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

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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;

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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

Table 1
Institutions involved in the planning process to determine the provision of RMNH services.

	Yes n (%)	No n (%)	Don't know n (%)	No reply n (%)
Ministries (national and sub-national representatives)				
Health	69 (94.5)	1 (1.4)	–	3 (4.1)
Education	26 (35.6)	34 (46.6)	6 (8.2)	7 (9.6)
Finance	41 (56.2)	20 (27.4)	6 (8.2)	6 (8.2)
Health facilities				
Hospitals	54 (73.9)	11 (15.1)	3 (4.1)	5 (6.9)
Primary health care	47 (64.4)	19(26.0)	1 (1.4)	6 (8.2)
Professional associations of				
Physicians	41 (56.2)	25 (34.3)	2 (2.7)	5 (6.9)
Obstetricians/Gynaecologists	54 (73.9)	11 (15.1)	3 (4.1)	5 (6.9)
Nurses	39 (53.4)	23 (31.5)	3 (4.1)	8 (11.0)
Midwives	58 (79.5)	10 (13.7)	–	5 (6.85)
Other structures				
HRH Observatory (or similar)	33 (45.2)	16 (21.9)	17 (23.3)	7 (9.6)
Community Associations	22 (30.1)	33 (45.2)	12 (16.4)	6 (8.2)
Women's Groups	25 (34.3)	32 (43.8)	8 (11.0)	8 (11.0)
Other	23 (31.5)	14 (19.2)	20 (27.4)	16 (21.9)

Table 2
Institutions involved in the planning process to determine the provision of midwifery services.

	Yes n (%)	No n (%)	Don't know n (%)	No reply n (%)
Ministries (national and sub-national representatives)				
Health	68 (93.2)	1 (1.4)	–	4 (5.5)
Education	22 (30.1)	37 (50.7)	3 (4.1)	11 (15.1)
Finance	30 (41.1)	28 (38.4)	5 (6.9)	10 (13.7)
Health facilities				
Hospitals	51 (69.9)	12 (16.4)	2 (2.7)	8 (11.0)
Primary health care	41 (56.2)	23 (31.5)	1 (1.4)	8 (11.0)
Professional associations of				
Physicians	21 (28.8)	39 (53.4)	3 (4.1)	10 (13.7)
Obstetricians/Gynaecologists	34 (46.6)	24 (32.9)	5 (6.9)	10 (13.7)
Nurses	19 (26.0)	40 (54.8)	2 (2.7)	12 (16.4)
Midwives	52 (71.2)	13 (17.8)	–	8 (11.0)
Other structures				
HRH Observatory (or similar)	29 (39.7)	20 (27.4)	15 (20.6)	9 (12.3)
Community Associations	12 (16.4)	36 (49.3)	12 (16.4)	13 (17.8)
Women's Groups	15 (20.6)	34 (46.6)	12 (16.4)	12 (16.4)
Other	18 (24.7)	15 (20.6)	21 (28.8)	19 (26.0)

associations – 52, 71%; hospitals – 51, 70%; primary health care services – 41, 56%; obstetrics and gynaecology associations – 34, 47%).

The involvement of stakeholders was similar across income groups apart from the women's groups more frequently reported by low-income countries' associations, and the community associations more often in high-income countries (Table 3).

Planning the midwifery workforce required

The perception of midwives associations was that the process through which governments estimate the number of midwives required to provide midwifery services was generally determined at national level (Table 4), as part of the plan for RMNH (63%), the national health plan (58%) or as part of the plan for all HRH (52%). When stratifying midwives' associations by income group (Table 5), it was observed that associations reported more often planning undertaken at national level in middle- and low-income, with at least 80% and 60% respectively reporting at least a type of national planning. In high-income countries, RMNH planning at national level was reported by 52% of the associations.

In middle-income countries, in addition to national planning, midwives associations reported that specific plans for midwifery were developed in just under half (47%) of countries. In high-income countries, associations reported what seemed a mixed use of processes, with 45% reporting a national plan specific to midwifery and 40% reporting midwifery workforce sub-national planning at facility level (Table 4).

