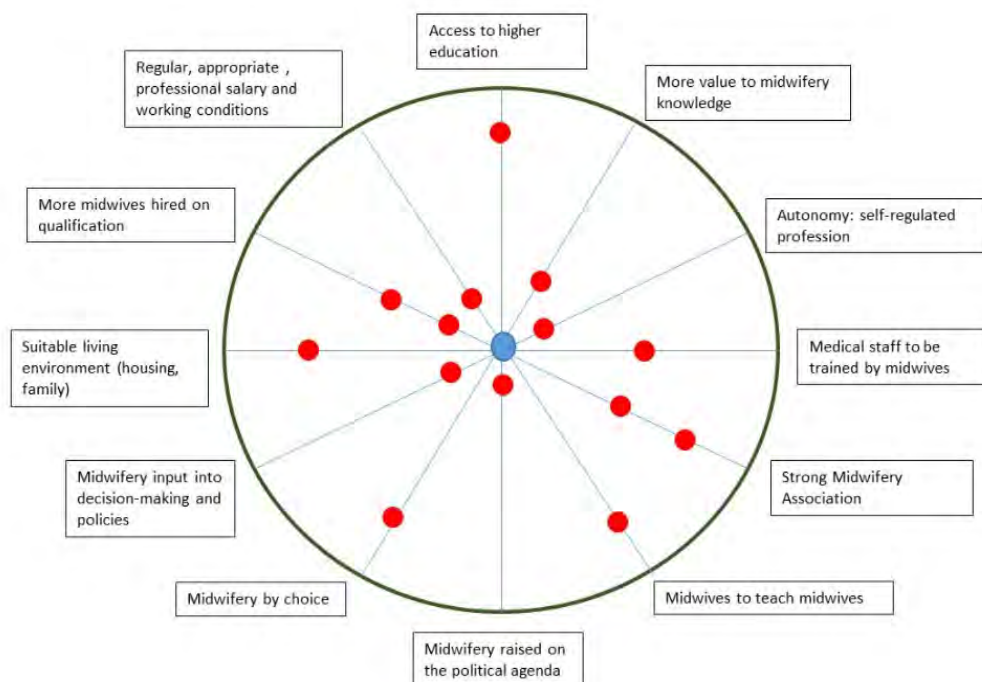
3.1 Findings from the workshop

The three workshop groups identified a range of barriers to the provision of quality care (see Annexes 1 and 2 for the workshop programme and detailed findings). Groups were then given the chance to discuss how these issues or problems could be tackled by exploring the question: *For you to feel safe, secure and satisfied in your working life what needs to change to address these problems – particularly in the social and economic areas?*

The results presented here are the **opinions of the participating midwifery personnel**. The areas for change (or initiatives) identified by the participants in the different language groups were quite similar. All three groups wanted to see a better recognition and definition of midwifery either through better regulatory frameworks, clearer job descriptions or strengthened midwifery associations. There was also a strong call for better pre-service and in service training and for a recognized position in the medical hierarchy. The Spanish and English-speaking groups were interested in more representation in decision-making and in the development of regulatory and legal frameworks. The Spanish-speaking group also called for education on gender, ethics, equality and rights within the health system and among midwifery personnel. The Arabic-speaking group was more focused on basic working conditions for midwifery personnel and in encouraging girls to choose midwifery as a profession.

In the Spokes Tool diagrams below (Figures 2, 3 and 4) the boxes outside the wheel are the areas that the participants identified as needing changes or new initiatives. The dots along the lines represent the feasibility or likelihood of the change happening. If the dot is closer to the outside of the wheel (near the box) then the participants think that they are closer to achieving the change – or that there is more potential for achieving the change. Dots close to the centre indicate a greater challenge. Where there are two dots on one line, this represents differences between participants in the same group (for example an experience in an urban area may differ to that in a rural area).

Figure 2. English-speaking midwifery personnel – proposals for change



Changes that are nearer to being achieved: access to higher education; suitable living environments and supportive families; ability to choose midwifery as a career path; functioning midwifery associations; midwifery personnel available to train other midwifery personnel.

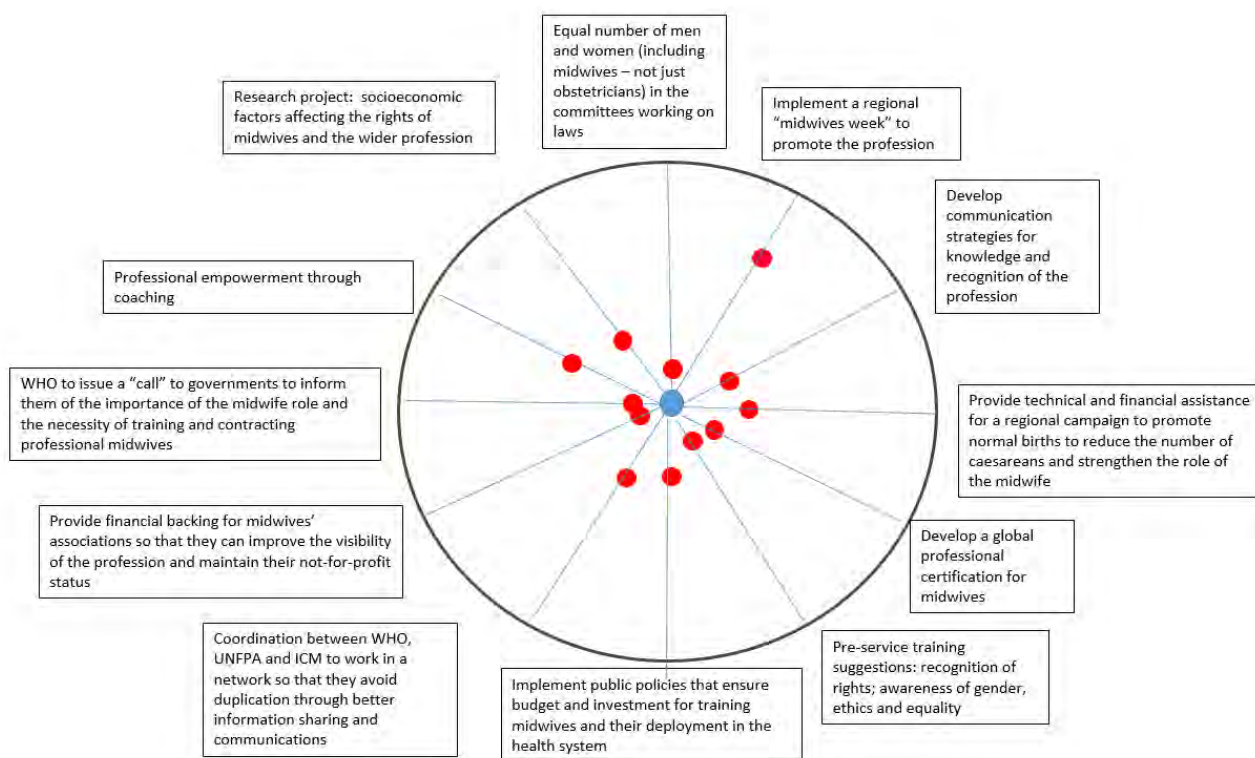
Changes that are more challenging to achieve: Involvement of midwifery personnel in decision-making fora; increase in professional autonomy; improved salaries; midwifery raised on the political agenda and more value given to midwifery knowledge and practice.

The group members then voted on their priorities for action out of all the desired changes, and the top three were identified.

Priorities for Action: (i) ensuring that midwifery associations are strong and are working for the fulfilment of midwifery personnel's rights; (ii) increasing the voices of midwifery personnel in decision-making and policy development; (iii) increasing professional autonomy and self-regulation of midwifery personnel.

In addition, the English-speaking midwifery personnel felt that they experience excessive workloads and exhaustion. Midwifery personnel from the United Kingdom and the USA said that they are highly pressurized to care for increasing numbers of women in an ever-decreasing amount of time. This impacts on their ability to provide quality services.

Figure 3. Spanish-speaking midwifery personnel – proposals for change

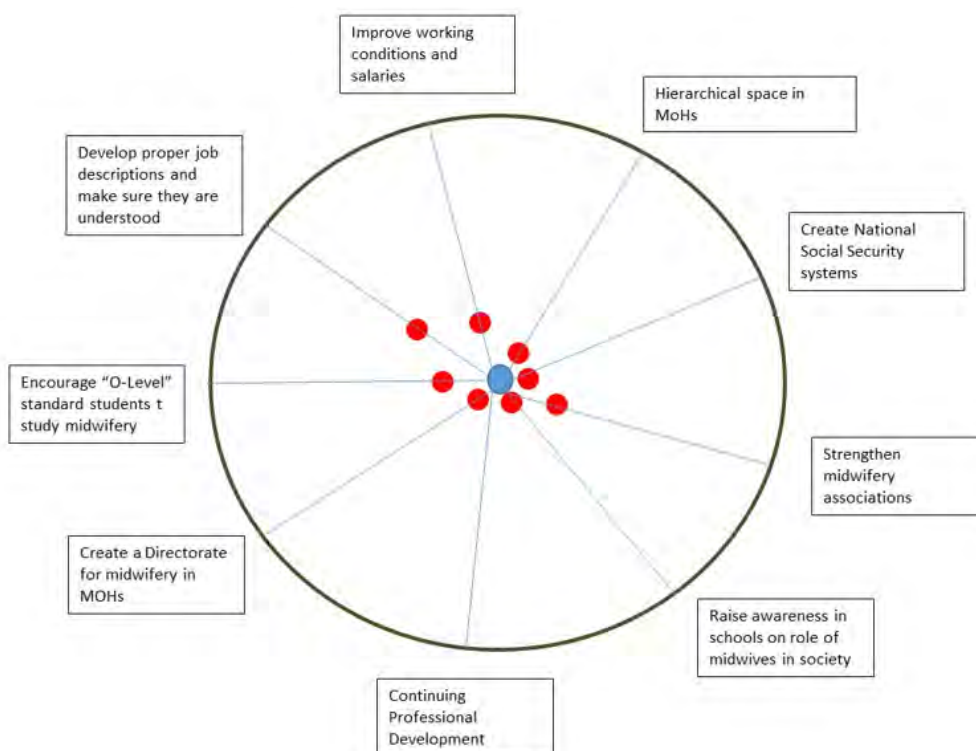


Changes that are nearer to being achieved: The Spanish-speaking midwifery personnel (who were all from Latin America) felt that a regional “midwifery week” was quite likely to happen. They were also optimistic that there would be a new research project to look at socioeconomic factors affecting the rights of midwifery personnel. Professional empowerment through coaching was also within reach and to a lesser extent coordination between WHO, the United Nations Population Fund (UNFPA) and ICM to avoid duplication. Also a bit less likely was the provision of technical and financial assistance for a regional campaign to promote normal births to reduce the number of caesareans and strengthen the role of the midwife.

Changes that are more challenging to achieve: Promotion of understanding of the roles of midwifery personnel; financial backing for midwifery associations; inclusion of women (midwifery personnel as well as obstetricians) in the committees working on policy and law; inclusion of rights, gender, ethics and equality in pre-service training; development of a global professional certification for midwives.

Priorities for Action: (i) development of communications strategies to spread awareness and to ensure greater recognition for the midwifery profession; (ii) WHO to issue a call to governments to increase recognition for midwifery personnel and promote training and contracting; (iii) provide more financial support to midwifery associations and maintain their not-for-profit status.

Figure 4. Arabic-speaking midwifery personnel – proposals for change



MoH: Ministry of Health.

Changes that are nearer to being achieved: The midwifery personnel from the West Bank and Gaza Strip and Yemen could not identify any areas of their work that they felt were operating satisfactorily. It was agreed that the system in the West Bank and Gaza Strip was somewhat more developed than in Yemen, but that both countries are struggling with conflict, political turmoil and disruption to services. The development of job descriptions seemed the most likely progress that might take place.

Changes that are more challenging to achieve: Raising awareness about midwifery with the general population, especially in schools; creation of a midwifery directorate within the ministries of health; and the creation of social security systems (insurance, pensions); improvement in working conditions and adequate salaries for midwifery personnel. Also the provision of continued professional development.

Priorities for Action: (i) create a professional directorate of midwifery within the ministries of health; AND create a system for continuing professional development; (ii) strengthen the midwifery associations; (iii) give the role of midwifery personnel proper recognition, with authority and decision-making power, within the health system.

3.2 Findings from the global online survey

In this section we present an overview of the combined online survey findings (see Annex 3 for the online questionnaire and Annex 4 for detailed responses). The survey was carried out in two rounds: first in four languages (English, French, Spanish and Arabic) targeted globally, then it was re-issued in French and English targeted specifically to African midwifery personnel as there had been a low response from the continent on the first round.

Question 1: Country of employment

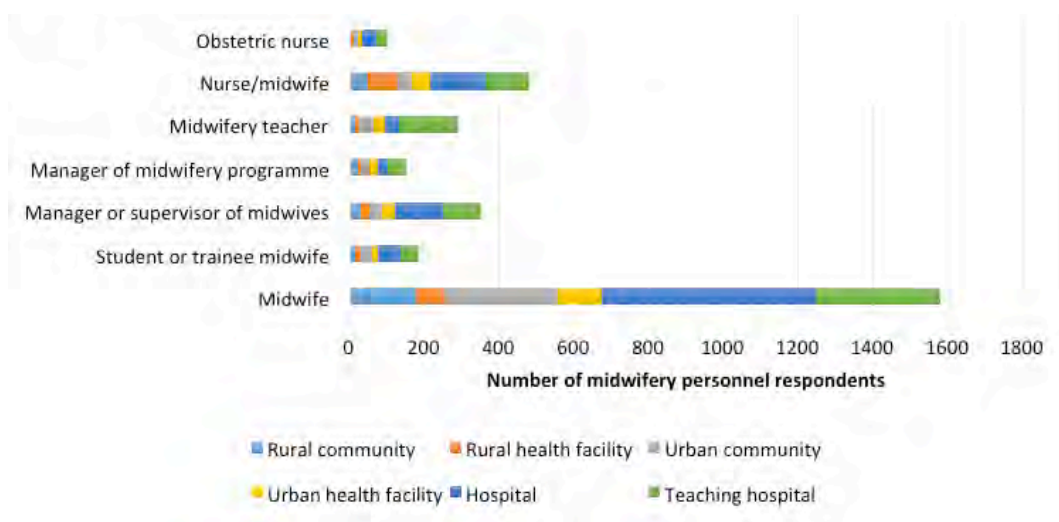
There were a total of 2470 responses from 93 countries. Some of the English and French-speaking African countries had been sent the questionnaire on two occasions, so where there was overlap, it was eliminated. The results are given by language as follows.

- The two English language surveys had a total of 1791 respondents from 75 countries – 58% from 25 countries in Europe, 20% from Africa, 8% from the Americas, 11% from Asia and the Pacific, and 3% from the Middle East.
- The Spanish language survey had 246 respondents from 10 countries – 50% from Spain, 46% from six countries in Latin America and 3% from two European countries and the USA.
- The two French language surveys had a total of 177 respondents from 24 countries – including 19 African countries.
- The Arabic language survey had 256 respondents from four countries – the majority (92%) were from Yemen, 6.8% from Saudi Arabia, 0.4% from Algeria and 0.4% from the West Bank and Gaza Strip.

Question 2: Job title and place of work

The majority (80%) of respondents were working in either a teaching hospital or a general hospital, and 68% of respondents classified themselves as midwives, although there was some variation by region (reflected in the different language surveys). Latin American and Spanish midwives were less likely to be working in rural areas and more likely to be classified as an obstetric nurse than in other regions. African respondents were more likely to classify themselves as nurse–midwives. Overall, 23% were working in primary health centres in rural areas and 33% were working in similar facilities in urban areas. The remaining 44% were working in hospitals and teaching hospitals in urban areas

Figure 5. Job title and place of work

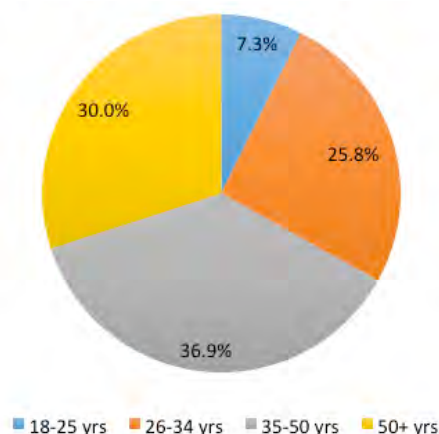


Question 3: Age of respondents

Thirty per cent of respondents were aged over 50 years and held senior positions in hospitals with access to the Internet and therefore this survey

Most of the regions that responded had a similar age spread except for the midwifery personnel from Yemen, 75% of whom were under 35 years of age. This reflected the data collection method and the fact that participants in the first community midwife courses graduated in 1998.

Figure 6. Age of respondents

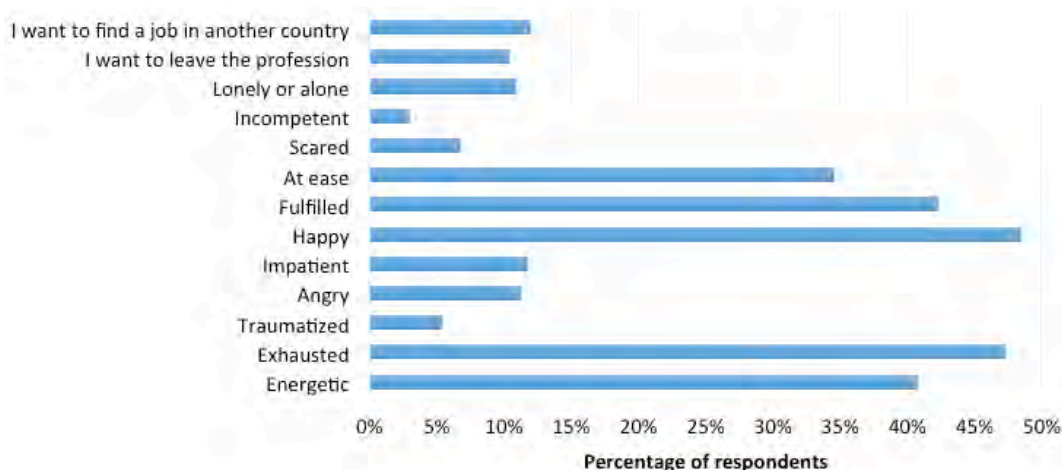


Questions 4 and 5: Conditions at work and how midwifery personnel feel at work

Just over half of midwifery personnel feel that they are treated with respect (58%), listened to by health professionals (77%) and are supported to do their jobs (61%). However, only between 41% and 48% of respondents said that they feel fulfilled, happy and energetic.

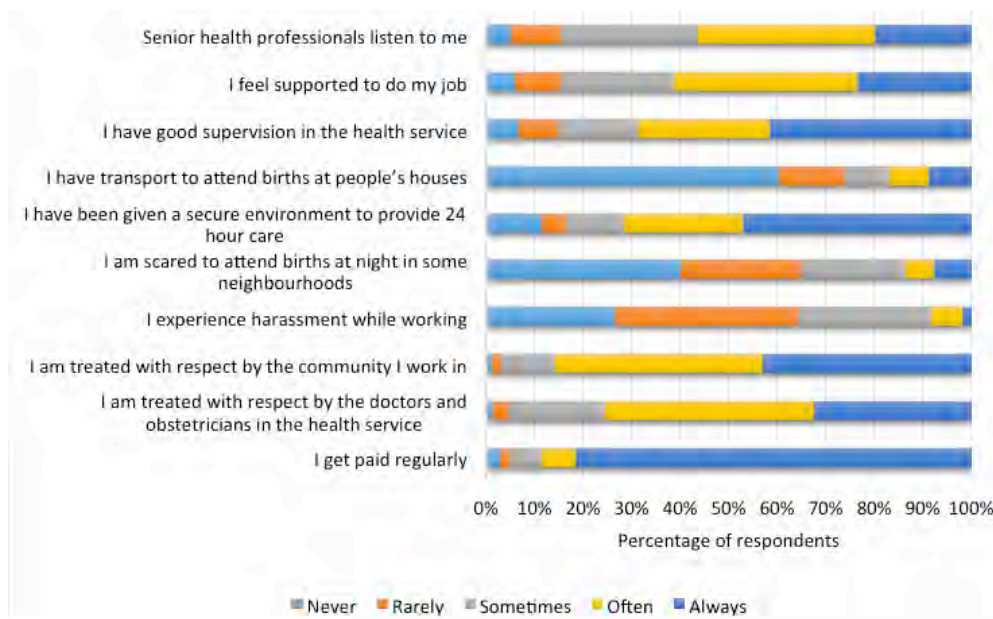
However Figures 7 and 8 also show that in some places of work midwifery personnel sometimes feel unsafe, unsupported, disrespected and unable to provide care in people’s homes. Some 37% of respondents experience harassment at work, while 15% are rarely or never supported at work and 15% rarely or never have good supervision. Consequently, a significant proportion (45%) of midwifery respondents are exhausted and around 10% feel traumatized, lonely, scared or angry. These negative feelings are likely to be the result of social, professional and economic pressures, which often intersect, and may run the risk of midwives developing burnout.

