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The involvement of midwives associations in policy and planning about the midwifery workforce: A global survey

Sofia Castro Lopes, RN, MS (Research Associate)[a,*], Patricia Titulaer, BSc, MIH (Midwifery, Technical Midwife Advisor)[b], Martha Bokosi, RN, RM, MSc (Project Coordinator)[b], Caroline SE Homer, RM, PhD (Professor)[c], Petra ten Hoope-Bender, RM, MBA (Senior Associate)[a]

[a] Instituto de Cooperación Social Integrare, Calle Balmes, 30, 3-1, 08007 Barcelona, Spain
[b] International Confederation of Midwives (ICM), Laan van Meerdervoort 70, 2517 AN The Hague, The Netherlands
[c] Centre for Midwifery, Child and Family Health, University of Technology Sydney, City Campus, Ultimo, NSW, Australia

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ABSTRACT

Objective: a fit-for-purpose midwifery workforce is needed to respond to the current and future needs in sexual, reproductive, maternal and newborn health and to achieve universal health coverage. Evidence-based policy and planning that involves all stakeholders, including professional associations can assist with the development of such a workforce. The aim of the study was to explore how and when midwives' associations are involved in the planning processes for the midwifery workforce and which tools and approaches the associations perceived were used to support human resources for health policy.
Methods: all 108 member associations of the International Confederation of Midwives were invited to participate. A questionnaire collected data including: the involvement of the association in the national planning dialogue, processes and methods for participation and engagement; mechanisms to guide and inform decision-making; and, the tools, data and evidence used to influence human resources for health policy. A descriptive analysis was conducted and comparisons were made by country group based on national income strata.
Results: 73 (68%) midwives' associations participated in the study, representing 67 (71%) countries. In most (95%) countries, the planning process to determine the provision of reproductive, maternal and newborn health was centralised at the ministry of health level and included midwives' associations amongst others. Less than two thirds of associations reported involvement in planning and policy. The planning processes in which they took part were the reproductive, maternal and newborn plan (63%), the national health plan (58%), and the human resources for health plan (52%). Planning was more frequently undertaken at national than sub-national levels in middle- and low-income countries than in high-income countries. Midwives associations were often unaware of the human resources for health approaches used to calculate the number of midwives required, and reported low use of benchmarks, guidelines and supporting tools during their involvement in the planning process.
Conclusion: although midwives associations were involved in planning and decision-making processes for midwifery, their participation was often limited. These associations represent a key provider group in sexual, reproductive, maternal and newborn health and as such have a greater capacity to contribute to policy development and planning and have a meaningful contribution to the achievement of the goals of universal health coverage.

Background

The new post-2015 development agenda has defined universal health coverage (UHC) as a key health priority for the next 15 years (Clift, 2012; Sheikh et al., 2013; World Health Organization, 2014). For sexual, reproductive, maternal and newborn health (SRMNH) this will constitute a challenge due to the lack of an effective health system or an available midwifery workforce (PMNCH, 2012; WHO, 2012;

* Corresponding author.
E-mail addresses: sofia.lopes@icsintegrare.org (S.C. Lopes), p.titulaer@internationalmidwives.org (P. Titulaer), M.Bokosi@internationalmidwives.org (M. Bokosi), caroline.homer@uts.edu.au (C.S. Homer), petra@petratenhoope.org (P. ten Hoope-Bender).

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Shamian, 2014). There is an increasing recognition that midwives are pivotal in the provision of SRMNH services and the returns from investing in a proficient, motivated and supported midwifery workforce who are fit for purpose and practice are immense (WHO, 2013; Renfrew et al., 2014; Shetty, 2014). The State of the World's Midwifery (SoWMy) 2014 (UNFPA et al., 2014) showed that midwives can provide 87% of the needed essential care for women and newborns, when educated and trained to international standards and supported within a functional health system and enabling environment.

A '*fit-for-purpose, fit-to-practice midwifery workforce*', can only be achieved through adequate and evidence-based planning where future SRMNH needs are efficiently anticipated (Campbell, 2013; Campbell et al., 2013) A diversity of workforce planning approaches are used across, and within, countries (Dreesch et al., 2005; WHO, 2010, 2008), however little is known on how, when and by whom these processes are undertaken. The engagement of stakeholders is recommended to increase dialogue and cohesion between reality on the ground and the development of policy (Dussault et al., 2010). The professional associations within countries, such as the midwives' associations, are often important key stakeholders and can play an important role in policy discussions (ICM, 2014a; UNFPA et al., 2014).