The respondents were unclear regarding which planning process they considered the most important: nearly 40% of the associations did not answer this question (Table 6), whereas only 19% considered the national health plan and 15% the RMNH plan to be the most important. The development of national or RMNH plans seems to be a rather irregular process undertaken only occasionally (33%), across all country income groups.

The perception of midwives regarding the basis on which governments estimate the number of midwives varied across regions. Just over half (55%) of the midwives' associations in low-income countries reported the use of *number of midwives per total population* and 40% in middle-income countries reported the use of *number of midwives per birth* as approaches used for workforce planning (Table 5). There was a low use of benchmarks and guidelines to inform the estimation process (32%) by decision-makers as well as the limited use of tools or software to support the planning process (10%). Guidelines usually included midwives and midwifery staffing strategies, normative and regulatory laws for health facilities and national strategies, road maps and guidelines for RMNH (Table 7).

Involvement in the process of midwifery workforce planning

This section focuses on the qualitative information provided in response to the open-ended questions about their participation and

Table 3
Institutions involved in the planning process to determine RMNH and midwifery decision by midwives income country.

	Low-income n (%), n=20			Middle-income n (%), n=15			High-income n (%), n=38		
RMNH decisions	**Yes**	**No**	**Do not know/ No reply**	**Yes**	**No**	**Do not know/ No reply**	**Yes**	**No**	**Do not know/ No reply**
Ministries*									
Health	17 (85.0)	3 (15.0)	–	15 (100.0)	–	–	37 (97.4)	1 (2.6)	–
Education	10 (50.0)	2 (10.0)	8 (40.0)	4 (26.7)	8 (53.3)	3 (20.0)	12 (31.6)	24 (63.2)	2 (5.3)
Finance	12 (60.0)	1 (5.0)	7 (35.0)	11 (73.3)	3 (20.0)	1 (6.7)	18 (47.4)	16 (42.1)	4 (10.5)
Health facilities									
Hospitals	16 (80.0)	1 (5.0)	3 (15.0)	10 (66.7)	2 (13.3)	3 (20.0)	28 (73.7)	8 (21.1)	2 (5.3)
Primary health care	17 (85.0)	–	3 (15.0)	8 (53.3)	5 (33.3)	2 (13.3)	22 (57.9)	14 (36.8)	2 (5.3)
Professional associations of									
Physicians	13 (65.0)	2 (10.0)	5 (25.0)	9 (60.0)	5 (33.3)	1 (6.7)	19 (50.0)	18 (47.4)	1 (2.6)
Obs/Gyn†	14 (70.0)	1 (5.0)	5 (25.0)	9 (60.0)	3 (20.0)	3 (20.0)	31 (81.6)	7 (18.4)	–
Nurses	13 (65.0)	1 (5.0)	6 (30.0)	8 (53.3)	6 (40.0)	1 (6.7)	18 (47.4)	16 (42.1)	4 (10.5)
Midwives	15 (75.0)	1 (5.0)	4 (20.0)	11 (73.3)	4 (26.7)	–	32 (84.2)	5 (13.2)	1 (2.6)
Other structures									
HRH Observatory (or similar)	13 (65.0)	1 (5.0)	6 (30.0)	8 (53.3)	4 (26.7)	3 (20.0)	12 (31.6)	11 (29.0)	15 (39.5)
Community Associations	5 (25.0)	6 (30.0)	9 (45.0)	3 (20.0)	8 (53.3)	4 (26.7)	14 (36.8)	19 (50.0)	5 (13.2)
Women's Groups	8 (40.0)	5 (25.0)	7 (35.0)	4 (26.7)	7 (46.7)	4 (26.7)	13 (34.2)	20 (52.6)	5 (13.2)
Midwifery services decisions									
Ministries*									
Health	17 (85.0)	–	3 (15.0)	14 (93.3)	–	1 (6.7)	37 (97.3)	1 (2.6)	–
Education	5 (25.0)	6 (53.3)	9 (45.0)	3 (20.0)	8 (53.3)	1 (6.7)	14 (36.8)	23 (60.5)	1 (2.6)
Finance	10 (50.0)	4 (20.0)	6 (30.0)	8 (53.3)	4 (26.7)	3 (20.0)	12 (35.6)	20 (52.6)	6 (15.8)
Health facilities									
Hospitals	15 (75.0)	1 (5.0)	4 (20.0)	7 (46.7)	3 (20.0)	5 (33.3)	29 (76.3)	8 (21.1)	1 (2.6)
Primary health care	13 (65.0)	3 (15.0)	4 (20.0)	6 (40.0)	5 (33.3)	4 (26.7)	22 (57.9)	15 (39.5)	1 (2.6)
Professional associations of									
Physicians	9 (45.0)	3 (15.0)	8 (40.0)	6 (40.0)	5 (33.3)	4 (26.7)	11 (55.0)	1 (5.0)	8 (21.1)
Obs/Gyn†	11 (55.0)	1 (5.0)	8 (40.0)	6 (40.0)	4 (26.7)	5 (33.3)	17 (44.7)	19 (50.0)	2 (5.3)
Nurses	8 (40.0)	3 (15.0)	9 (45.0)	3 (20.0)	8 (53.3)	4 (26.7)	8 (21.1)	29 (76.3)	1 (2.6)
Midwives	13 (65.0)	2 (10.0)	5 (25.0)	8 (53.3)	6 (15.8)	2 (13.3)	31 (81.6)	6 (15.8)	1 (2.6)
Other structures									
HRH Observatory (or similar)	12 (60.0)	1 (5.0)	7 (35.0)	5 (33.3)	5 (33.3)	5 (33.3)	12 (31.6)	14 (36.8)	12 (31.6)
Community associations	3 (15.0)	6 (30.0)	11 (55.0)	1 (6.7)	8 (53.3)	6 (40.0)	8 (21.1)	22 (57.9)	8 (21.1)
Women's groups	3 (15.0)	5 (25.0)	12 (60.0)	2 (13.3)	6 (40.0)	7 (46.7)	10 (26.3)	23 (60.5)	5 (13.2)