Figure 7. How midwifery personnel feel on a daily basis in their job



Most of the statements in Figure 8 are about the security, support and treatment that midwifery personnel receive while working and are therefore relevant to social barriers to providing quality of care. However qualitative information from the survey showed that the roots of some of these experiences are both social (low status of midwifery personnel, gender inequality and discrimination against women as leaders and decision-makers) and professional with links to inefficiencies in the health system (for instance lack of good management systems or supportive supervision, low investment in security or homebirth attendance, not enough midwifery personnel in general, and no place for midwifery personnel in the medical hierarchy).

Figure 8. Conditions at work



Note: Figures presented in this chart represent the percentage where the question was relevant. The number of respondents who said the question was irrelevant were excluded from the total figure.

Question 6: Why midwifery personnel think they are sometimes treated badly.

Data in Figure 9 show that midwifery personnel think health system issues are a significant reason for poor conditions at work. For example 68% of respondents said that there were not enough staff so that they are all overworked; 55% said that the health system is disorganized; 40% think managers are not doing their jobs properly and 43% attribute poor conditions to lack of equipment and supplies. However, social barriers appear to underpin some of the experiences of midwifery personnel with a quarter of respondents linking the poor treatment and conditions to gender inequality and discrimination against women; and 19% think that poor training adds to the low status of midwifery personnel. Interestingly, a higher percentage of African respondents have marked all of the above as social and professional barriers.

BOX 4: FURTHER EXAMPLES OF BARRIERS, EXTRA COMMENTS GIVEN TO QUESTION 6.

Ghana: "Supportive policies are absent or weak. Midwives are not consulted at policy level."

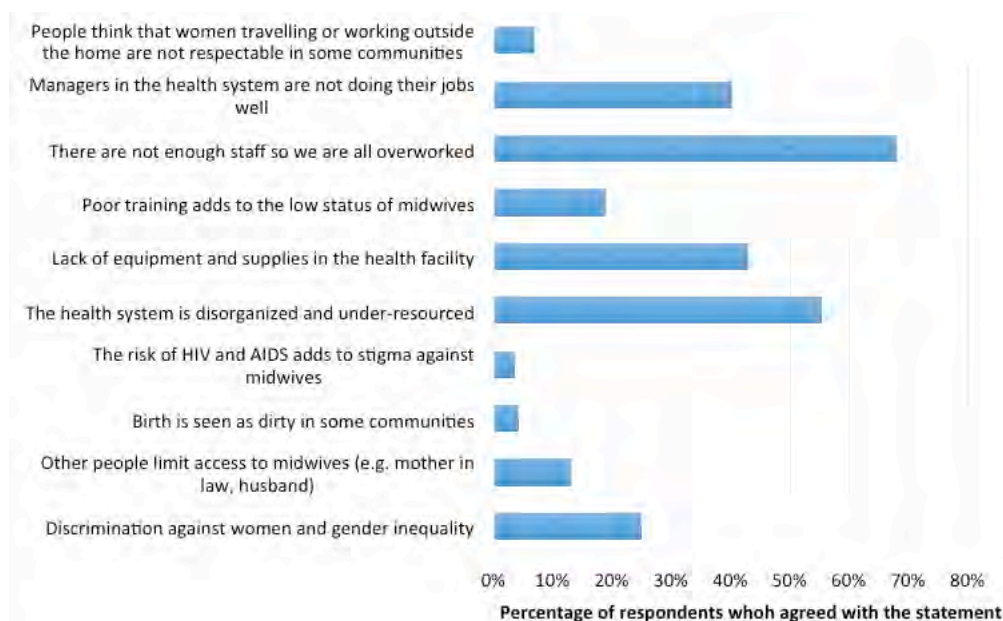
Liberia: "We have no influential person at policy-maker level who is eager for midwives rights and responsibility and benefits. We are not fully empowered because of lack of basic human needs."

Nigeria: "Poor remuneration for midwives and lack of career path as a midwife."

Rwanda: "The population does not know the role of midwives."

Uganda: "One of the problems is the high level of corruption that means money allocated to health services is not used as specified [at all levels] and in the past health workers have been poorly paid/delayed to be paid and even unpaid. The reputation in some hospitals is poor as they do not care for women who cannot afford to "pay". Also they are "known" to be rude to the ladies both verbally and physically... so women fear to deliver in hospital. There is often an absence of equipment or drugs as some have been directed to medical staff's private clinics/business as it means they get more income as people pay for the services rendered. Here medical care is seen as a business, people open a drug shop or clinic as income generation."

Figure 9. Why midwifery personnel think they are sometimes treated badly

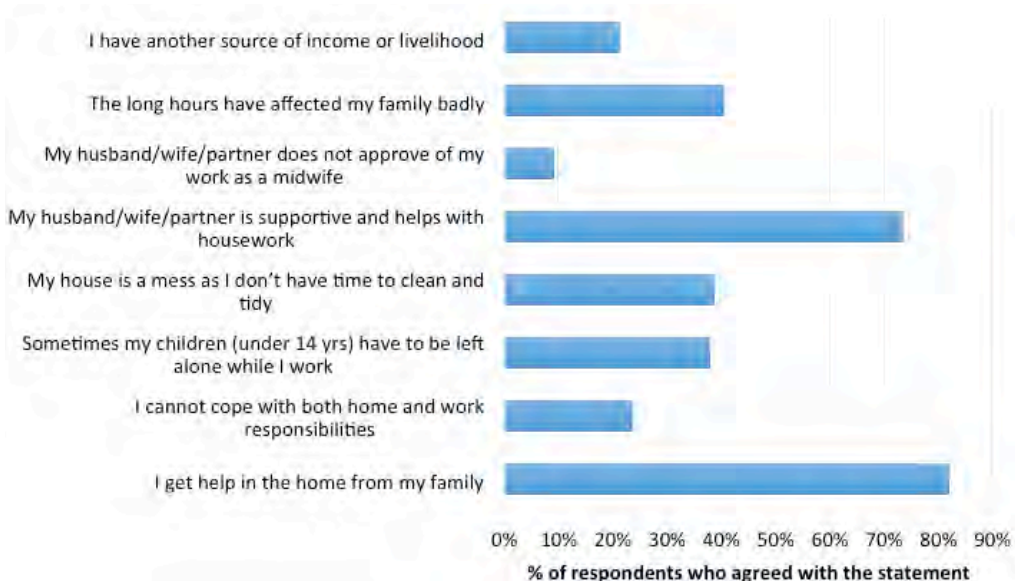


Question 7: Combining work as a midwife with family life

One of the significant social barriers for most midwifery personnel is the challenge of combining family, caring and reproductive responsibilities with working life. The long and stressful hours of work have badly affected 40% of respondents’ families in the survey. Nearly 40% of respondents feel that their house is a mess as they don’t have enough time to clean and tidy and likewise 38% are leaving children under 14 years alone while they work. Economic pressures mean that just over 20% of women have another source of income, which must add to the time pressure and exhaustion that they feel.

However, the affected midwifery personnel are not entirely on their own as 82% of respondents get some help from their families and around 74% are being supported and helped with housework by their husbands.

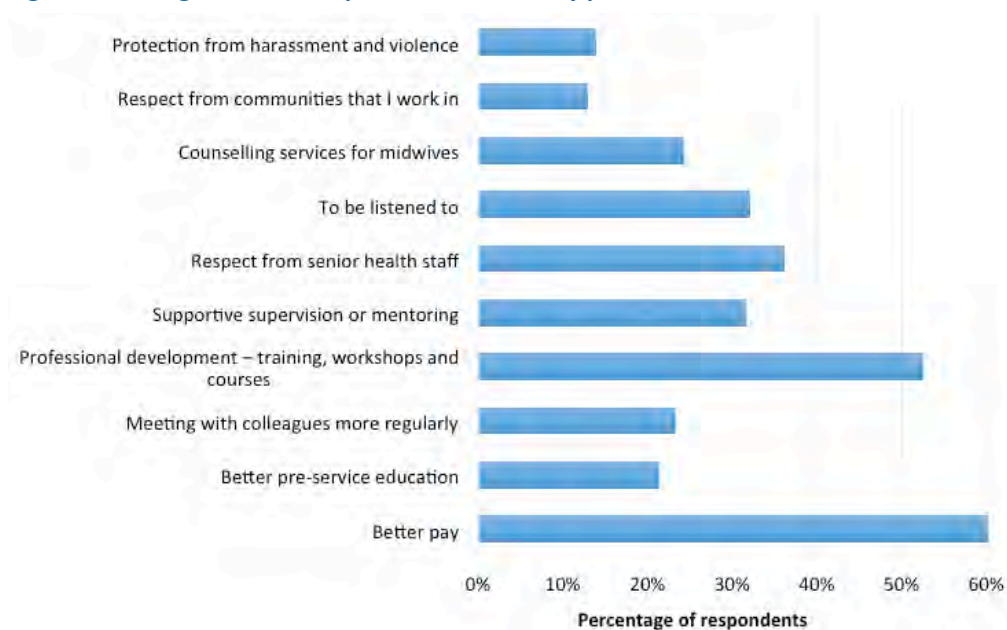
Figure 10. Combining family life with work as a midwife



Question 8: Changes that midwives would like to see

One of the most important changes that respondents would like to see is better pay (70%). However, professional development (53%) was also an important area and was particularly valued by the Spanish-speaking (67%) and African (71–86%) respondents. Some 36% of respondents wanted respect from senior health staff and 32% (53% of African respondents) would value supportive supervision and being listened to.

Figure 11. Changes that are important to midwifery personnel



BOX 5: FURTHER SUGGESTIONS FOR CHANGES, EXTRA COMMENTS GIVEN TO QUESTION 8

Ethiopia: “Further training in obstetrics so that midwives could be allowed to conduct caesarean sections especially in rural communities.”

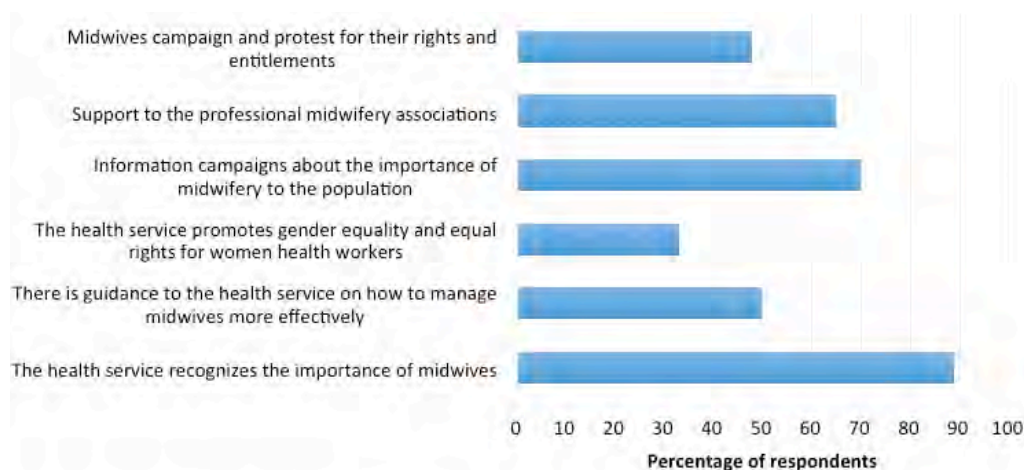
Kenya: “Create a forum for sharing experiences and getting more involved in research work.”

United Kingdom: “That midwives should be given as much respect for their expertise in pregnancy and normal birth as the obstetric doctors are given for their expertise in abnormality of pregnancy and birth. Midwives should be able to practice in a truly autonomous way. Micro-management does not make for good practitioners.”

Question 9: How to encourage changes

Power, agency and status – all related to the social area of the WHO analytical framework – are seen to be important for progress. A large majority of respondents think that changes can be encouraged by increasing midwifery personnel’s recognition and status, both within the health service and among the general public. Some 89% of respondents think that recognition of the importance of midwives by the health service is important for change to take place; 70% of respondents think there is a need for information campaigns to make sure the public knows the importance of midwifery personnel; and 65% (between 75–88% in African, Arabic- and Spanish-speaking countries) of respondents would like to see support for professional midwifery associations.

Figure 12. How changes can be encouraged



BOX 6: SUGGESTIONS FROM AFRICAN COUNTRIES FOR ENCOURAGING CHANGE, EXTRA COMMENTS GIVEN TO QUESTION 9

- A profession separate from nursing and regulations specifically for midwives.
- More jobs for midwives, to show how important they are in the society.
- More working personnel to be employed, especially in Zambia where graduates often wait for years before finding employment.
- In South Africa, midwives and nurses have one governing body, i.e. South African Nursing Council (SANC). “Midwives should have their own governing body, as essentially we are not nurses. We are midwives.”
- Encourage midwives as policy-makers. Educational planners and researchers need to have enough knowledge of the profession (midwife) and the scope of practice of midwives.

Question 10: Examples of good practice

Midwifery personnel were asked to give first-hand examples of initiatives that had stimulated positive change in their countries for their profession. The most often cited examples were:

- An increase in the availability and quality of training, mentoring and supervision for midwifery personnel, in particular the introduction across many countries of BEmONC (Basic Emergency Obstetric and Newborn Care) and ESMOE (Essential Steps in Managing Obstetric Emergencies). Midwifery personnel believe this has significantly contributed to the reduction in maternal and newborn deaths.
- Investment in resources including more personnel, cleaner, more hygienic and better equipped maternity units and access to free delivery packs.
- The formation and widespread recognition of midwives associations, specialist midwife-led units and the Midwives Service Scheme have all contributed hugely to improved communication between midwifery personnel, obstetric, gynaecological and nursing professions, and the wider public.
- The use of maternity support workers or less qualified staff to do some of the less specialist tasks thereby taking the burden from overworked midwifery personnel.
- Social and professional awareness and recognition for the work of midwifery personnel.

- Encouragement of homebirths and natural births within the health system, including listening to pregnant women’s choices and upholding rights, thereby enabling midwife-led care.
- Exchanges of learning, and roles, between midwifery personnel and nurses and other colleagues.

BOX 7: MORE EXAMPLES OF GOOD PRACTICE, EXTRA COMMENTS GIVEN TO QUESTION 10

Kenya: “In the county that I work in, trainings and professional development programmes have been organized by the health department through donor support. These trainings are on emergency obstetric care. Once midwives are armed with such practical knowledge, it becomes easy for them to apply this knowledge in their day-to-day work.”

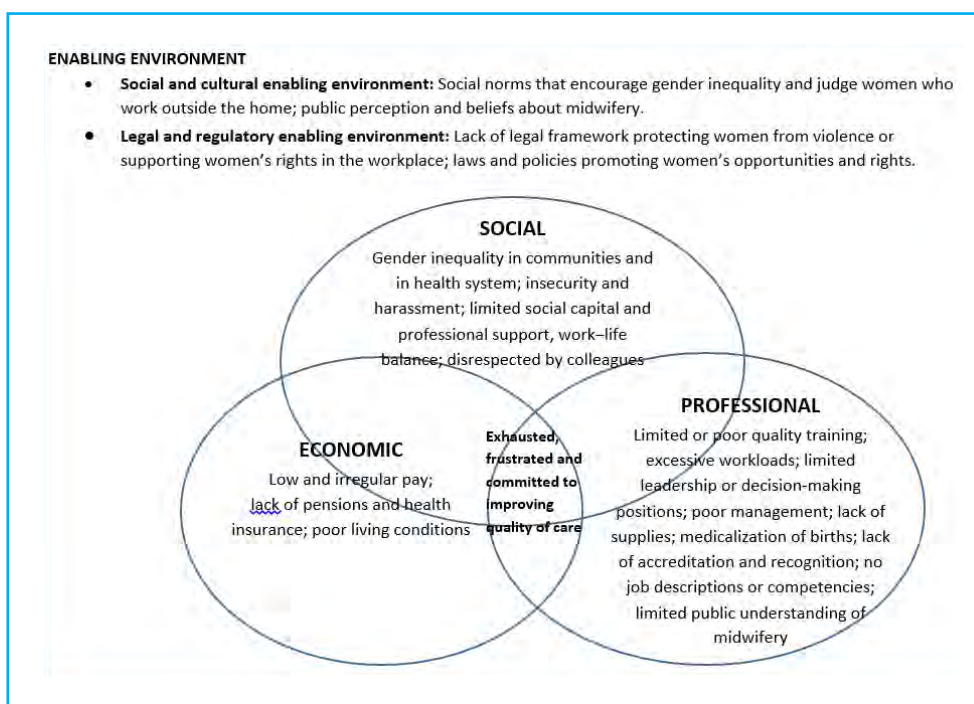
Peru: “Having midwife managers and supervisors who are part of the management team allows our issues to be more visible and enables the correct decisions to be made.”

Rwanda: “The continuous professional development for midwives is improved and it increases the knowledge and skills to better serve. The recognition of midwives in Rwanda from the Rwanda Association of Midwives [makes a difference] which goes together with their named profession as ‘Midwives’ not named ‘Nurses’.”

3.3 Summary of key findings

The analysis of the findings from both the workshop and the global online survey demonstrated that WHO’s analytical framework of the barriers facing midwives is useful and relevant. Participants expressed that the framework could be developed further by also considering the enabling environment, in other words the context in which the barriers are being experienced (Figure 13).

Figure 13. Key findings from consultation with midwifery personnel: barriers to quality of care



3.3.1 Barriers experienced by midwifery personnel

The workshop and online survey participants expressed concern about nine key issues that were described as contributing to the three barriers. These are represented in Figure 2.

SOCIAL BARRIERS

1. **Unequal power relations and gender inequality within the health system and within communities** can negatively impact the ability of midwifery personnel to provide quality of care. Inequality manifests itself in a number of ways, for example a midwife stated “midwifery personnel are not independent practitioners in Malta but are subservient to the medical profession”. Unequal power relations can also underpin professional and economic barriers:
 - When hierarchical power is wielded by other health professionals it can undermine the authority and decision-making ability of midwifery personnel.
 - In general, midwifery personnel lack safety and security while doing their jobs – they either experience sexual harassment and violence from work colleagues or from within the communities they serve.
 - Limited senior midwifery positions in the health system constrain decision-making power and capability. This is compounded by limited opportunities for midwifery personnel to develop leadership capabilities.²¹ This means that midwifery personnel may be unable to challenge the status quo and take up leadership roles should they exist.
 - As most midwives are women, many experience social restrictions or lack of support from their family even though they carry out productive, reproductive, caring and household responsibilities.
2. **Lack of security, fear of violence and harassment and social isolation**
 - Midwifery personnel often experience poor living conditions and social isolation.
 - Harassment at work was experienced by 37% of all the midwifery personnel who took part in the survey.
 - Midwifery personnel lack secure conditions or transport to attend births at night.
3. **Limitations in social capital, solidarity and organizational power**
 - Many midwifery associations lack the power and resources to provide support to the profession and to support individual midwifery personnel.
 - Many midwifery personnel lack personal and community networks for support.

PROFESSIONAL BARRIERS

4. **Lack of adequate pre- and in-service midwifery education and professional development.** This impacts negatively on preparation for the midwifery role and the building of personal autonomy, resulting in low levels of skill and confidence.
5. **Midwifery personnel often suffer from poor overall human resource policies and management**
 - Poor management (up to 30% of survey respondents working in Africa stated they did not feel supported in their jobs).
 - Insufficient midwifery personnel and support staff leading to excessive workloads and exhaustion.

²¹ Though in the Latin America region the Fairtrade Labelling Organization (FLO) has a programme to develop leadership skills among young midwifery personnel.