The International Confederation of Midwives (ICM) has been a main promoter of the recognition and development of the profession of midwives and midwives associations around the world (ICM, 2012). A midwives association is defined by ICM as 'a platform for developing strong, supportive, positive relationships among midwives and between the profession of midwifery and other stakeholders such as governments and other health care providers' (ICM, 2014b). Associations are required to fulfil a number of requirements in order to become a member of ICM (ICM, 2014b), including having a constitution, governing body and regular meetings. ICM supports the associations through a set of guidelines and tools from their inception as a member to their development, strengthening and as a partner in the continuous development of the profession. As part of this, the ICM Member Association Capacity Assessment Tool (MACAT) (ICM, 2011a, 2011b), is one method of helping member associations to take up their role and responsibility during policy and workforce planning discussions.

This study was conducted as part of the annual ICM Member Association survey, which is used to inform the organisation about the composition of its membership, their needs and strengths and guides the strategic direction. Recognising the potential role of midwives' associations in midwifery workforce planning, the 2014 survey focused on their perceived involvement in policy and workforce development. The aim of the study was to explore how and when midwives associations are involved in the planning processes for the midwifery workforce and which approaches and tools the associations perceived were used to support human resources for health (HRH) policy.

Methods

All 108 ICM member associations at the time (February–April 2014) were invited to participate. An independent research team contacted by email the focal point from each association providing a brief description of the aim of the study and inviting them to take part.

Data were collected through a self-completion questionnaire (copy available from first author), which was developed and pretested, by an independent research organisation contracted to coordinate the SoWMy2014 and members of the ICM Research Standing Committee. The questionnaire was organised in six groups of questions, collecting information about the involvement of different institutions including midwives associations in the planning process and national planning dialogue, and their perceptions about the type of processes and approaches, the use of guidelines and tools to inform decision-making at country or government-level and about their participation and roles in this process. The questionnaire included both tick-box and open-ended questions, where respondents were invited to give their answers in their own words. As different definitions of a midwife are used across countries, in this study we used the definition from the International Standard Classification of Occupations (ISCO 2008) (ILO, 2009). The questionnaire was piloted with three professional associations of midwives from low-, middle- and high-income countries (De Vaus, 2013).

The questionnaire was issued in English, French and Spanish, to all ICM member association representatives through an online research platform. A link to the online questionnaire was provided to participants and displayed on the ICM website. Participants were also given the name of a contact from the research team to provide support during completion and submission.

Completed questionnaires were submitted online or retrieved by email, when online submission was not possible, and recorded in the online platform. The independent research organisation provided technical support for queries and, where required, followed-up with respondents for clarification. Data were entered into an Excel spread sheet and a descriptive analysis was undertaken. For the qualitative information provided in the open-ended questions, a conventional content analysis (Hsieh and Shannon, 2005) was performed, with the identification of categories. Stratification of the members associations by country income group, based on the World Bank classification (low-, middle- and high-) (World Bank, 2014), was performed to identify similarities and differences in the involvement patterns by income group.

The survey was approved by the ICM Board and the ICM Research Standing Committee, and return of the survey was considered as consent. It was considered a quality improvement activity and confidentiality of participants was assured.

Findings

In total, 68% (73 out of 108) of midwives associations from 67 (71%) countries responded. Nearly half ($n=35$, 48%) were from low- and middle-income countries. More than half (56%) of the associations were created between 1980 and 2000, of which 68% were in high-income countries. Of the midwives' associations set up after the year 2000, almost 80% were from low- and middle-income countries.

Involvement in policy and planning

In the participating associations, the planning process to determine the broad provision of reproductive, maternal and newborn health (RMNH) was mainly centralised at the ministry of health level (95%) and involved different institutions and stakeholders, including midwives association (Table 1). Among the most frequently participating groups were the professional associations (midwives – 58, 80% and obstetricians and gynaecologists – 54, 74%) and health facilities (hospitals – 54, 74% and the primary health care services – 47, 64%). In some cases, midwives' associations reported the involvement of community associations (30%) and women's groups (34%) in the national policy planning process. Not-for-profit organisations, such as United Nations agencies and religious institutions were identified by 32% as other institutions that were also often involved.

Similar results were observed in the more specific area of planning for midwifery services, despite the overall decrease in the proportion of institutions (Table 2) involved (midwives