* National and sub-national representatives.
† Obs/Gyn – Obstetrician/Gynaecologist.

Table 4
Process through which governments estimate the required number of midwives or midwifery workforce.

	Yes n (%)	No n (%)	Don't know n (%)	No reply n (%)
National				
Health plan	42 (57.5)	19 (26.0)	7 (9.6)	5 (6.9)
Plan for RMNH	46 (63.0)	17 (23.3)	5 (6.9)	5 (6.9)
Plan for all HRH	38 (52.1)	21 (28.8)	10 (13.7)	4 (5.5)
Plan specific to midwives	31 (42.5)	27 (37.0)	7 (9.6)	8 (11.0)
Sub-national				
Plan for all HRH	26 (35.6)	26 (35.6)	14 (19.2)	7 (9.6)
Plan specific to midwives	21 (28.8)	31 (42.5)	12 (16.4)	9 (12.3)
Facility-based planning[a]	26 (35.6)	25 (34.3)	12 (16.4)	10 (13.7)
Commissioned review to inform government planning	22 (30.1)	29 (39.7)	13 (17.8)	9 (12.3)

[a] Following national planning guidelines.

roles in the process of workforce planning and policy development. Across all countries, midwives' associations reported challenges in being able to effectively influence policy, planning and decision-making processes and ensuring the role of the midwife was understood. While there are some similarities different themes emerged from high-income countries compared with low- and middle-income countries, which are shown separately below.

Midwives associations in high-income countries

The associations in high-income countries identified four main categories that reflect the diversity of planning processes. These are summarised below with illustrative quotes.

'There is no planning for midwives'

A lack of planning – either by the lack of professional recognition or by the limited involvement in policy discussions and decision-making processes was evident. For example:

> *Midwifery is not an autonomous profession and we are not involved in decisions or planning of the profession.*

> *The role of our association is mostly educational – we are not regularly invited to provide evidence or support the process of government planning.*

Table 5
Process and basis used to estimate midwives by midwives association income country.