6. **Health system issues that add to stress and limit the ability of midwifery personnel to provide good quality care**
 - Lack of clarity on norms and standards for midwifery personnel, for example job descriptions and protocols for roles and responsibilities.
 - Lack of access to supplies.
 - Private sector markets and medical hierarchy leading to medicalized births, which constrains opportunities for quality midwifery care.
7. **Lack of accreditation and regulation: unclear status, definition and role for midwifery personnel²²**
 - There can be weak professional identity due to lack of strong professional associations or weak regulations around midwifery roles. This is compounded by the increasing medicalization of birth, which limits the autonomy of midwifery personnel.
 - Often there are no regulations or public policy that support the work of midwifery personnel.
 - Sometimes midwifery personnel are not given a job description and there is no documentation of the midwifery competencies that are expected from the role. This can also mean that midwifery personnel are not aware of their employment rights.
 - These factors contribute to a lack of public awareness of the importance of midwifery personnel.

ECONOMIC BARRIERS

8. **Low salaries that are not comparable with other similar professions and sometimes not enough to live on**
 - Midwifery personnel in low-income countries are less likely to receive their salaries regularly.
 - This has led to some midwifery personnel holding a second job to make ends meet.
 - Poor living conditions and lack of financial support compound the stress of the other barriers.

ENABLING ENVIRONMENT

9. **Social norms and legal and regulatory environment that encourage gender inequality and low public opinion of midwifery**
 - Some communities may think negatively of women working as midwives and travelling to do their jobs at night; they may also lack an understanding of the midwifery role.

3.3.2 What needs to change

(i) Participants proposed the following:

Social sphere:

- midwifery personnel would like better social support networks, peer support, networking and sharing experiences;
- good quality living environment;
- to improve the image and status of midwives with the public through wide-scale awareness raising (e.g. regional midwifery day);

²² The state of the world's midwifery reports (2013, 2014). New York: UNFPA, highlight the multiple definitions and roles that midwifery personnel fulfil in different countries.

- research into the socioeconomic factors affecting the rights of midwifery personnel;
- inclusion of rights, gender, ethics and equality in pre-service training and across the health system;
- counselling services for midwifery personnel.

Economic sphere:

- better pay, health insurance and social security systems for midwifery personnel.

Professional sphere:

- improved professional development, workshops and courses, access to higher education;
- where not yet in place, education of midwives by experienced midwifery educators (rather than through a medical model by doctors only);
- midwifery personnel would like better professional support – strengthened and well-resourced midwifery associations, peer support, networking and sharing experiences;
- improved pre-service education (e.g. standardization of midwifery curriculum across regions);
- supportive supervision and mentoring at work;
- respect from senior staff;
- increasing professional autonomy and self-regulation of midwifery personnel.

Health systems:

- create and improve opportunities for positions of influence and power for midwifery personnel within the health system;
- create opportunities for senior midwifery leaders within government institutions, for example a department of midwifery in ministries of health.

Legal and regulatory enabling environment:

- increase the voices of midwifery personnel in decision-making and policy development (e.g. inclusion of women and midwifery personnel as well as obstetricians, in the committees working on policy and law);
- improve laws and protocols around midwifery;
- WHO should issue a “call” to governments to increase recognition for midwifery personnel and promote training and better contracts.

(ii) Examples of improvements already in place:

Midwifery personnel taking part in this consultation were asked to provide examples of where their conditions had been improved. The top six most quoted areas were:

- an increase in the number of midwifery personnel;
- training and professional development – one referred to mandatory training, one mentioned clinical coaches for support and education;
- specialist midwife-led units or midwife group practice (for instance with shared call-out);
- the use of maternity support workers or less qualified staff to do some of the less specialist tasks thereby taking the burden from overworked midwifery personnel;
- equal pay campaigns and increase in pay;
- better supervision and management.

Cataluña, Spain: Service users' opinions of and respect for midwives was improved after a protocol was developed to encourage and define normal hospital births, without unnecessary intervention and attended by a midwife.

United Republic of Tanzania: The strengthening of supportive supervision, coaching and mentoring has improved the quality of midwifery services. **Increased advocacy activities** in the country against high maternal and perinatal deaths has increased recognition of midwives as an important cadre.

Yemen: The establishment of the National Midwifery Association has resulted in better training, midwifery personnel feeling supported and represented, and there has been an increase in home visits and homebirths attended by midwifery personnel.

4. Discussion

This section discusses the findings from the workshop and global online survey and is organized in line with the three categories of barriers identified in the WHO analytical framework: social, economic and professional. However, as shown in Figure 1 there is some overlap between the barriers. For example, when discussing midwifery personnel's lack of power within the health system and lack of voice in policy forums, these are social (because of gender inequality and lack of empowerment) *and* professional concerns (because of the issues around poor management and support within the health service). The initiatives for tackling these barriers would, therefore, need to address both the social and professional barriers.

4.1 Social barriers

Gender Inequality: The ways in which gender inequality affects the midwifery profession are increasingly being documented.²³ Although “midwifery personnel are the front and centre health professionals” (ICM Triennial Congress participant) midwifery personnel feel that they have been excluded from participation in the policy arena and development of services. They report that their ability to provide quality care is seriously compromised by the lack of voice and senior positions given to midwifery within the health system and within the broader political agenda. Many attribute this to underlying gender inequalities. Because midwifery is a female-dominated profession, it is the profession as a whole that experiences gender inequities as well as the individual. This means that male midwives are also likely to be affected by these issues.

A number of midwifery personnel consulted during the ICM Triennial Congress workshop felt that the status they are given is not as high as that experienced by other members of the health professions. **Lack of status and subordination by the medical profession** was a frequently quoted issue. This was linked with low recognition of the qualifications and status of midwifery personnel, as well as a lack of autonomy – or an autonomy that is threatened within the health system. For example, midwifery personnel being harassed at work is indicative of gender inequalities, because of women's lack of power within the system. A significant proportion of respondents, particularly in Africa, say that disrespect in the workplace extends to **harassment** – verbal bullying and, at times, physical and sexual abuse. This affects their feelings of self-worth and their ability to provide quality care.

Some midwifery personnel said that appropriate regulatory structures and systems, when properly implemented, are important in order to adequately recognize midwifery skills and to address gender inequality and harassment in the workplace. Moreover, they feel that without wider efforts to work for gender equality and social change, these measures are not enough to ensure that midwifery personnel will be free from workplace harassment and able to find the respect they deserve. Recent research by Cardiff University emphasizes how important a strong sense of professional identity and effective informal and formal support systems are for creating midwives' resilience in the workplace.²⁴

²³ Filby A, McConville F, Portela A (2016) What Prevents Quality Midwifery Care? A Systematic Mapping of Barriers in Low and Middle Income Countries from the Provider Perspective. PLoS ONE 11(5): e0153391. doi:10.1371/journal.pone.0153391.

²⁴ Hunter B, Warren L. Midwives' experiences of workplace resilience. *Midwifery*. 2014 Aug;30(8):926–34. doi: 10.1016/j.midw.2014.03.010.

Across the board, midwifery personnel referred to **lack of voice and lack of space in the political agenda and exclusion from decision-making fora**. In spite of the fact that midwifery personnel say that their professional associations are strong in some countries, these professional bodies have so far been unable to move midwifery high enough up the political agenda for midwifery personnel to feel adequately supported in their work and appropriately compensated for it. These barriers are attributed by some midwifery personnel to institutionalized gender inequity which permeates all sectors, levels and aspect of their societies.

Not always feeling respected: Midwifery personnel from some countries do not feel respected by the community. This feeling is particularly strong in countries where only certain types of work are thought suitable for women. In Yemen, for example, midwifery personnel said that they are not respected because they work at night, and are subject to sexual harassment in homes, hospitals and communities: “Men taunt us, and invite us to come and teach them to put on a condom – we have to go through the community without looking at them; we want to be able to hold our heads up high.” During the workshop, midwifery personnel said that this disrespect stems, in part, from public misunderstanding of the role of midwifery.

Issues of safety and security: The majority of midwifery personnel from higher-income countries said they feel relatively safe and secure when carrying out their work both during the day and at night. However, midwifery personnel from some countries – especially Afghanistan, Yemen and a number of African countries – noted that they are not always safe at night. In many countries women need to be accompanied by a chaperone when out after dark.

Inability to find work–life balance: Whether or not midwifery personnel are able to gain support from their families, so that they can balance their work and home lives better, depends very much on where they come from and the wider social expectations on women. For example, women from the West Bank and Gaza Strip and Yemen said that they can expect little or no help in the home from their husbands, and are responsible for running all aspects of the household and child-rearing, as well as bringing in a salary. Some midwifery personnel said that they are entirely dependent on their extended family to provide childcare. Midwifery personnel from the West Bank and Gaza Strip have a crèche system for children during the day – but no night nursery. In many other countries, no childcare is available within the health system. During the workshop, a number of midwifery personnel said that night work and exhaustion mean that they are not able to have a social life. They also feel that their children suffer because of the heavy workloads that often force midwives to leave young children at home alone; or they are too tired to give children proper attention.

BOX 8: COMMENTS ON THE LACK OF POWER MIDWIFERY PERSONNEL HAVE WITHIN THE SYSTEM

European country: Obstetricians are sometimes disrespectful and don't value our work.

Greece: Obstetricians have taken over childbirth and midwifery personnel work mostly as their obstetric nurses, following orders and discouraged to voice their opinion.

Malta: Midwifery personnel are not independent practitioners in Malta but are subservient to the medical profession.

Turkey: The public see midwifery personnel as caregivers or nurses' aides and midwifery laws are incomplete and inconsistent. There is a medical domination of the maternity care system.

4.2 Economic barriers

Salary levels and regular pay: The majority of midwifery personnel from middle- and higher-income countries reported that pay is received regularly. This is not always the case in lower-income countries. Across the respondent countries, midwifery personnel feel that their pay is not in line with the heaviness of their workloads or the seriousness of their responsibilities. Some midwifery personnel spoke of the need to find a second job to bring in enough money to feed their families.

Pensions and insurance: During the workshop, midwifery personnel from the West Bank and Gaza Strip and Yemen discussed the issue of inequity in pension schemes and the lack of health insurance. Midwifery personnel from the West Bank and Gaza Strip pointed out that they have to work 30 years before they can get a pension, whereas staff in the education sector only have to work 25 years.

Inadequate resourcing of midwifery: Midwifery personnel feel that because midwifery does not come high on the political agenda, and because the doctors and other medical staff may feel threatened by midwifery, there is inadequate resourcing of midwifery services. The vital role of midwifery is not recognized and funding is not sufficient.

Inadequate housing and isolation: Midwifery personnel from some lower-income countries reported that they may be posted to isolated areas where they are unable to afford adequate and safe housing, and from where they are unable to afford transport home to see their families. This economic pressure leads to increased feelings of isolation and lack of support – especially if midwifery personnel feel there is a cultural, or linguistic, gap between themselves and the communities in which they work.

4.3 Professional barriers, including health systems issues

Structures, systems and mechanisms: Midwifery personnel from many countries pointed to the lack of, or weakness in, structures, systems and mechanisms including professional associations and regulatory bodies, within national health systems, which can adequately and effectively support midwifery as a profession, and midwifery personnel as workers. This was true for midwifery personnel from the higher-income countries as well as from lower-income countries, Yemen for example. Midwifery personnel from Yemen said that there is no system to speak of, and that the system developed over the last decades has collapsed in recent years.

Lack of resources within the health system: Lack of equipment and supplies and insufficient personnel were the most important reasons for poor conditions at work cited by African midwives. These issues affected a large number of participants. Several African midwives stated that there had been no improvements in the health system, however others cited increased investment in midwifery and better recognition due to new policies and regulations.

Increasing medicalization of birth: Midwifery personnel said that the increasing medicalization of birth increases the likelihood of devaluation of the midwifery profession. Some said that doctors – particularly obstetricians and gynaecologists – may feel threatened by midwifery personnel and midwifery and may discourage women from a midwifery-led birth. This reflects recent Latin American research presented at the ICM Congress in 2014 (see Annex 5).

Lack of opportunities for leadership and power: Despite the very varied health systems that respondents came from, lack of opportunities for midwifery personnel to build and develop leadership within the hierarchy of the health system was a common theme. Many felt this as disempowerment. For example, participants from the USA said that midwifery is subsumed within the nursing profession.

Lack of training opportunities and continuous professional development: Many midwifery personnel feel unsupported in their continuing careers, with little opportunity for development. Some, from lower-income countries, indicated that training opportunities would usually go to doctors with midwives being overlooked when training is on offer.

Increasingly heavy workloads and exhaustion: Midwifery personnel from across the range of participating countries commented that workloads are increasing and they are often exhausted. They say that the increasing pressure (often with scarce resources and equipment) to carry an ever greater case-load, means that their ability to give quality care is seriously compromised.

Satisfaction at work: In spite of all the key issues outlined above, the majority of midwifery personnel report feeling happy, fulfilled, energetic and at ease in their work at the same time as feeling exhausted. This may point to the high level of commitment and strong sense of purpose that the profession demands.

5. Conclusions

The findings from the largest global online survey of midwives to date – the voices of over 2470 midwives in 93 countries – describe that midwives are deeply committed to providing the best quality of care for women, newborns and their families. But they are also deeply frustrated by the realities they experience that constrain their efforts, and the lack of voice they have in creating change.

The constraints described align well with the analytical framework arising from the WHO systematic mapping of social, professional and economic barriers, with the addition of weak social and cultural enabling environments and limited legal and regulatory support.

A critical and recurrent issue voiced through this exercise is that, because most midwives are women, what they experience is embedded in the context of gender inequality. Importantly, this finding is universal. It does not matter if you are a midwife in a high-, middle- or low-income country, the experience is similar, yet reflects local context.

From the perspective of social barriers, many midwives described being disrespected at work and by the communities they support, being physically unsafe and sexually harassed at work, living in inadequate accommodation, and with difficulties in managing their triple roles of paid employment (productive), domestic and reproductive responsibilities (being mothers themselves), as well as supporting the community. Economically, the midwives described a relationship between the low social status of childbirth and the low salaries and pensions offered. Professionally, the participants expressed concern about a lack of understanding of what “midwifery” is, the devaluing of the midwifery profession combined with the increasing medicalization of birth, and the underlying weakness in midwifery education and regulation.

All midwives voiced constructive and feasible solutions to overcome the barriers identified. For many, this was the first time they were given an opportunity to express these views. Yet their solutions are not yet being heard. The reasons given for the lack of voice were described in the context of hierarchies within health systems, which they described as preventing opportunities for the midwifery profession to engage in leadership. The reality expressed is that exclusion denies the profession the positions of power and influence required to affect the change needed to improve quality of care.

The midwives who so generously contributed their time to this process are women who provide care to, and receive care from, other midwives. They describe their realities of how it feels to be a midwife, a woman and often a mother. The world is now in a new era of the Sustainable Development Goals (SDGs), with a Global Strategy for Women’s, Children’s and Adolescents Health (2015–2030) based upon the principles of community-ownership, gender responsiveness and equity-driven community engagement. This report indicates that – if the voices of midwives are listened to, and if midwives are enabled to overcome gender inequalities and assume positions of leadership – quality of care can be improved for women and newborns globally.

ANNEX 1

Midwives' voices, Midwives' realities – workshop guide for facilitator

Plenary introduction (5 mins)

- Aims and structure of the workshop
- Presentation of main findings from the literature review
- Split into language groups (Spanish, English and Arabic)

1. Introduction (2 mins)

We will be talking about:

- The economic situation that you as midwifery personnel face in work and in your personal lives.
- Your professional situation including opportunities for education, training and professional development.
- The social and personal context in which you as midwifery personnel are working, including gender and cultural norms in the health sector, communities and families.

2. Identifying issues and problems (20 mins)

Identify issues or problems that affect you and other midwifery personnel in your country. Work in groups of three (or if the whole group is small – five or less – work together). Each small group should discuss and write these issues/problems down on “post-it” notes with the relevant country specified. As these points are written down, someone from the group should come up to the flipchart and place the “post-it” into the appropriate circle (either the social, economic or professional area).

The facilitator should summarize the problems in the social and economic areas – say we will also be recording the problems in the professional area but will concentrate on the other two for now.

3. Spokes Tool activity – work as a whole group (40 mins)

“For you to feel safe, secure and satisfied in your working life what needs to change to address these problems/issues? Particularly in the social and economic areas.”

We discuss this openly for about 10–15 minutes. Then say we need to write these down – keep referring to what we have and what else is needed. We will probably get between eight and 12 suggested changes (solutions) written down on the coloured circular cards.

The cards are placed in a circle on the flipchart paper on the floor– equidistant from a central point. Lines are drawn from the central point to each of the cards – like the spokes of a wheel.

The centre is you (the midwife). Let's look at where you are now in getting to each of the solutions or changes that you want to see happen. Each point is discussed and a sweet is placed along the spoke for that change/solution to indicate how far we have got in achieving this change. The closer the sweet is to the card – the nearer we are to achieving the change.

There should be consensus about where the sweets sit for each change/solution. Make sure that disagreement is recorded by the facilitator in case there is no consensus.

When it is all decided move back into the group and ask everyone to reflect on what they have done and agreed. Are there any inconsistencies or contradictions? The note taker should draw the spokes following the position of the sweets. Then ask which are the three most important priorities – give each participant three sweets and ask them to vote – one sweet on one solution/change – or two on one and one on another – or all three on one change. Record the results and, if there is time, discuss.

ANNEX 2

Workshop brainstorming of issues – results

English-speaking midwifery personnel:

Professional barriers

- Empowered (female) midwifery personnel seen as a threat to male medical colleagues: power relations gender and politics.
- Haiti: Non-regulated shortage of trained midwifery personnel.
- The USA: Frivolous complaints from physicians against midwifery personnel – professional disrespect. Lack of full practice authority – law makes us reluctant to offend or go against organized medicine.
- Impossible workloads and exhaustion.
- Very young midwifery personnel.
- The USA: rigid hierarchical model.
- Afghanistan: Little to no professional continuing development opportunities for rural midwives.
- Uganda: Lack of control over supplies.
- Excessive workload and exhaustion.
- Haiti: easier for the government to support NGOs rather than professional midwifery personnel.
- Autonomy: self-regulated profession. Non-hierarchical. Collaboration. Still encounter problems even if are self-regulated.
- Stronger midwifery associations are needed.
- Medical staff to be trained by midwifery personnel.
- Valuing midwifery knowledge more.
- Political agenda – midwifery.
- Midwifery personnel to teach midwifery personnel.
- More midwifery personnel and hired on qualification.
- Access to higher education.
- Regular professional wage and working conditions are needed.
- Midwifery should have the chance to input into decision-making and policy at all levels.

Social barriers

- Women choosing doctors for care (technology).
- Australia: Language barriers.
- Afghanistan: Security risks related to female gender --> midwife being a professional.
- Afghanistan: Female midwife must be accompanied by a male to travel which inhibits autonomy.
- Sierra Leone: Depression, being posted to insecure place, poor living environment, away from family. Isolated.
- Living environment that is suitable (housing, family).

Economic barriers

- The United Kingdom and the USA: Economic pressure to see more women/period of time. Violates value of spending time with women.
- Afghanistan: Low salary for midwifery personnel (cannot afford housing and school for children).

Spanish-speaking midwifery personnel:

Professional barriers and enabling environment

- Lack of professional identity as midwifery personnel (obstetras) – Paraguay.
- Lack of definitions of the role of midwifery personnel/midwifery (la obstetriz) – Ecuador and Paraguay.
- Gaps in midwife recruitment which is limiting women's access to services – Uruguay.
- Lack of legal workplace protection – Ecuador and Paraguay.
- Regulations around competencies is inadequate; there is low management capacity. Midwifery personnel lack knowledge of their rights with respect to the law and regulations; limitations in the law – Argentina, Peru and Uruguay.
- Weak regulations; lack of up to date organizational norms and jobs for midwifery personnel – Paraguay.
- No deployment/contracting of midwifery personnel in the health system in Ecuador.
- Despite being one of the oldest professions, we are ignored in favour of other professions – Uruguay.
- Low access to decision-making posts/management positions – Uruguay.
- Overload of work in the public sector – Ecuador and Paraguay.
- Hierarchical and medicalized health system – Chile.
- No recognition of the midwife's role in Ecuador.
- Sexual harassment and attack – Chile.
- Gender inequality in academic study – Chile.
- Professional violence when accessing employment – Paraguay.
- Doctor-centred care – Chile.
- Inadequate work conditions – Chile.
- Limited training opportunities – Chile.
- Lack of public policies that prioritize the role of midwifery personnel and the contracting of midwifery personnel – Ecuador and Paraguay.
- Lack of legal back-up – Paraguay.
- Advocacy – Paraguay and Uruguay.

Social barriers

- Social invisibility of the profession in the health private sector – Argentina and Chile.
- Discrimination between women who are married/not married, with children/without children – Chile.
- Lack of leadership capabilities – Ecuador and Paraguay.
- Many midwifery personnel are head of families (divorced mostly) – Ecuador.
- Discrimination against men becoming midwifery personnel – Chile.
- Service users are violent to health providers; insecurity when visiting communities. Low social recognition of the midwife profession – Argentina, Peru and Uruguay.

- Lack of recognition of our skills and competencies in society – Paraguay and Uruguay.
- Lack of dissemination or communication about the midwifery personnel role in the community – Ecuador and Paraguay.
- Gender inequality in accessing work – Chile.

Economic barriers

- Low status – machista model applied to female professionals – Uruguay.
- Lack of economic recognition of midwife lecturers and professors – Argentina and Chile.
- Salary gaps – Chile.
- Lack of regulations in midwifery education – Chile.
- Lack of economic investment to contract midwifery personnel in the public sector and in the private sector – Ecuador and Paraguay.
- Low remuneration – Argentina, Ecuador, Paraguay and Uruguay.
- Income is insufficient for the work undertaken and in relation to other professions (doctors) – Argentina, Chile and Paraguay.
- High taxes; low benefits; multiple employments – Argentina, Uruguay.
- There is no legitimacy of the professional role in relation to the remuneration – Uruguay.

Arabic-speaking midwifery personnel

Professional barriers

- To be able to get a retirement pension, you have to work a long time: 30 years in the West Bank and Gaza Strip and 25 years in Yemen.
- In the West Bank and Gaza Strip, the 2003 law on pensions leads to confusions over spouses' rights.
- Medical teams look down on midwifery personnel in the West Bank and Gaza Strip, and Yemen.
- In the West Bank and Gaza Strip and Yemen there is a lack of continuing professional development. Yemeni midwifery personnel have to go outside Yemen for any specialist training.
- In both the West Bank and Gaza Strip and Yemen, you cannot get higher degrees.
- Incentives are lacking in both the West Bank and Gaza Strip and Yemen. For example, it is always doctors who get sent abroad for further training.
- In both the West Bank and Gaza Strip and Yemen, there is no proper system. The system is corrupt and destroyed by conflict and the fragility of the state. If a system exists, it is not unitary: in the West Bank and Gaza Strip, for example, there is no consistency between the ministries, so the education ministry gives 90 days maternity leave, and the health ministry only 70.
- In Yemen, there is no health insurance. In the West Bank and Gaza Strip there is government-regulated insurance, but you still have to pay.
- In Yemen, there are no crèches in hospitals and this affects our availability for work. In the West Bank and Gaza Strip, there may be a crèche in the hospital, but there are no night nurseries.
- There are no proper rules or regulations (the West Bank and Gaza Strip and Yemen).
- In Yemen, men are disrespectful when we are working: they do things like ask us to show them how to put on a condom.
- We are not respected as decision-makers (the West Bank and Gaza Strip and Yemen).

- In both the West Bank and Gaza Strip and Yemen, the general public AND the medical professionals are ignorant of what midwifery personnel roles are.
- Midwifery personnel are not involved at decision-making levels in either the West Bank and Gaza Strip or Yemen.
- In the West Bank and Gaza Strip and Yemen, midwifery personnel do not really know their rights, duties or job descriptions.
- In the West Bank and Gaza Strip and Yemen, the pressure of work is high, with long hours and too many clients, yet our status is low.

Social barriers

- In Yemen, we have really low status because we do night work and it is not considered “proper” for women to be out after dark (this is not the case in the West Bank and Gaza Strip).
- In Yemen, our parents do not support us in our work – but they are grateful for the income it brings.
- In Yemen, our husbands don’t give us any help in the home. In the West Bank and Gaza Strip they might, but generally they make things difficult.
- In Yemen, the extended family, especially in-laws, cause all sorts of problems and object to us working.
- In Yemen, midwifery is not high status.
- In both the West Bank and Gaza Strip and Yemen, our social life suffers because we do shiftwork.
- Not having night-duty nurseries means our children suffer too.
- In the West Bank and Gaza Strip and Yemen, our work affects our home life and our children too.
- In both the West Bank and Gaza Strip and Yemen, there is no justice because we are oppressed by men.

Economic barriers

- “It’s obvious”: in both the West Bank and Gaza Strip and Yemen salaries are low and we don’t get them regularly.
- In Yemen it is hard nowadays to have enough money to eat.
- In the West Bank and Gaza Strip, midwifery personnel sometimes look for other work to bring enough money in.

ANNEX 3

Online survey questionnaire

1. Which country do you currently work in?
2. What is your job title and the setting in which you work?
3. How old are you?
4. Score following statements in terms of how often they affect you in your life as a midwife. (Never, rarely, sometimes, often, always, not relevant):
 - I get paid regularly
 - I am treated with respect by the doctors and obstetricians in the health service
 - I am treated with respect by the community I work in
 - I experience harassment while working
 - I am scared to attend births at night in some neighbourhoods
 - I have been given a secure environment to provide 24 hour care
 - I have transport to attend births at people's houses
 - I have good supervision in the health service
 - I feel supported to do my job
 - Senior health professionals listen to me
5. How would you say you feel on a daily basis in your job (tick three): Exhausted, Traumatized, Angry, Impatient, Happy, Fulfilled, At ease, Scared, Incompetent, Lonely or alone, I want to leave the profession, I want to find a job in another country.
6. Previous research has shown that midwives are sometimes treated badly or experience poor conditions at work. Why do you think this happens? Please draw on your own experience (if relevant) and that of colleagues in your country. Tick the three that are most important to you:
 - Discrimination against women and gender inequality
 - Other people limit access to midwives (e.g. mother in law, husband)
 - Birth is seen as dirty in some communities
 - The risk of HIV and AIDS adds to stigma against midwives
 - The health system is disorganized and under-resourced
 - Lack of equipment and supplies in the health facility
 - Poor training adds to the low status of midwives
 - There are not enough staff so we are all overworked
 - Managers in the health system are not doing their jobs well
 - People think that women travelling or working outside the home are not respectable in some communities
 - Other

7. How easy is it to combine your family life with your work as a midwife? Please mark whether you agree or disagree with each statement below:
- I get help in the home from my family
 - I cannot cope with both home and work responsibilities
 - Sometimes my children (under 14 yrs) have to be left alone while I work
 - My house is a mess as I don't have time to clean and tidy
 - My husband/wife/partner is supportive and helps with housework
 - My husband/wife/partner does not approve of my work as a midwife
 - The long hours have affected my family badly
 - I have another source of income or livelihood
8. If you had the chance to make changes to your experience of being a midwife, which changes would be most important to you? Tick the three most important:
- Better pay
 - Better preservice education
 - Meeting with colleagues more regularly
 - Professional development – training, workshops and courses
 - Supportive supervision or mentoring
 - Respect from senior health staff
 - To be listened to
 - Counselling services for midwives
 - Respect from communities that I work in
 - Protection from harassment and violence
 - Other
9. How do you think these changes could be encouraged? Tick as many as you like:
- The health service recognizes the importance of midwives
 - There is guidance to the health service on how to manage midwives more effectively
 - The health service promotes gender equality and equal rights for women health workers
 - Information campaigns about the importance of midwifery to the population
 - Support to the professional midwifery associations
 - Midwives campaign and protest for their rights and entitlements
 - Other
10. Please tell us of any improvements that are being made in your country, or your part of the health service, and how these improvements have helped midwives to do their jobs better.
11. Optional: If you would like us to keep in touch with you about this research, please provide your name and email address.

ANNEX 4

Online survey responses

The survey was carried out in two rounds: Stage 1 was targeted globally in four languages (English, French, Spanish and Arabic); then it was re-issued (Stage 2) specifically to African midwifery personnel in English and French making six language surveys in total. This was because there had been a low response from the continent in the first round.

Results for the six surveys are reported separately in the following material. Not all respondents answered the question about where they were currently working. In addition, there is some overlap between the countries in the Stage 1 and Stage 2 surveys. This has been taken into account when calculating the overall number of respondents and countries represented.

Question 1: Which country do you currently work in?

There were 762 responses from the United Kingdom (England, Wales, Scotland and Northern Ireland) and these figures have been excluded from the following pie charts for Question 1, in order to adequately illustrate the spread of respondents across countries. The rest of the English-language survey results include United Kingdom figures.

Chart A1: Stage 1 English Language survey – Europe responses (total 279) (excluding United Kingdom)

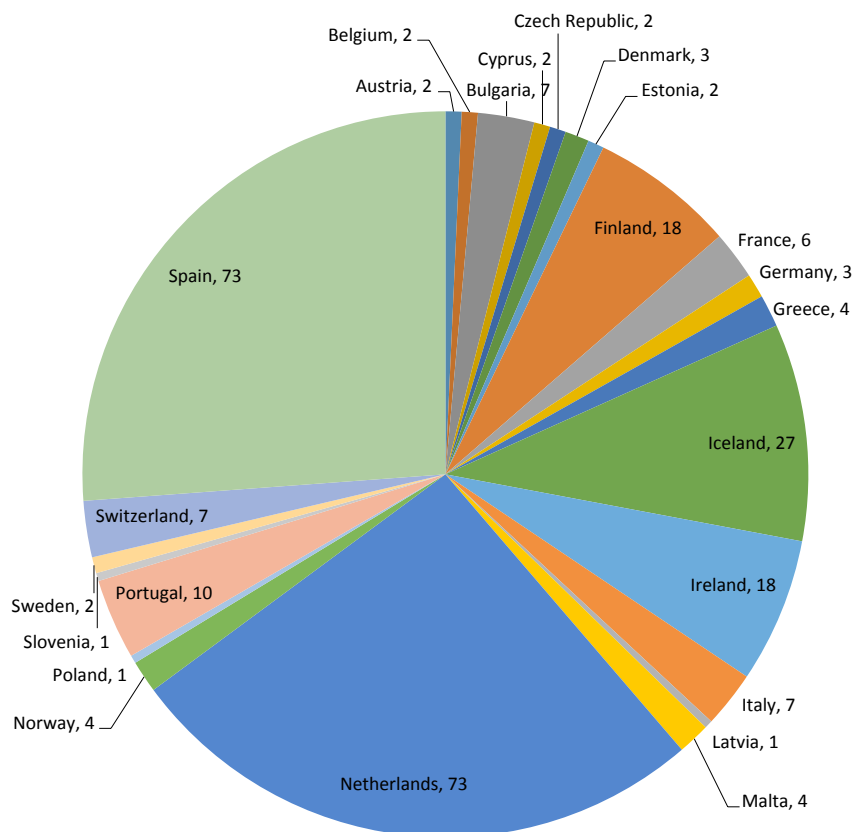


Chart A2: Stage 1 English Language Survey – Americas responses (total 154)

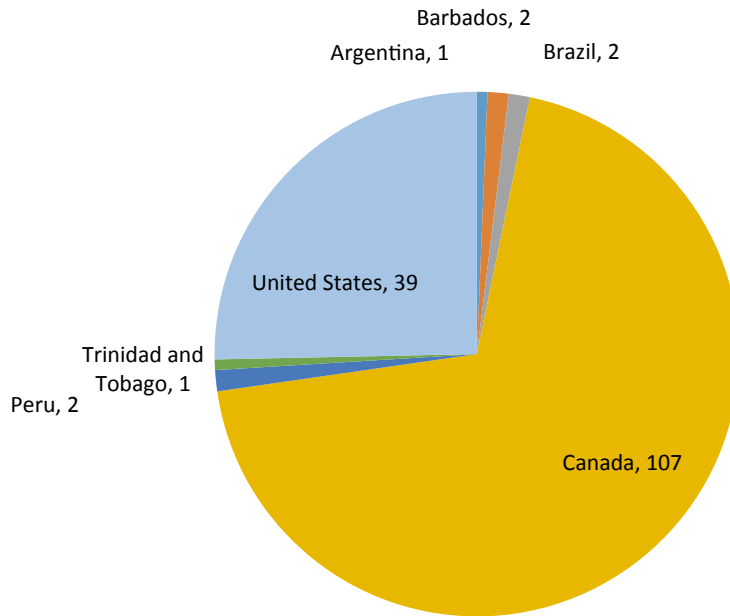


Chart A3: Stage 1 English-language respondents – Africa responses (total 64)

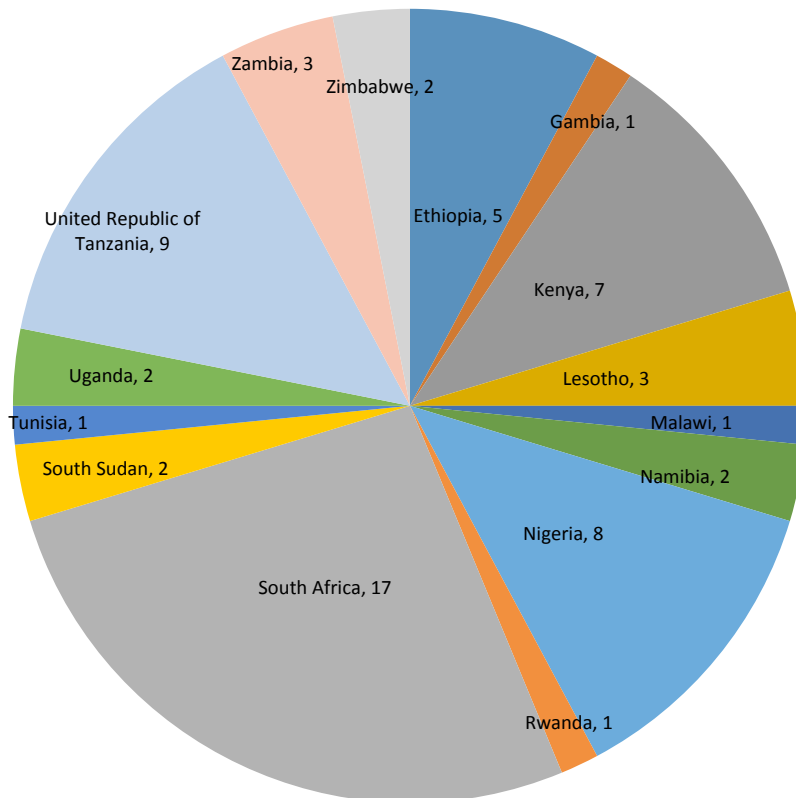


Chart A4: Stage 1 English-language respondents – Asia and the Pacific (total 196)

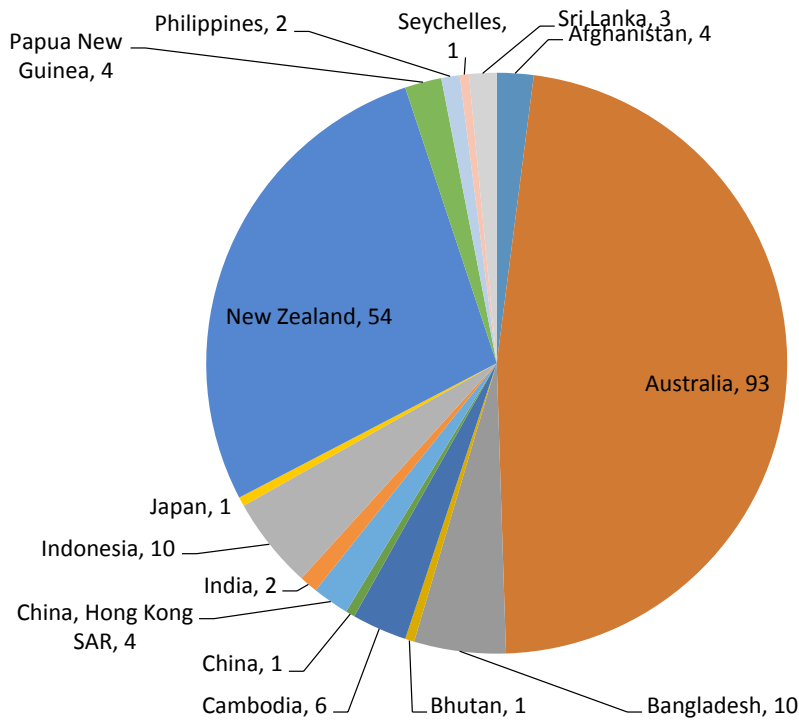


Chart A5: Spanish Language Respondents (total of 246)

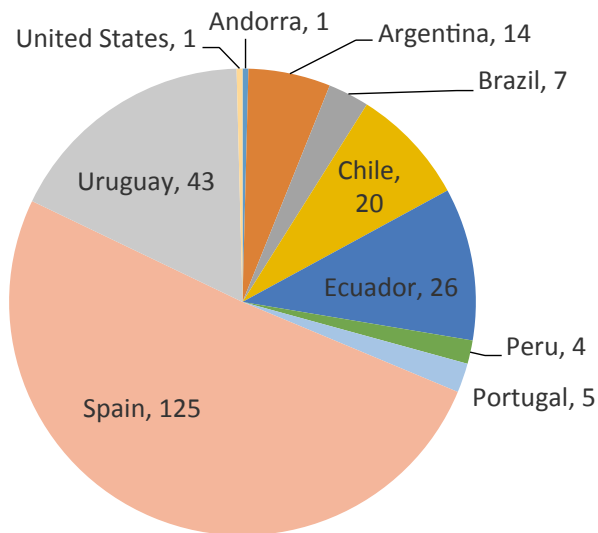


Chart A6: Stage 1 French Language Respondents (total 48)

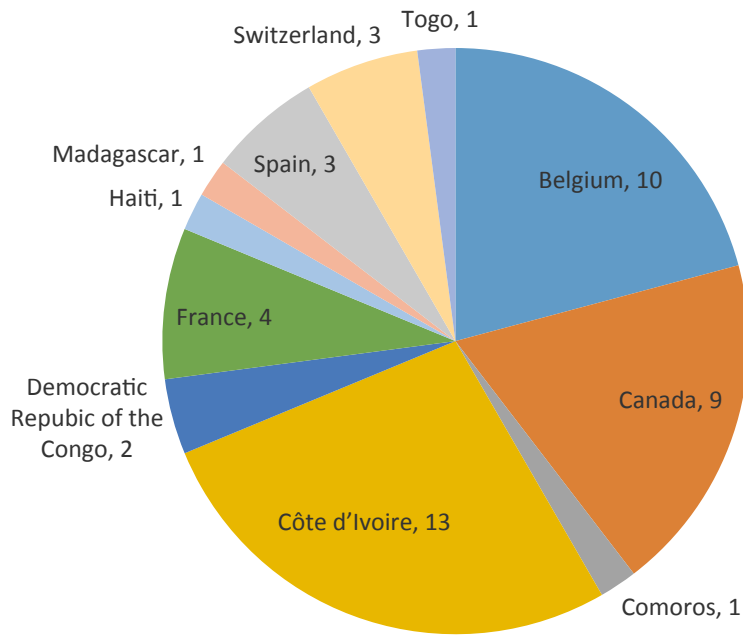


Chart A7: Stage 2 Africa French-Language Respondents (total 135)

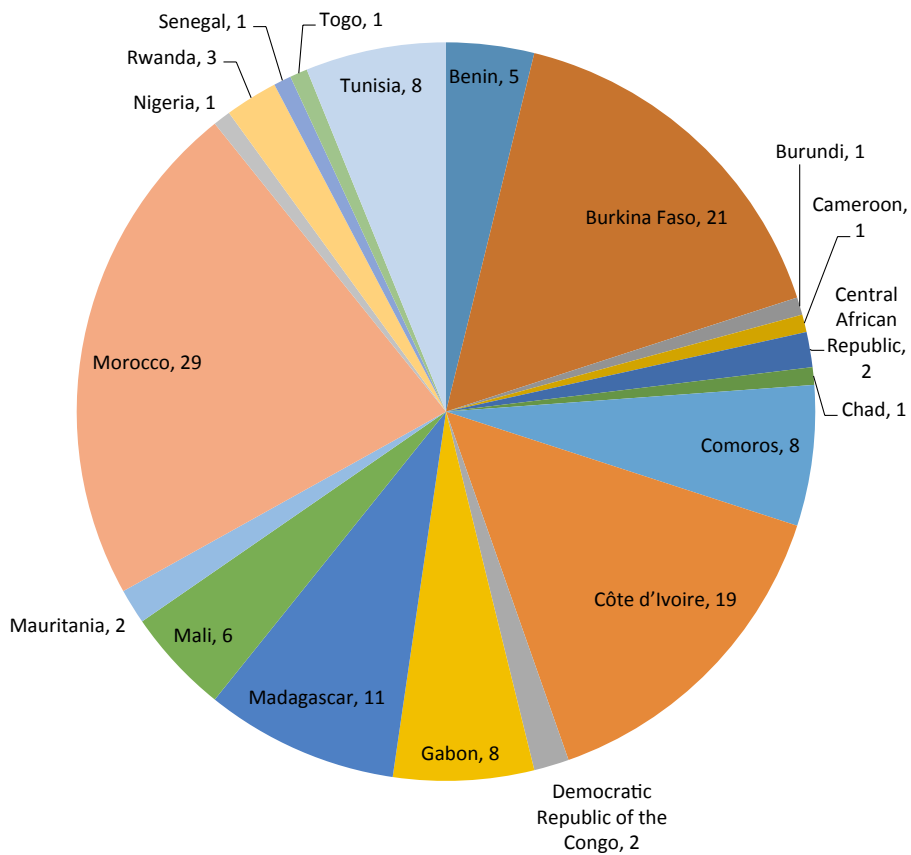
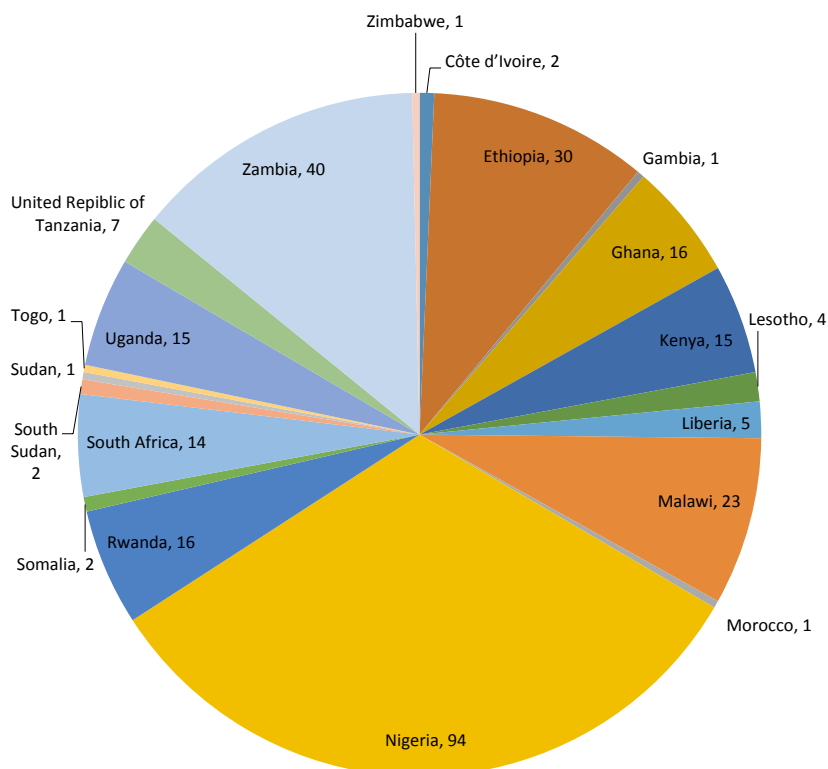


Chart A8: Stage 2 Africa, English-language respondents (total 296)

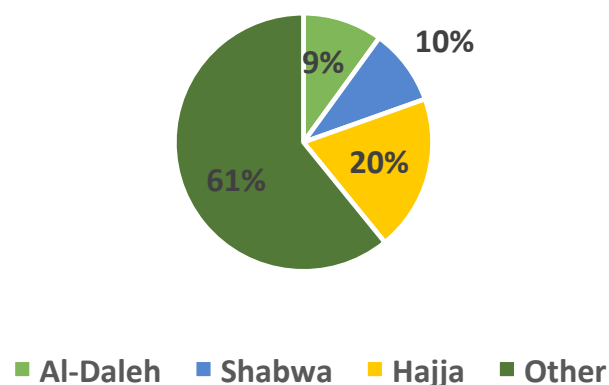


The Arabic-language survey had 256 participants from four countries with the majority from Yemen (92%), 6.8% from Saudi Arabia, 0.4% from Algeria and 0.4% from the West Bank and Gaza Strip (one respondent did not answer the question).

The Yemeni midwifery personnel in the survey are from 17 governorates (there are 22 governorates in total), which differ in geographical location, economic, political and social aspects. This diversity enriched the survey by showing the different types of problems and concerns that the midwifery personnel are facing. Interestingly no responses were received from governorates where the Yemeni Midwifery Association does not have a functioning branch – even though a couple of those governorates (Dhamar and Hodeidah) have received considerable donor input into midwifery over the last decades.

Sixty one per cent of the respondents are from 14 governorates including Sana’a and Aden, 20% of the respondents are from Hajjah governorate, while 10% are from Shabwa and 9% are from Al-Daleh.

Chart A9: Distribution of Yemeni midwifery personnel by governorate



Question 2: What is your job title and the setting in which you work?

Chart A10: Stage 1 English-language Survey – Job title

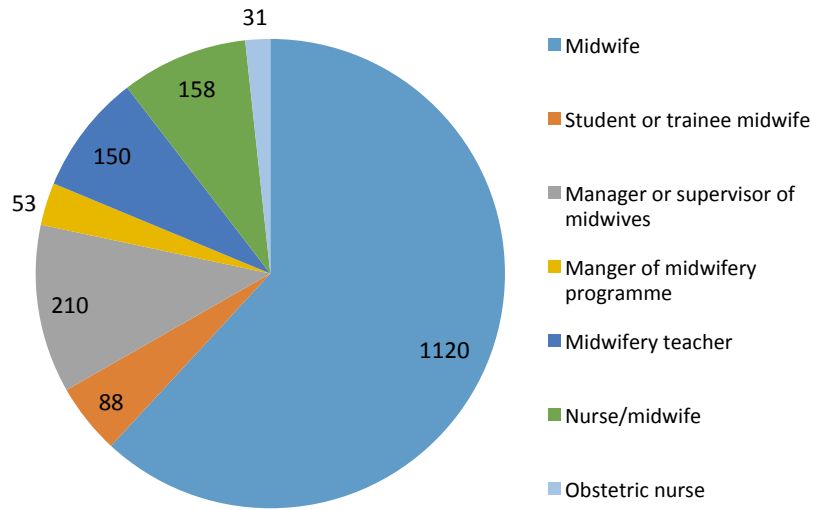


Chart A11: Spanish-language Survey- Job title

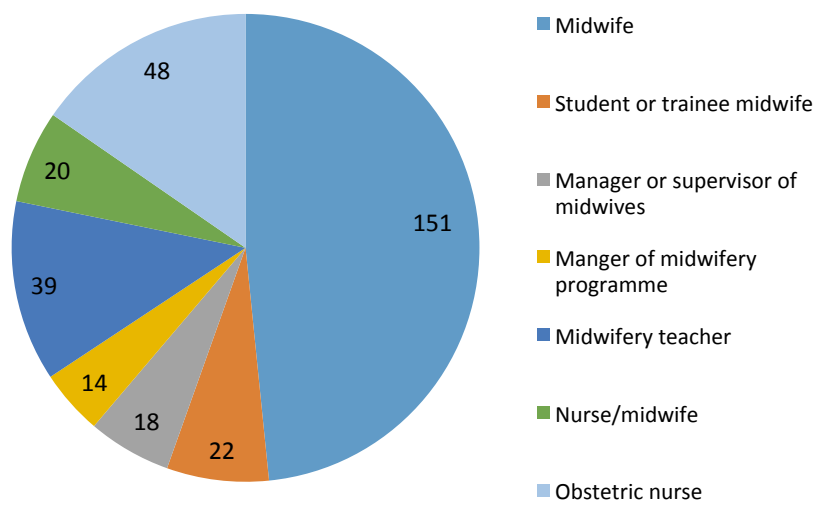


Chart A12: Stage 1 French-language Survey – Job title

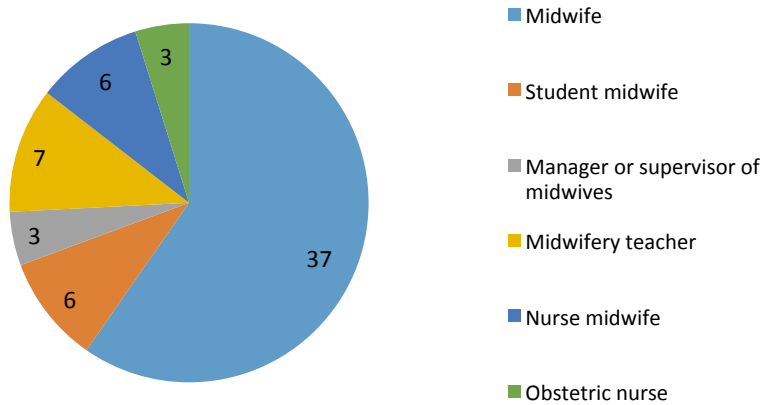


Chart A13: Stage 2 Africa survey English-language – Job Title

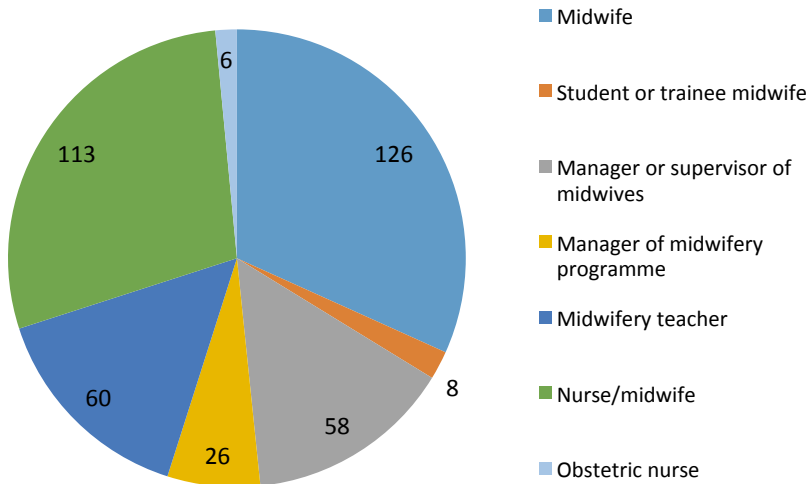
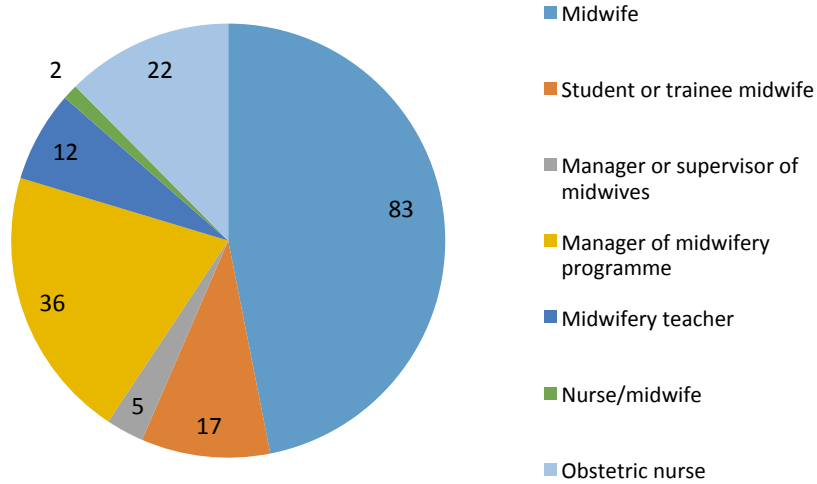


Chart A14: Stage 2 Africa survey French-language – Job title



Most of the respondents are midwifery personnel: English-language (1120), Spanish-language (151) and French-language (37), and there is also a good representation of midwifery managers, teachers and nurse–midwife personnel.

Most of the respondents in the English-language survey are working in a general hospital or teaching hospital. However there is a good spread of work locations, with over 300 working in urban communities and just under 200 working in rural communities. Many more English Africa survey respondents were working in teaching hospitals and were supervisors or teachers (over 50% were either a midwifery teacher, manager or supervisor in the Africa English survey and just under one third in the Africa French survey). There are also more English-speaking African midwifery personnel who describe themselves as nurse–midwives, rather than midwives, compared with English-speaking midwifery personnel generally; this illustrates the wide mix of midwifery personnel.

Chart A15: Stage 1 English-language survey – Job title and place of work

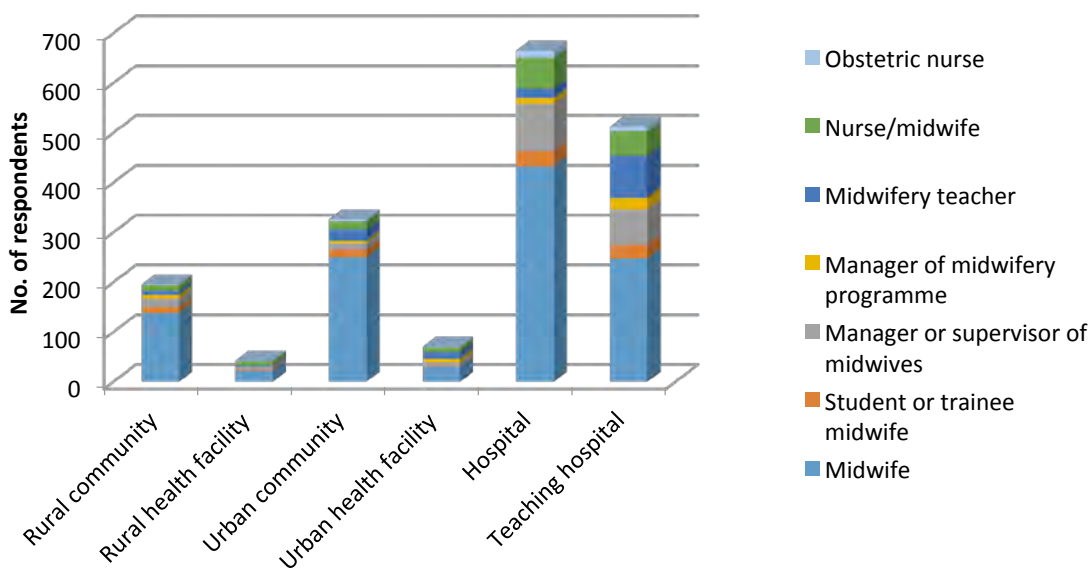


Chart A16: Stage 2 Africa survey English-language – Job title and place of work

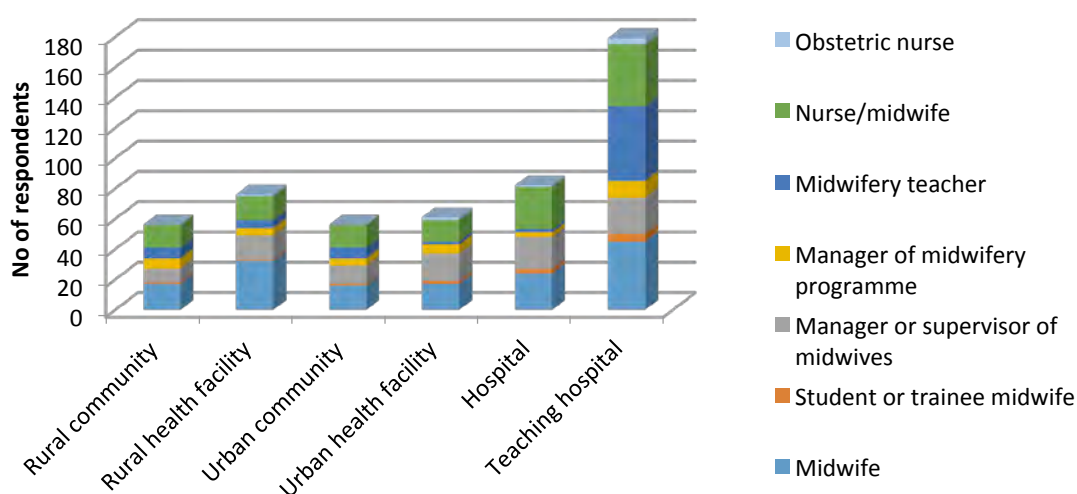
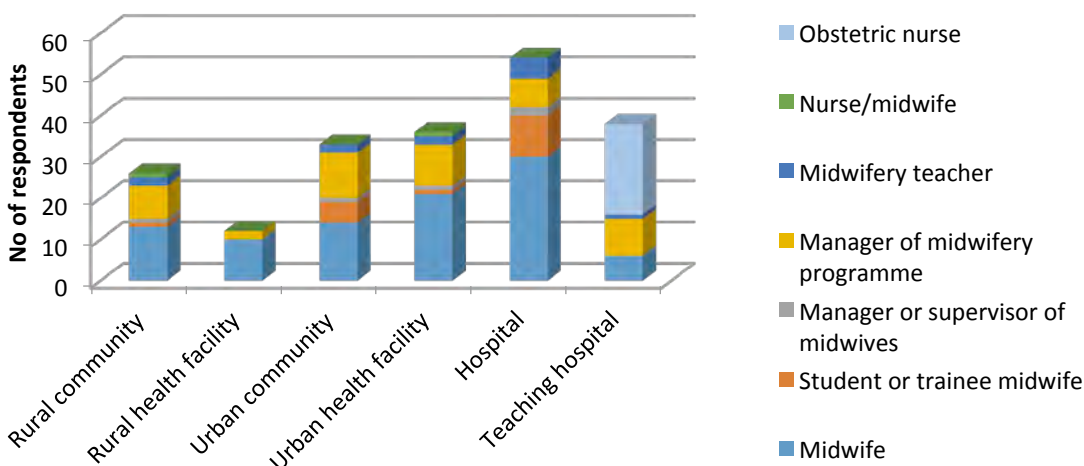
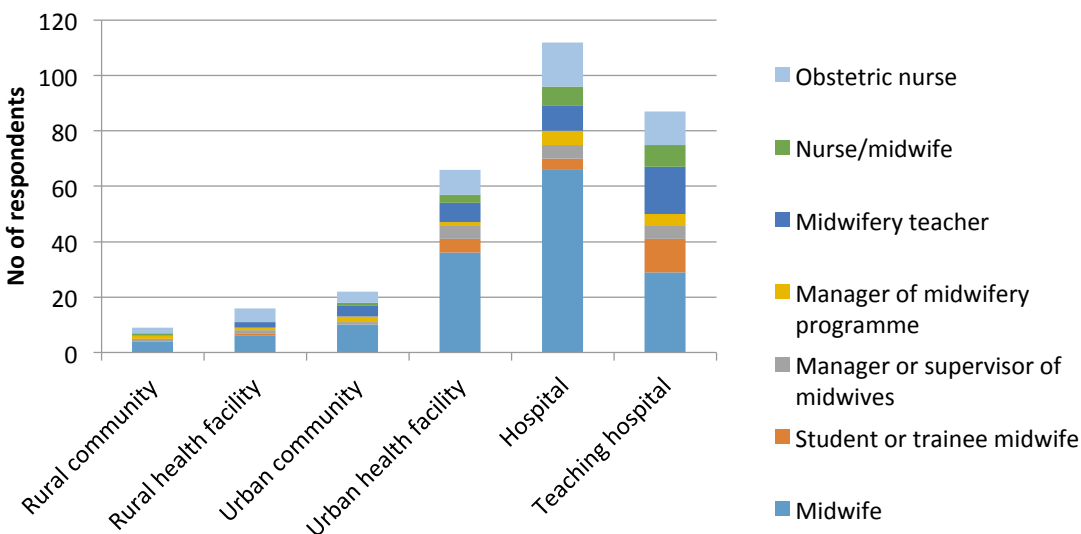


Chart A17: Stage 2 Africa survey French-language – Job title and place of work



The Spanish-speaking respondents were virtually all in hospitals, teaching hospitals or urban health facilities. There were very few based in communities or in rural areas.

Chart A18: Spanish-language survey – job title and place of work



Question 3: How old are you?

Interestingly 75% of the English-language respondents were over 35 years of age with 25% under 35 years. However the Africa English survey had a more even spread with approximately one third in each age group. The Africa French survey showed that 70% of respondents were over 35 years. The other surveys had a similar age profile – except for the Arabic-language survey, where the majority of respondents (75%) were under 35 years of age. The Spanish-language survey had 32% of respondents under 35 years and but the Stage 1 French-language survey showed 11% of respondents were over 35 years.

The majority of the Yemeni midwifery personnel are between 26 and 34 years old since the first batch of community midwife training courses graduated in 1998 (previously there were traditional birth attendants and skilled birth attendants). Most of the midwifery personnel

who are 50 years old and above received their training in Aden before the unification of Yemen in 1990, but they worked all over the country afterwards. The Yemeni respondents in the Arabic survey were reached directly through their country network, not just through the Internet, and so had a different profile.

The age spread may reflect the fact that the survey came through the ICM and would have had a high proportion of ICM members many of whom are possibly leaders in professional associations.

Question 4: Midwifery personnel conditions at work

Conditions at work vary across the different surveys and this is probably associated with the income level of the country and the development stage of the health system. Issues such as respect from doctors and obstetricians, and supervision and support, score much higher in the higher- and middle-income countries (i.e. in the Stage 1 English and Spanish-speaking surveys).

The midwifery personnel responding to the Stage 1 English and Spanish-language surveys showed a high level of job security and support, with the majority (around 95%) always or often paid regularly compared with around 78% of the Africa midwifery personnel. The Arabic-language survey participants, the majority of whom are working in Yemen, showed a different profile of working conditions. Only 53% of the midwifery personnel are paid regularly (often or always).

Respect from the communities that they work in is fairly uniform across all of the surveys, with 88% of the Stage 1 English-speaking midwifery personnel treated with respect by the communities that they work in, compared with 88% of the Africa French-speaking respondents and 78% of the Africa English-speaking respondents.

Interestingly, across all of the countries there are challenging working conditions related to harassment, with between 21% (Spanish-speaking survey) and 43% of respondents saying they sometimes, often or always, experience harassment while working. The security situation in Yemen may have affected midwifery personnel who work in the community, with 58% of midwifery personnel stating that they are scared to attend births at night in some neighbourhoods. In-depth knowledge of the social situation suggests that this is not only because of potential conflict situations but because of attitudes to women who are "out of the house at night" and wider gender power relations.

Support for midwifery personnel and supervision appears to be working best for those answering the Spanish-speaking and Stage 1 English-speaking surveys (the majority of whom come from middle- to high-income countries), with only 8% say they are unsupported. Whereas between 19% and 37% of respondents in the Africa French-speaking and Arabic-speaking surveys say they rarely or never feel supported or receive good supervision. See Table 1 below for a comparison of working conditions between the six surveys.

Table 1: Conditions at work

| | Stage 1 English | Africa English | Africa French | Spanish | Stage 1 French | Arabic |
|--|-----------------|----------------|---------------|---------|----------------|--------|
| Always, often or sometimes | | | | | | |
| I experience harassment while working | 38% | 37% | 41% | 21% | 43% | 21% |
| I am scared to attend births at night in some neighbourhoods | 26% | 30% | 27% | 14% | 29% | 58% |
| Rarely or never | | | | | | |
| I have been given a secure environment to provide 24 hour care | 8% | 28% | 27% | 5% | 25% | 39% |
| I have transport to attend births at people's houses (when relevant) | 19% | 57% | 42% | 55% | 50% | 65% |
| I have good supervision in the health service | 8% | 19% | 31% | 13% | 33% | 36% |
| I feel supported to do my job | 8% | 20% | 36% | 8% | 32% | 37% |
| Senior health professionals listen to me | 11% | 15% | 25% | 12% | 18% | 36% |

Chart A19: Stage 1 English-language survey – conditions at work

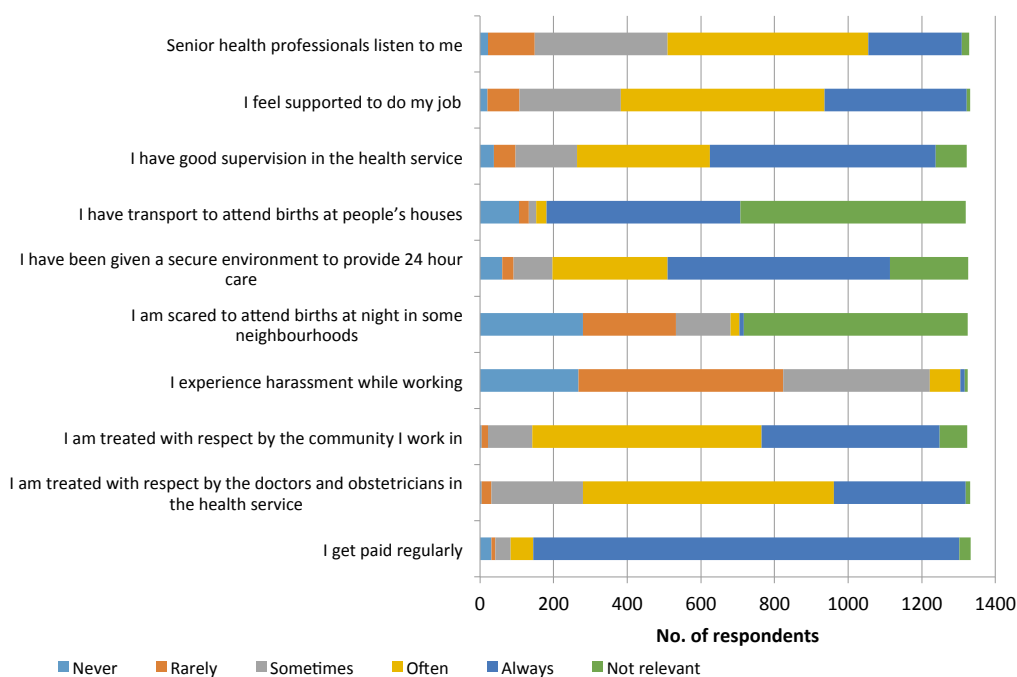


Chart A20: Spanish-language survey – conditions at work

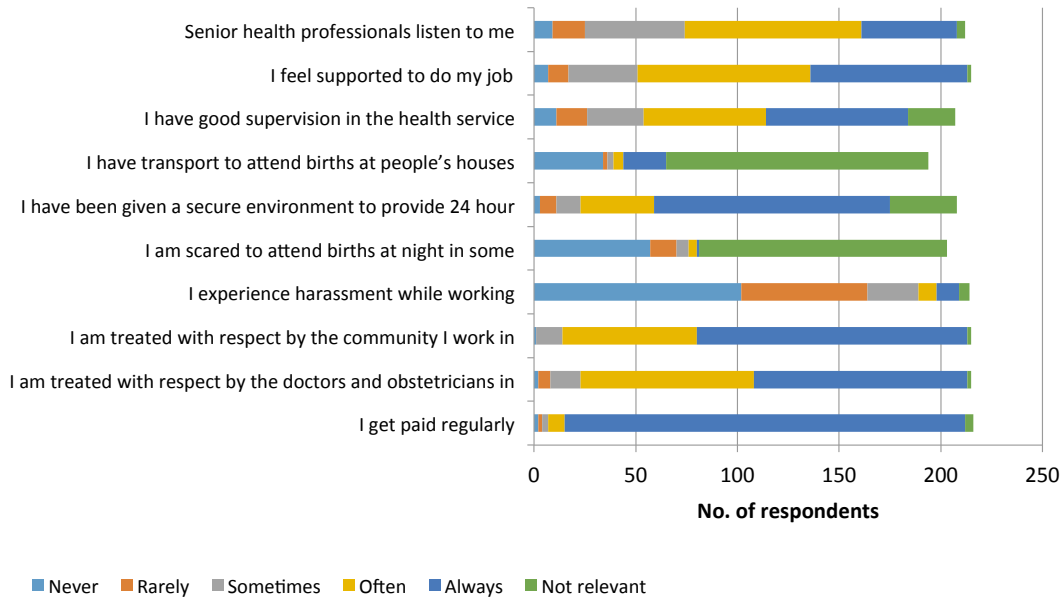


Chart A21: French-language Survey: Conditions at work

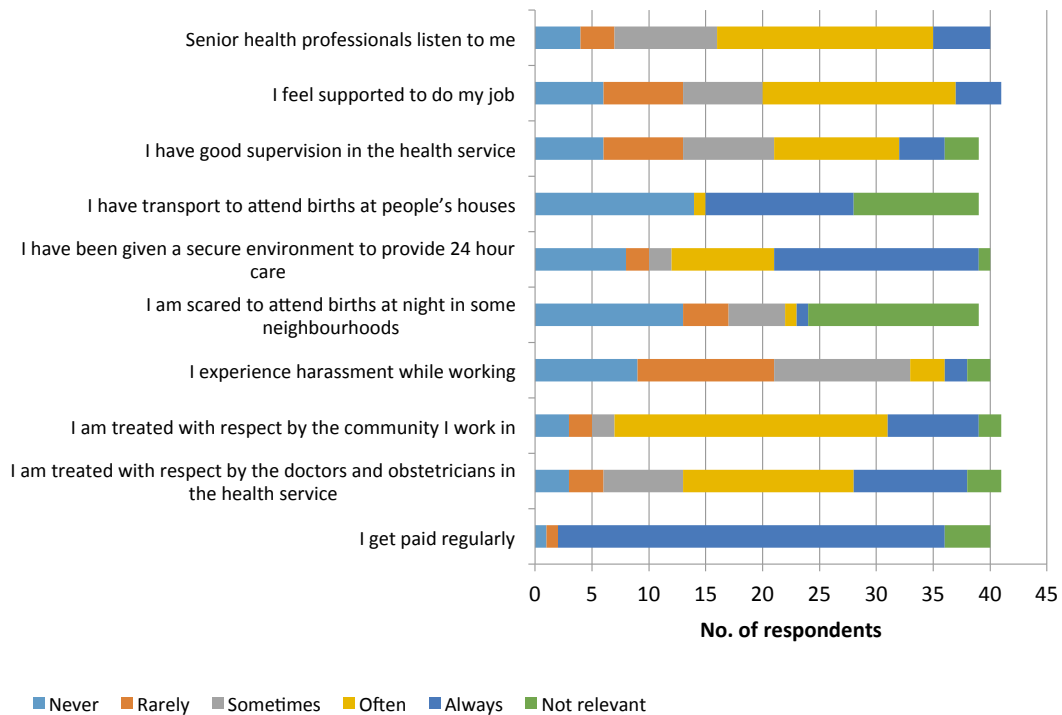


Chart A22: Arabic-language survey – Conditions at work

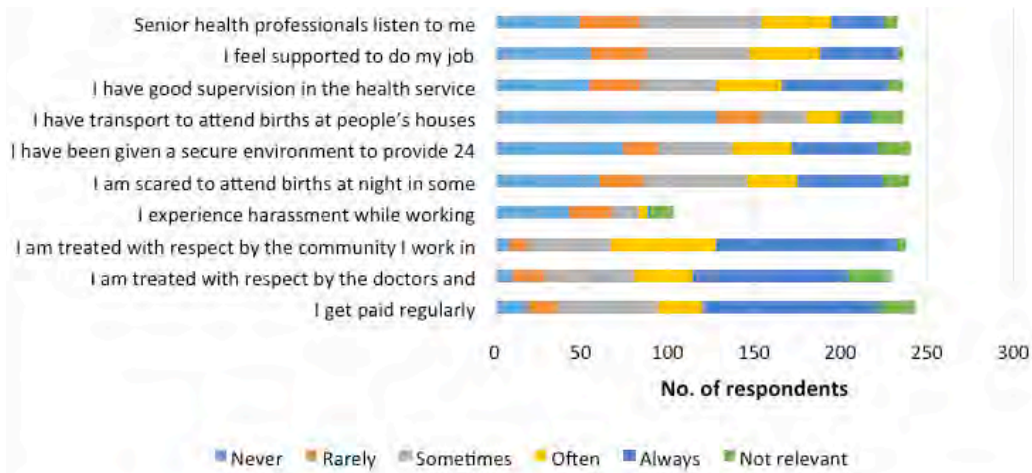


Chart A23: Africa English-language survey – Conditions at work

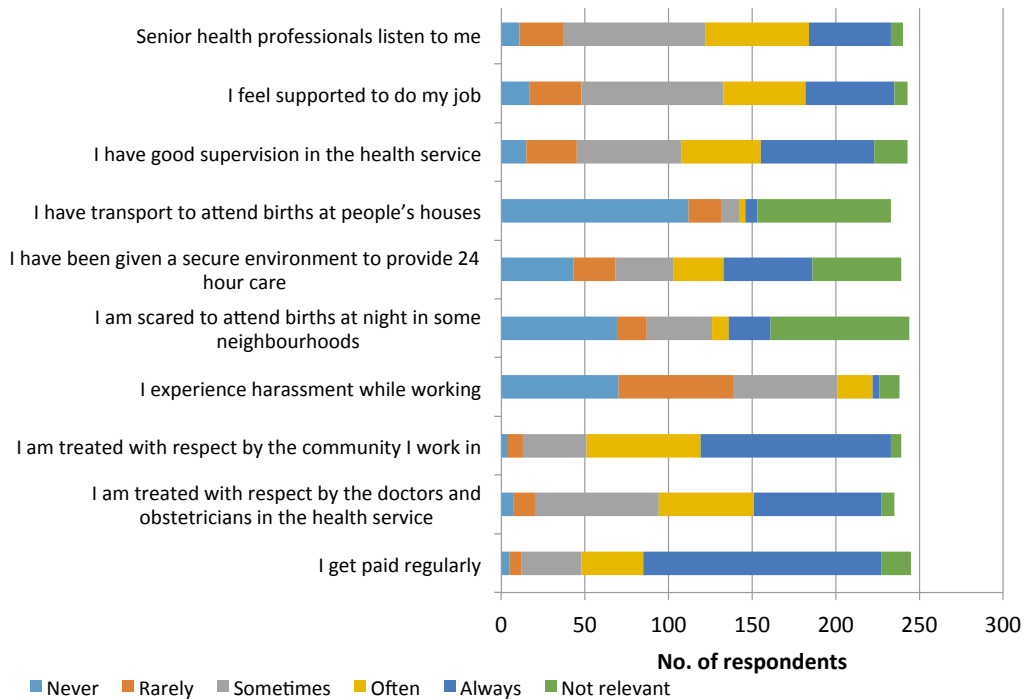
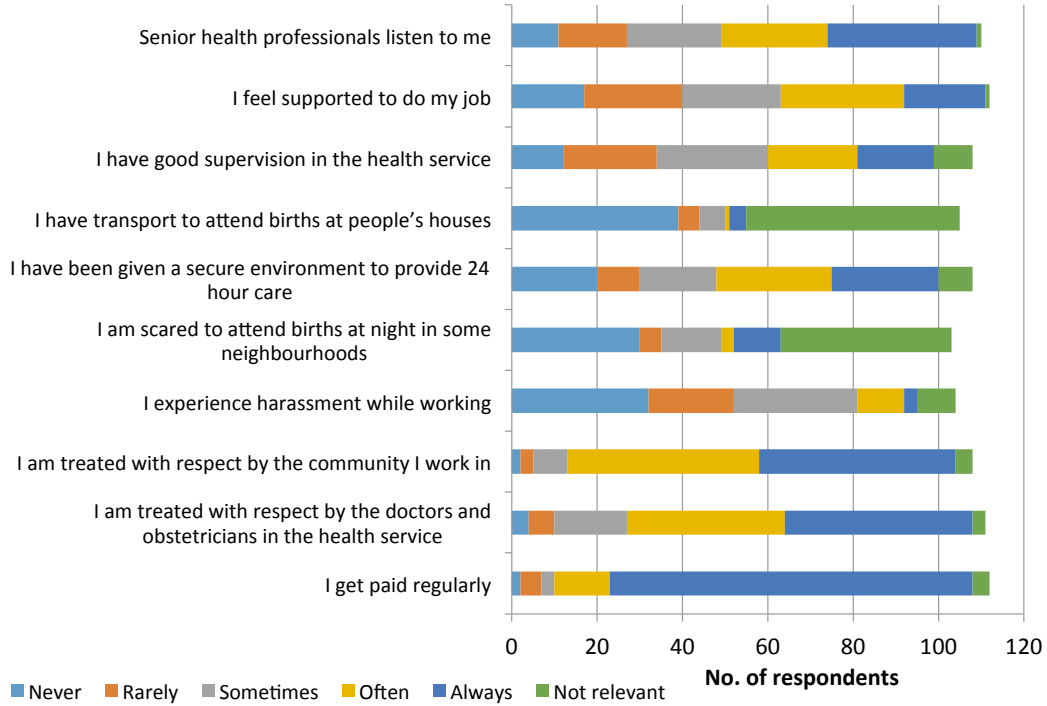


Chart A24: Africa French-language Survey – Conditions at work



Question 5: How would you say you feel on a daily basis in your job?

Chart A25: Stage 1 surveys – How do you feel at work

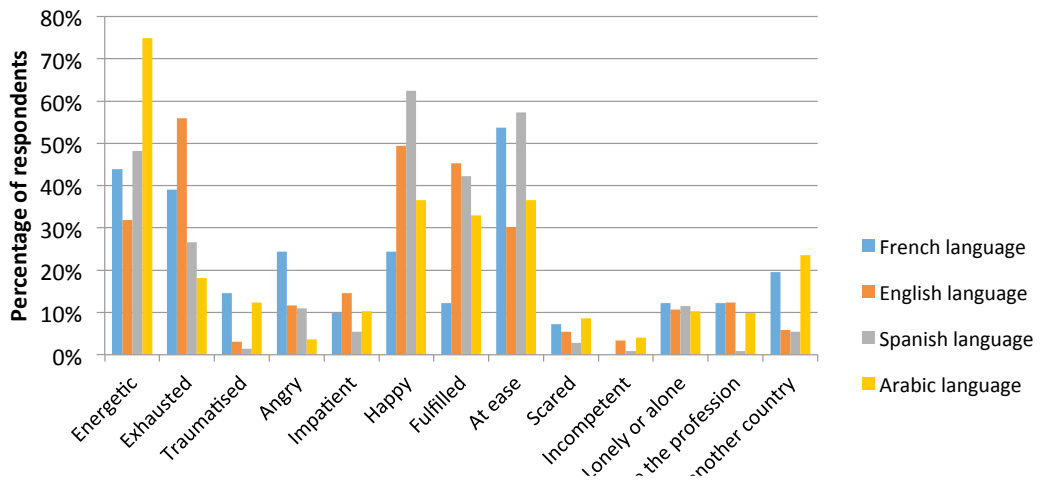
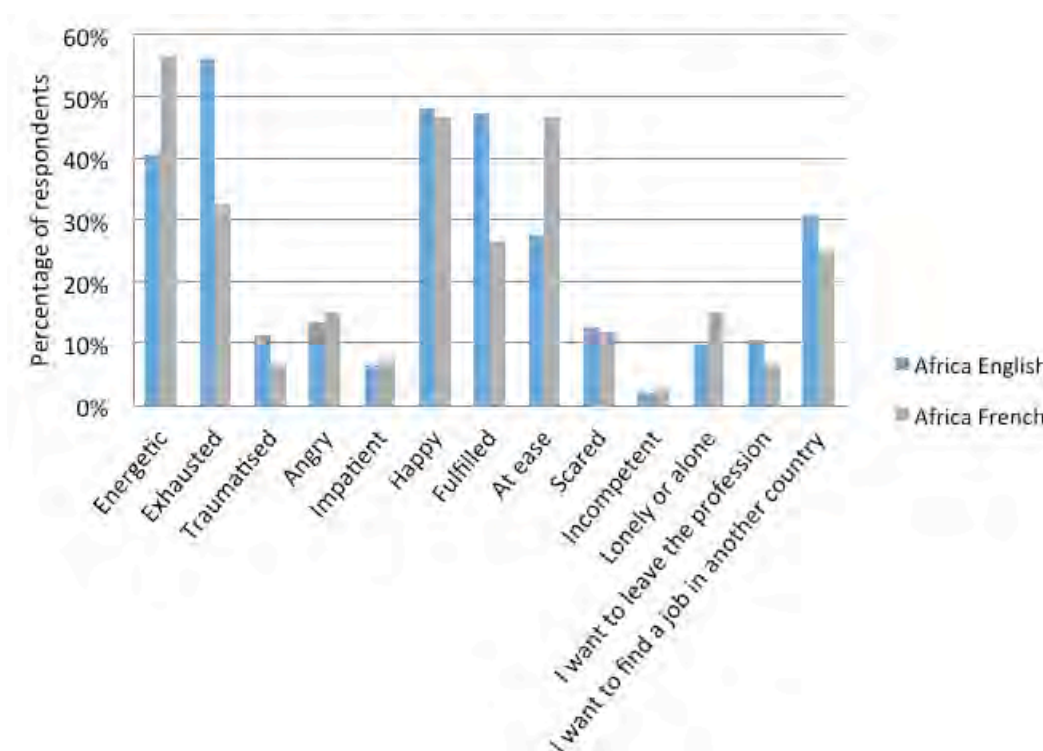


Chart A26: Stage 2 Africa surveys – How do you feel at work



Question 6: Previous research has shown that midwifery personnel are sometimes treated badly or experience poor conditions at work. Why do you think this happens? Please draw on your own experience (if relevant) and that of colleagues in your country. (Tick three that are most important to you).

The majority of respondents across the six surveys thought the reasons were to do with disorganization and under-resourcing in the health system, not enough staff, and managers not doing their jobs well. There was also significant concern about lack of equipment and supplies, particularly for Africa-based respondents who rated this as their most important issue.

Discrimination against women and gender inequality got the highest ranking from the Arabic and Spanish surveys, with 35% of respondents in the Arabic survey stating that people did not think midwifery was a respectable role for women. Between 20–30% of all respondents thought that midwifery personnel are treated badly because of discrimination and gender inequality; these are issues related to the social sphere and overlapping with the professional sphere.

Between 10% and 17% of Africa-based midwives consider that HIV and AIDS adds to the stigma against midwives, whereas under 3% of international respondents raised this as an issue.

Chart A27: Stage 1 surveys – Why midwives are treated badly or experience poor conditions

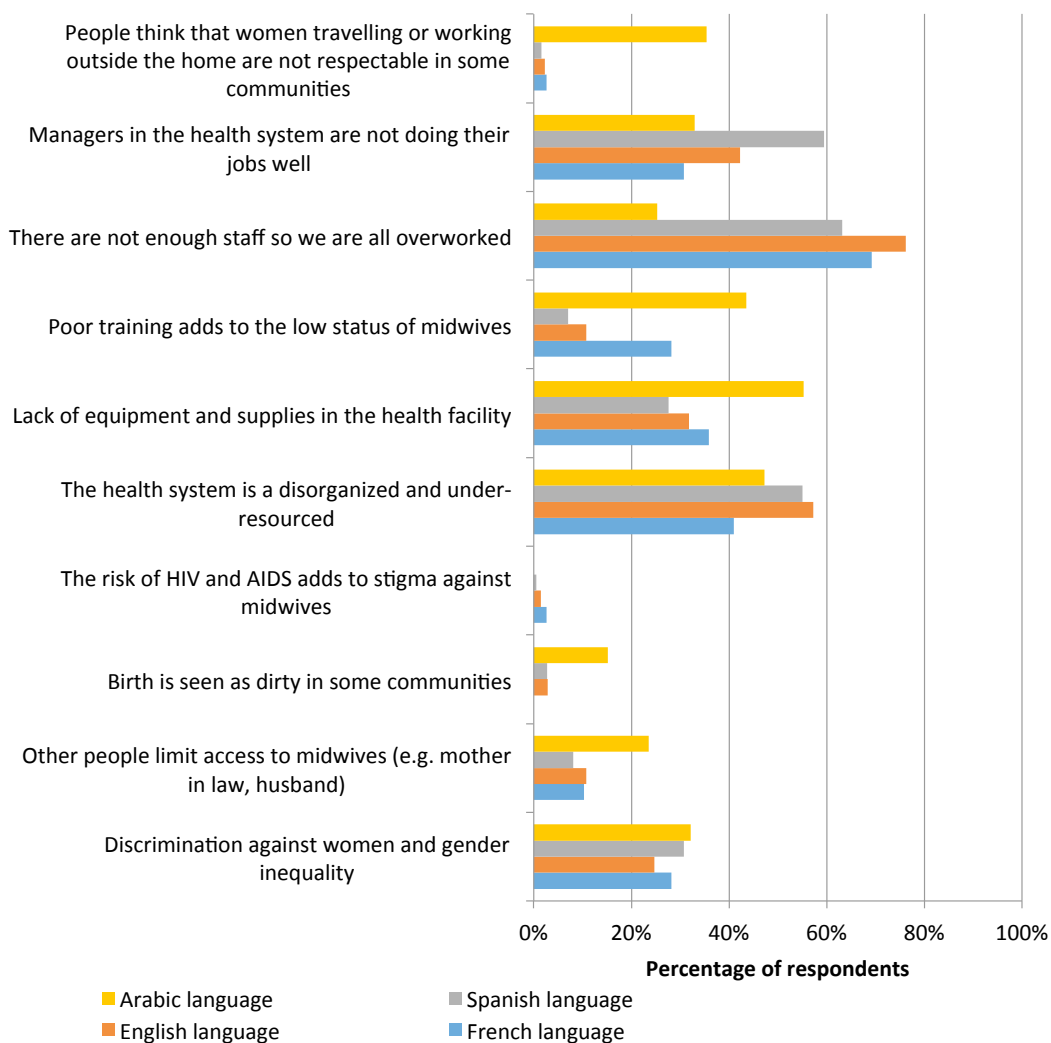
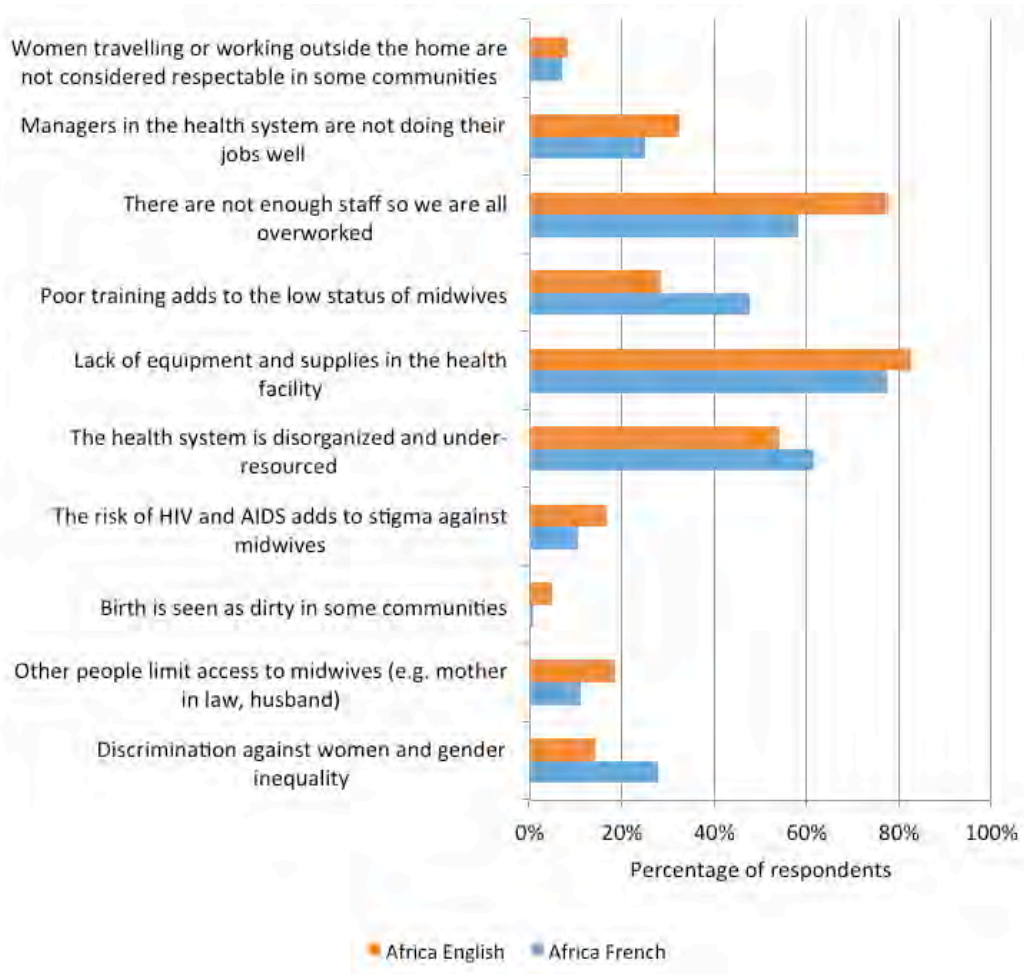


Chart A28: Stage 2 Africa surveys – Why midwifery personnel are treated badly or experience poor conditions



BOX 1: EXTRA COMMENTS ON QUESTION 6

Canada: “Medical providers limit midwifery services as they are unwilling to share health-care dollars with midwives, as they are afraid their income will decrease”.

Bangladesh: “There is no supervision and monitoring, no appreciation for good work”.

Finland: It is midwifery personnel themselves who have “created and perpetuated a culture of giving more and expecting less”.

Ghana: “Supportive policies are absent or weak. Midwives are not consulted at policy level.”

Liberia: “We have no influential person at policy-maker level who is eager for midwives rights and responsibility and benefits. We are not fully empowered because of lack of basic human needs.”

Morocco: “Absence of a statute that protects midwives in Morocco.”

“Our voice is not heard.”

“Discordance between the strategy of our healthy system and reality.”

New Zealand: “The media is absolutely brutal against midwives and the occasional poor outcome is jumped on and splashed about in the media, often without fully reporting the facts, and this gives midwives a bad rap overall, particularly new graduate midwives”.

Some respondents stated that these issues of poor treatment and conditions were not a problem in their country – notably the Netherlands, which has a strong midwifery culture.

Ireland: “The potential of the midwife role is not recognized.”

Respondents from Africa emphasized low pay, poor recognition and voice, and insufficient regulatory environment.

Nigeria: “Poor remuneration for midwives and lack of career path as a midwife.”

Rwanda: “The population does not know the role of midwives.”

United Republic of Tanzania: “Midwives are generally respected but the media make our job difficult at times.”

United States: “Male domination and economics of the health system. Political and legal climate creates fear for midwives and limits access.”

Uruguay: “It is a struggle to feel like we are part of the health team, given that health service provision is based on economic interests rather than on service provision norms and scientific evidence. In the private sector maternal health services have become a business which misinforms service users and limits autonomy – and a practice that verges on a total lack of ethical principles. In the public sector the obstetric business has not taken root given the lack of economic resources. Many of the midwives in Uruguay aim to get fully trained and gain experience in public sector hospitals even though we know that the salaries are much lower than the private sector.”

Health system, supervision and poor standards were also mentioned as a reason for poor treatment of midwives.

Question 7: How easy is it to combine your family life with your work as a midwife?

Midwifery personnel are having difficulty balancing their unpaid household and reproductive responsibilities with their jobs as midwifery personnel. Though this is common for all working women, there is the added stress in some countries of social stigma or resistance about being a midwife (nearly 40% of the Arabic-speaking midwifery personnel said that their husband/partner did not approve of their work as a midwife).

A large number of the midwifery personnel who responded do get help with housework from their partner and their families, though the Arabic-speaking respondents reported they do not get much help from their husbands. Between 30–57% of midwifery personnel are having to leave children aged under 14 years alone while they work, and this is higher (53–63%) among African respondents. Nearly 60% of Arabic-speaking midwifery personnel and between 20–25% of African respondents stated that they could not cope with their combined household and work responsibilities. Between 30–45% of midwifery personnel say that the long working hours have affected their family badly. In addition between 20–30% of midwifery personnel have another source of income, showing that they cannot live from the salary they are paid.

Chart A29: Stage 1 surveys – How easy is it to combine your family life with your work as a midwife?

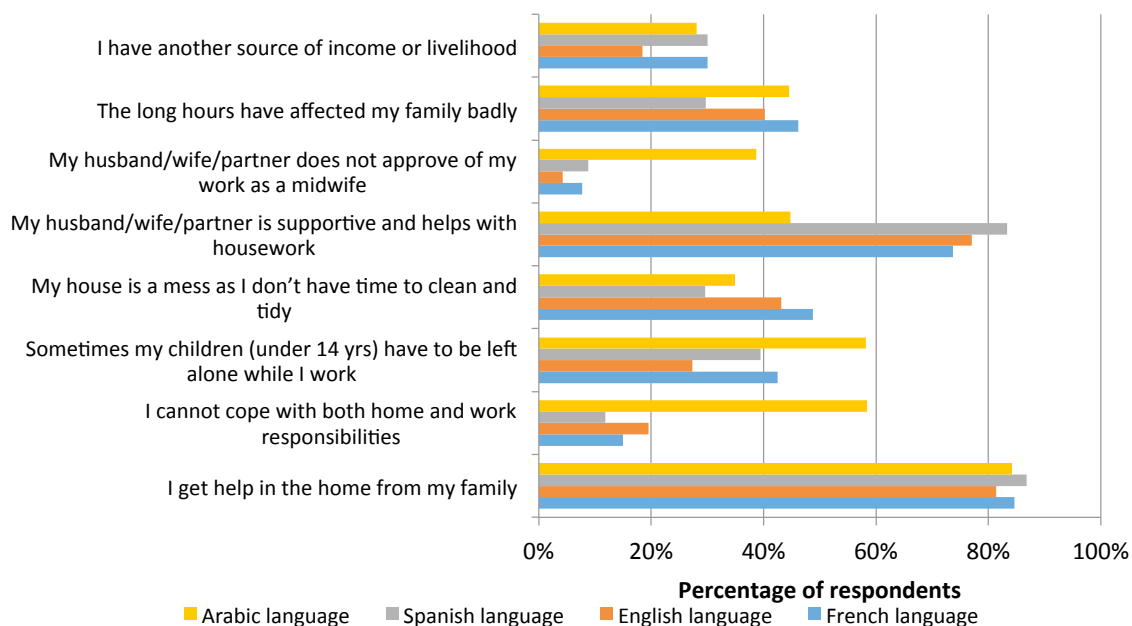
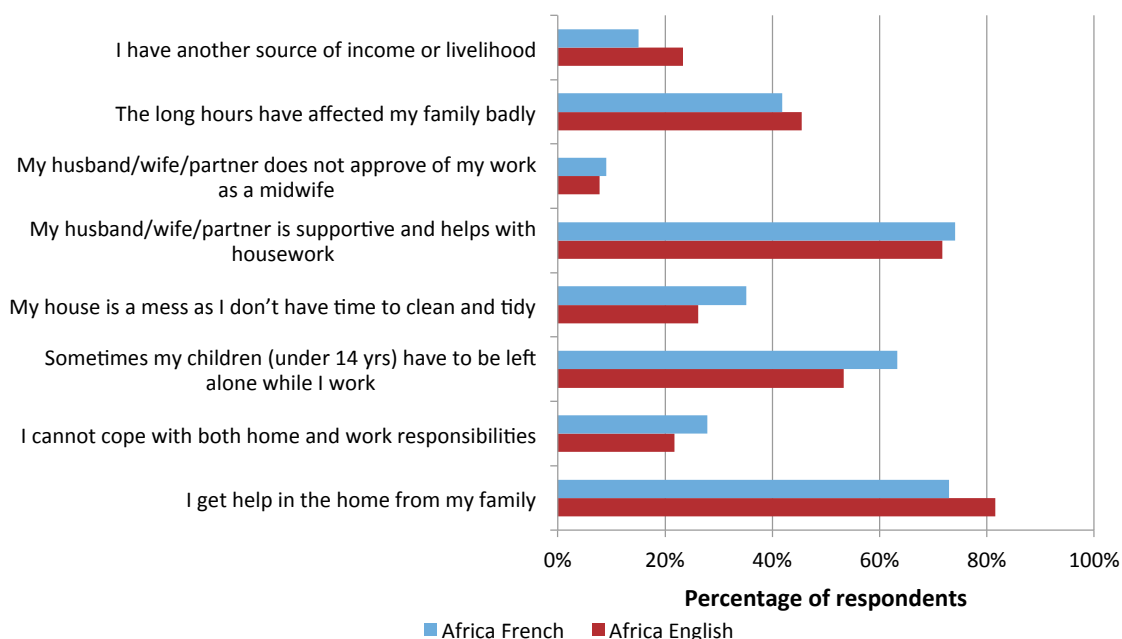


Chart A30: Stage 2 Africa survey – How easy is it to combine your family life with your work as a midwife?



Question 8: If you had the chance to make changes to your experience of being a midwife, which changes would be most important to you? (Tick the three most important).

The social and professional environment appears to be important to midwifery personnel, with social connections and support, and professional development and training mentioned frequently, though economic considerations were also extremely important. Not surprisingly the majority of respondents across the four surveys would like better pay, and a significant number would like better professional development, especially the Spanish-speaking respondents (67%) and the Africa respondents (71% and 86%). The Arabic-speaking respondents (60%) wanted better pre-service education and given that many of these respondents were newly qualified and young, this shows that current education is not enough. Other aspects of how midwifery personnel are managed and supported were also important – such as meeting with colleagues, being listened to (40% from English-speaking respondents), respect from senior health staff (50% of Spanish-speaking respondents) and receiving supportive supervision (53% of Africa English-speaking respondents).

Chart A31: Stage 1 surveys – Changes that midwifery personnel feel are most important

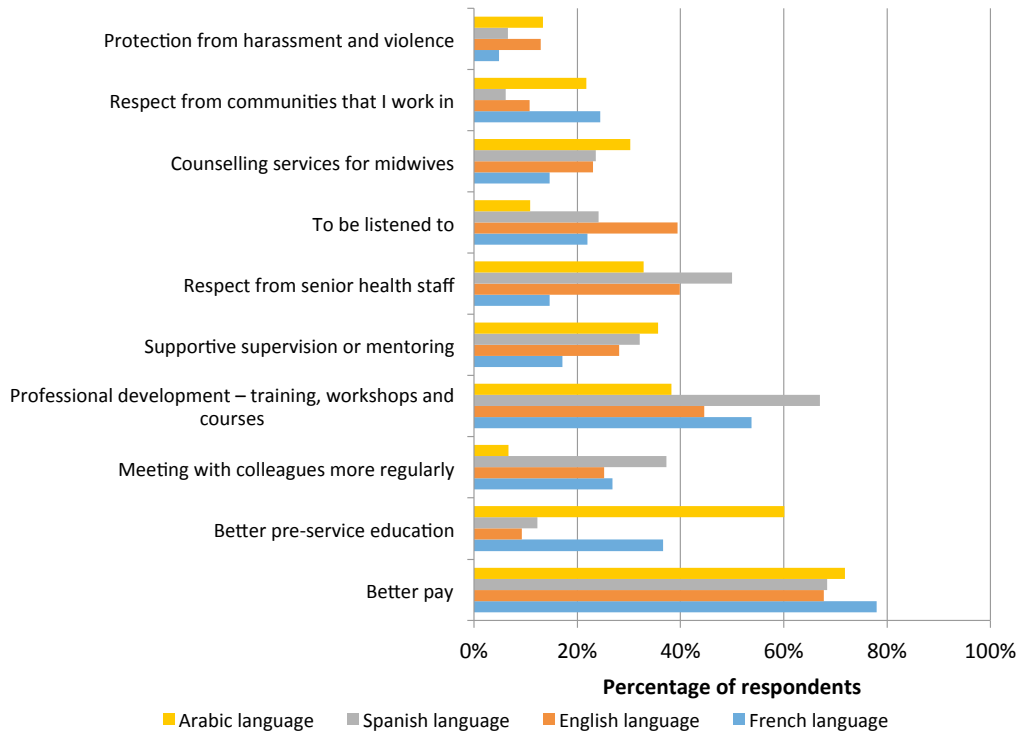
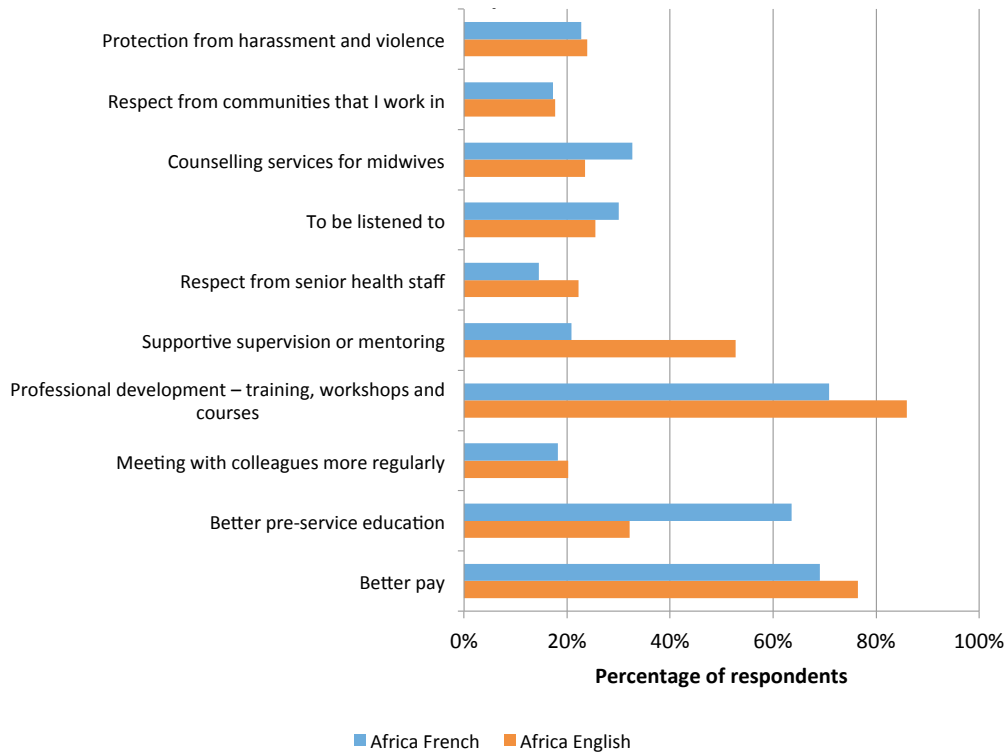


Chart A32: Stage 2 Africa surveys – Changes that midwifery personnel feel are most important



The responses showed that English-speaking midwifery personnel are asking for less paperwork, more time with pregnant women to support them with natural births, more community-based care, and better support from peers and managers. Midwifery personnel also want to see more autonomy and recognition from the health service, especially from doctors and obstetricians. They also want to be recognized and commended for their good quality work and to be better managed and led, while at the same time maintaining their autonomous responsibilities.

BOX 2: EXAMPLES OF FURTHER CHANGES THAT RESPONDENTS WOULD LIKE TO SEE

Ethiopia: “Further training in obstetrics so that midwives could be allowed to conduct caesarean section especially in rural communities.”

Kenya: “Create a forum for sharing experiences and getting more involved in research work.”

Liberia: “Motivations such as scholarship should be provided for committed midwives, including student midwives, to study abroad in the same field and return to your country to serve in the midwifery institutions as there are no midwifery educators in my country.”

Sri Lanka: “In Sri Lanka there are three categories engaged in midwifery:

- a) Midwives who have completed a one and a half years’ full-time midwifery course and obtained a diploma certificate and a licence to practice midwifery. They work in the field and all hospitals. They are full-time workers engaged only in midwifery;
- b) Nurses who have obtained six months in-service midwifery training;
- c) Midwives, who after one and a half years’ training, and five years’ service, have completed a three year nursing course and are designated as nurses.

At present in the county there is no cadre of nurse–midwife. The second and third categories work only in hospitals. But they are not confined to maternity wards or labour rooms. For this reason, midwifery is in a mess and facing unnecessary problems. Midwifery in Sri Lanka has a history over 80 years. Maternal mortality rate in Sri Lanka is below 30 maternal deaths per 100 000 live births. Over 10 000 midwives work under the ministry of health.”

For the **Latin America** midwifery personnel the laws and protocols around roles and autonomy are very important and there is much to be done.

African Midwifery personnel were interested in improving training and networking.

Uganda: “Ugandan Nurses & Midwives Council was getting support from the Royal Collage of Midwives, but our project is finishing now and there is no more funding. I was in a high-level meeting with top Ugandan colleagues, to discuss midwifery supervision and the way forward. I fear it will now all collapse.”

United Kingdom: “That midwives should be given as much respect for their expertise in pregnancy and normal birth as the obstetric doctors are given for their expertise in abnormality of pregnancy and birth. Midwives should be able to practice in a truly autonomous way. Micro-management does not make for good practitioners.”

Question 9: How do you think these changes could be encouraged? (Tick as many as you like).

Although all of the measures for positive change listed in this question were rated fairly high, the top three were:

- (i) *The health service recognizes the importance of midwifery personnel* – this is overwhelmingly the most important measure (80–93%) and shows again the health system issues that act both as a barrier and an enabler to better social, cultural and economic lives for midwifery personnel.

(ii) *Information campaigns about the importance of midwifery to the population* – four of the surveys had a figure of over 80% with the remaining two (Stage 1 English-speaking and African French respondents) rating this measure lower at just over 60%. Midwifery personnel clearly recognize the importance of public support and the importance of women having an understanding of what midwifery is, so they can demand that maternity services support their rights.

(iii) *Support to professional midwifery associations* – this was highest in the Africa English (88%), Arabic and Spanish-speaking surveys, possibly in countries where the most support is required. Midwifery personnel are recognizing that they need to network and work together to enable the changes they want.

Chart A33: Stage 1 surveys – How changes can be encouraged

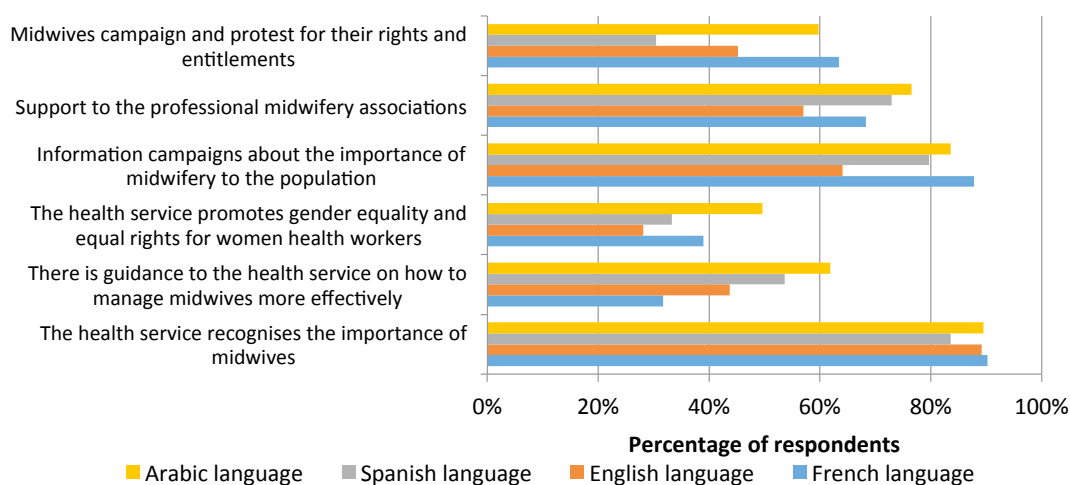
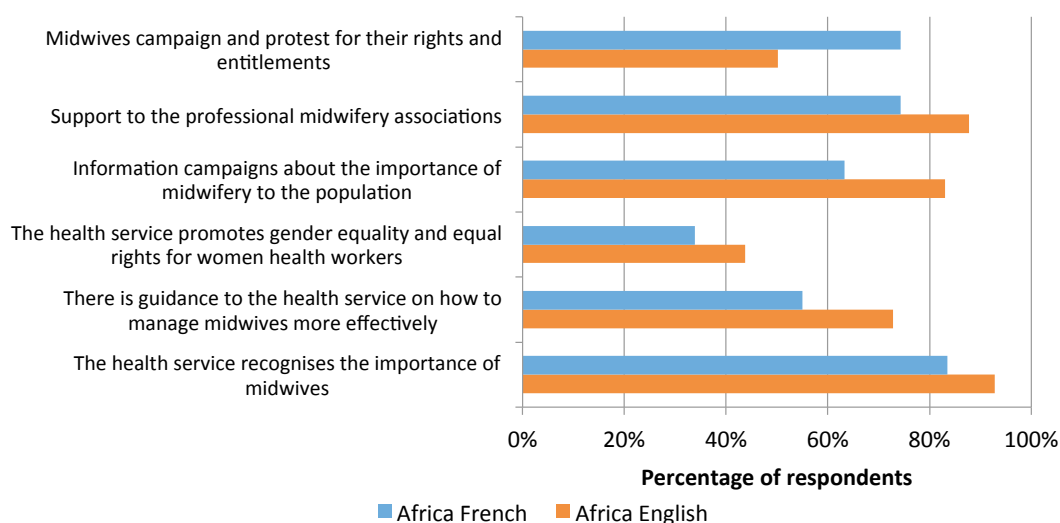


Chart A34: Stage 2 Africa surveys – How could changes be encouraged?



Question 10: Examples of improvements that help midwifery personnel to do a better job

The final survey question was an open question and asked: **Please tell us of any improvements that are being made in your country, or your part of the health service, and how these improvements have helped midwifery personnel to do their jobs better.**

Responses to this question ranged from 574 in the English-language survey, 132 in the Spanish-language survey, 34 in the French-language survey, 142 in the Arabic-language survey, 219 in the Africa English survey and 93 in the Africa French survey. The responses are grouped into topics to get an idea of the main areas where improvements are being made and what impact this was having.

In the Arabic survey approximately 15% of the midwifery personnel stated that not a single improvement has taken place in particular areas. However 44% of Yemeni midwifery personnel did record the establishment of the National Midwifery Association as an improvement. They explained that this is because the association is now reaching most of the governorates with different kinds of training and refresher courses, and they feel that there is a formal body talking sometimes on their behalf.

Nineteen per cent of Yemeni respondents were glad to see different types of training courses in health education, family planning, home visits, and inserting IUDs and implants. Five per cent of the Yemeni midwifery personnel said that in their areas women are more willing to use family planning methods, which they saw as an improvement. Four per cent stated that the community is more accepting of the midwifery personnel and more respectful towards their work. Finally, 4% stated that home visits and the regular mobile clinic was an improvement, and 3% mentioned that an increased number of women are giving birth under the supervision of a community midwife.

The most quoted areas of improvement (in order of importance) in the Stage 1 surveys were:

- An increase in the number of midwifery personnel;
- Training and professional development – one referred to mandatory training, one mentioned clinical coaches for support and education;
- Specialist midwife-led units or midwife-group practice (e.g. with shared call-out) – great this is so high up the list!
- The use of maternity support workers or less qualified staff to do some of the less specialist tasks – thereby taking the burden from overworked midwifery personnel;
- Equal pay campaigns and increase in pay;
- Better supervision and management;
- ICT improvements (e.g. BORN) – leading to improved audit and understanding of women's clinical history;
- Improved physical environment;
- Encouragement of homebirths and natural births within the health system, including listening to pregnant women's choices and upholding rights – and thereby enabling midwife-led care;
- Exchanges between midwifery personnel and nurses and other colleagues;
- Rotation of placements from community to hospital setting to maintain skills and connections;
- Opportunities for research and learning from evidence (e.g. NICE guidance and research in the United Kingdom);
- Flexible working patterns and shorter hours.

In general these less-often mentioned improvements are likely to have been noted by midwifery personnel from higher-income countries.

Examples of improvements given by survey respondents:

In Latin America there has been a particular emphasis on developing protocols, laws and norms (codes of conduct etc.). These have been used to clarify the roles of midwifery personnel and to establish their place at all levels in the health system, to define competencies and to improve pay and conditions. There also seems to be a movement in hospitals to encourage natural birth and women-led birthing positions (instead of requiring women to lie on the bed). Much of this work is done through, and with, professional associations and their role has sometimes been strengthened.

Argentina: “The creation of a law (*Ley del Colegio de Obstétricas de la Provincia de Buenos Aires*), has given the obstetric college the governance of matriculation, control of professional conduct and the policy power over the midwifery profession. This has given our profession an enhanced status with more respect.”

Canada: “The government monitors the prenatal care, birth and postnatal care of every woman through a computer program called BORN. This is a mandatory program and every birth attended by a health-care provider is put into this program. The government is starting to push health-care facilities to follow certain recommendations (e.g. no unnecessary episiotomies, encouraging skin-to-skin contact directly following the birth, breastfeeding etc.) a hospital gets flagged if they fall outside the normal standards (percentage-wise compared with other health-care facilities) and this has encouraged many health-care providers and facilities to make improvements in the health care and gets health-care providers “on the same page”.”

Cataluña, Spain: “Service users’ opinions of, and respect for, midwives was improved after a protocol was developed to encourage and define normal hospital births, without unnecessary intervention, and attended by a midwife.”

English-speaking country: “Midwives here are “supervised” with a “midwifery standards review” every 2 years, where stats and reflections are reviewed and discussed with a midwife interviewer and a consumer interviewer. This has been supportive for me.”

English-speaking country: “We have begun to rotate from hospital settings to the community and vice versa to improve the continuity for women – although this in itself has caused upset with some midwives as they feel they are being taken away from where they prefer to work. The rotation has enabled midwives to understand the roles that both hospital and community midwives do, and how we can better work together. This is being seen as both good and bad by women, as some see the same midwife whereas others see lots of different midwives depending on their rotation.”

Peru: “Having midwife managers and supervisors who are part of the management team allows our issues to be more visible and enables the correct decisions to be made.”

Uruguay: “We are working hard to make progress on professional conduct regulation – increasing competencies, professional guarantees, accessibility for service users and contribution to the health policies in the country.”

The Africa survey

Africa survey respondents reported a different range of improvements that have taken place in their countries. These ranged from improvements in training and supervision, to better health facilities, equipment and improved regulations and recognition. The following topics are in order of importance with relevant quotes from respondents:

An increase in the availability and quality of training, mentoring and supervision for midwifery personnel, in particular the introduction across many countries of BEmONC (Basic Emergency Obstetric and Newborn Care) and ESMOE (Essential Steps in Managing Obstetric Emergencies) has, the midwifery personnel believe, significantly contributed to the reduction in maternal and newborn deaths.

“Strengthening of supportive supervision, coaching and mentoring has improved the quality of midwifery services. Updating life-saving skills has improved knowledge, skill and attitude of midwives. Availability of EmONC services at selected rural health centres has improved maternal, newborn and child care and so reduction of morbidity and mortality at birth. Increased advocacy activities in the country against high maternal and perinatal deaths has made midwives known as an important cadre for reduction of maternal and perinatal deaths in the country.”

Manager/supervisor of midwives, hospital, United Republic of Tanzania

Investment in resources including more personnel, cleaner, more hygienic and better equipped maternity units and free delivery packs

“UNICEF supply our facility with equipment, drugs and instruments, including mama kits which help us to give free service and drugs to pregnant women during ANC [antenatal care]. And the mama kit helps during labour and delivery. Also the Midwives Service Scheme in Nigeria has helped in the delivery of midwives service at grassroots level which has encouraged an increase in ANC attendant and hospital delivery.”

Midwife, rural community/rural health facility, Nigeria

The formation and widespread recognition of midwives associations, specialist midwife-led units and the midwives service scheme have all contributed hugely to improved communication between midwifery personnel, the other obstetric, genealogical and nursing professions, and the wider public.

“The Nurses and Midwives Act is currently under review in order to broaden the scope of practice for midwives. There is good collaboration between the Midwives Association of Zambia and the General Nursing Council of Zambia. The midwifery training curriculum is also being reviewed as a way of strengthening life-saving skills such as EmONC and Helping Babies Breathe including instrumental delivery.”

Nurse/midwife, urban community, Zambia

“Health in Kenya is at the moment a devolved function. It has been devolved to semi-autonomous county governments that are funded by the national government. In the county that I work in, trainings and professional development programmes have been organized by the health department through donor support. These trainings are on emergency obstetric care. Once midwives are armed with such practical knowledge, it becomes easy for them to apply this knowledge in their day to day work.”

Nurse/midwife, teaching hospital, Kenya

The support of local, national and international charities, NGOs and other agencies

“Well, with the help of the international community, the health facility in which I worked has been renovated by Africa Union (AU) and Médecins Sans Frontières to buttress government’s efforts in restoring our damaged health system in my country. Liberia. Moreover, since we have been faced with the issue of low staff, additional midwives have been recruited on the Obstetrics ward of the hospital in which I worked (JDJ Hospital). At least, this adjustment has reduced the tension on the job a bit. Thus, we are now energized and working at ease. Over all, a great deal of improvement has taken place in my facility with the aid of partners and the international community.”

Midwife, hospital, Liberia

“The Ministry of Health (Malawi) has worked in partnership with nongovernmental organizations such as Save the Children, Jhpiego, to train midwives in mentoring midwives and other health workers to improve delivery of maternal and neonatal health service delivery.”

Midwifery teacher, teaching hospital, Malawi

“International organizations are allowed to organize workshops and trainings which has helped my country know current trends in midwifery practices.”

Midwife, hospital, Ghana

Social and professional awareness and recognition for the work of midwifery personnel

“There are more male midwives now compared to the former days. This improvement has helped the profession as a whole and also given female midwives confidence. It also makes the profession earn respect from people in the country.”

Nurse/midwife, teaching hospital, Nigeria

“The continuous professional development for midwives is improved and it increases the knowledge and skills to better serve. The recognition of midwives in Rwanda from the Rwanda Association of Midwives which goes together with their named profession as ‘Midwives’ not named ‘Nurses’.”

Midwifery teacher, teaching hospital, Rwanda

“We have formed a midwives association and midwives day is celebrated every year on 5th May.”

Nurse/midwife, teaching hospital, Uganda

“Midwifery has been recognized as an autonomous profession.”

Manager of midwifery programme, urban community, Ghana

Policy and strategic reforms from governments

“Previously there were very few midwives found in my country and the care for women and children was done by other health professionals who did not have the necessary skills. Now the government has started to train more numbers of midwives to fill this gap, and equip facilities with more number of midwives. The government is also giving special emphasis for the health of mothers and children to achieve the MDGs [Millennium Development Goals] and better reduce the maternal and child mortality and morbidity.”

Midwife, teaching hospital, Ethiopia

“Midwifery service scheme started in Nigeria in the year 2009, it has helped midwives reach out to the village women who cannot access quality care during birth and the Government of Nigeria has really tried in the area of provision of equipment like the midwifery kit which has really made the work of our midwives easy and also provision of long lasting treatment and essential drugs.”

Midwife, rural community/rural health facility, Nigeria

Other less mentioned areas of improvement included:

- Improved physical environment and standards of pay;
- Encouragement of homebirths and natural births within the health system, including listening to pregnant women’s choices and upholding rights thereby enabling midwife-led care;
- Exchanges between midwifery personnel and nurses and other colleagues;
- Rotation of placements from community to hospital setting to maintain skills and connections.

Of the total responses to this question, approximately 17% reported no improvements and comments included:

"I don't see any changes. We are still underpaid, overworked and frustrated that our jobs are seen as low status. I am young and passionate about midwifery but I have thought many times of leaving the profession."

Manager of midwifery programme, South Africa

"There hasn't been any relevant improvement in my country. Because the voices of midwives are still not listened to. We are stigmatized by our colleagues in the health profession. Opportunity for further studies too are not given, with the excuse that midwives are not important."

Midwife, hospital, Ghana

"There are no improvements. midwives are still underpaid even when they have work overload. Because of this many midwives are joining nongovernmental organizations which pay better. Lack of equipment is still a challenge and lack of good infrastructure where women still deliver in an open ward where rooms are not partitioned."

Midwife, teaching hospital, Zambia

ANNEX 5

Research as a potential next step

The combined workshop and survey data from higher-income and lower-income country participants has provided many insights into shared and differing experiences, which raise a number of further questions. To better understand the implications of what has been captured in this report and the impact on barriers to quality of care more research is needed across a range of countries and contexts. Specifically:

- What is the relative income status of midwifery personnel relative to other health professionals, including in isolated rural areas and urban settings?
- What is the difference between the impact on maternal and newborn outcomes of midwifery in privately-funded, publically-funded and not-for-profit midwifery services?
- What is the difference between the impact of midwifery on maternal and newborn outcomes in hospital, clinic and community-based contexts?
- What is the difference between the impact of midwifery on maternal and newborn outcomes in countries with established midwifery associations and those with weak or no midwifery associations?
- What is the difference between the impact of midwifery on maternal and newborn outcomes in countries with good regulatory frameworks for midwifery versus those without?

In particular, country-based research would be able to reach a larger number of midwifery personnel working in less accessible and more challenging contexts, which has not been possible in this consultation. Midwifery associations and service providers could support this research.

Research would situate social and professional attitudes to midwifery personnel and midwifery within a wider sphere of social values, norms and practices. It would generate potential for greater regional learning and sharing and inform development of good practice guidance.

This consultation has also shown that there are many innovative and progressive initiatives being implemented to address the social, professional and economic barriers that midwifery personnel face. However there were few examples of initiatives tackling gender inequality and some of the barriers that midwifery personnel face because they are mostly women.

In summary, it would be useful to review approaches that tackle the social, economic and professional barriers that midwifery personnel face in the health system, including in midwifery training, in the policy environment and in their communities. The active involvement of midwifery personnel, at all levels, in the development of the research and guidance, is crucial to building long-term leadership and capacity. The research findings are further needed to develop guidance to clarify midwifery roles and responsibilities within health systems and services.

This report documents the voices and realities of 2740 midwifery personnel in 93 countries and describes, from their perspective, the barriers they experience to providing quality, respectful care for women, newborns and their families. The findings highlight that hierarchies of power and gender discrimination hinder progress, but also demonstrate the great potential for improvements in quality of care when the voices of midwives are heard.

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