	Low-income n (%), n=20			Middle-income n (%), n=15			High-income n (%), n=38		
	Yes	No	Do not know/ No reply	Yes	No	Do not know/ No reply	Yes	No	Do not know/ No reply
Process to estimate midwives									
National									
Health plan development	14 (70.0)	1 (5.0)	5 (25.0)	12 (80.0)	1 (6.7)	2 (13.3)	16 (42.1)	17 (44.7)	5 (13.2)
Plan for RMNH	12 (60.0)	2 (10.0)	6 (30.0)	14 (93.3)	1 (6.7)	–	20 (52.6)	14 (36.8)	4 (10.5)
Plan for all HRH	13 (65.0)	1 (5.0)	6 (15.0)	12 (80.0)	1 (6.7)	2 (13.3)	13 (34.2)	19 (50.0)	6 (15.8)
Plan specific to midwives	7 (35.0)	5 (25.0)	8 (40.0)	7 (46.7)	4 (26.7)	4 (26.7)	17 (44.7)	18 (47.4)	3 (7.9)
Sub-national									
Plan for all HRH	9 (45.0)	4 (20.0)	7 (35.0)	7 (46.7)	1 (6.7)	7 (46.7)	10 (26.3)	21 (55.3)	7 (18.4)
Plan specific to midwives	6 (30.0)	6 (30.0)	8 (40.0)	4 (26.7)	4 (26.7)	7 (46.7)	11 (29.0)	21 (55.3)	6 (15.8)
Facility-based planning[a]	5 (25.0)	6 (30.0)	9 (45.0)	6 (40.0)	3 (20.0)	6 (40.0)	15 (39.5)	16 (42.1)	7 (18.4)
Commissioned review	7 (35.0)	4 (20.0)	9 (45.0)	3 (20.0)	5 (33.3)	7 (46.7)	12 (31.6)	20 (52.6)	6 (15.8)
Basis to estimate midwives									
Midwives per total population	11 (55.0)	3 (15.0)	6 (30.0)	5 (33.3)	7 (46.7)	3 (20.0)	3 (7.9)	23 (60.5)	12 (31.6)
Midwives per WCBA[†]	8 (40.0)	5 (25.0)	7 (35.0)	2 (13.3)	10 (66.7)	3 (20.0)	5 (13.2)	20 (52.6)	13 (34.2)
Midwives per births	6 (30.0)	5 (25.0)	9 (45.0)	6 (40.0)	8 (53.3)	1 (6.7)	13 (34.2)	13 (34.2)	12 (31.6)
Midwives per pregnancies	4 (20.0)	6 (30.0)	10 (50.0)	2 (13.3)	10 (66.7)	3 (20.0)	4 (10.5)	19 (50.0)	15 (39.5)
Midwives by type of facility	7 (35.0)	3 (15.0)	10 (50.0)	4 (6.7)	6 (40.0)	5 (33.3)	6 (15.8)	16 (42.1)	16 (42.1)
Midwives per beds in a facility	2 (10.0)	7 (35.0)	11 (55.0)	2 (13.3)	11 (73.3)	2 (13.3)	6 (15.8)	19 (50.0)	13 (34.2)
Time units to deliver services[‡]	–	8 (40.0)	12 (60.0)	2 (13.3)	8 (53.3)	5 (23.3)	2 (5.3)	21 (55.3)	15 (39.5)

[a] Following national planning guidelines.
[†] WCBA – women of childbearing age.
[‡] Time units in minutes.

Table 6
Processes identified as the most important to estimate the required midwives.

	n (%)
National	
Health plan	14 (19.2)
Plan for RMNH	11 (15.1)
Plan for all HRH	7 (9.6)
Plan specific to midwives	6 (8.2)
Sub-national	
Plan for all HRH	–
Plan specific to midwives	2 (2.7)
Facility-based planning[a]	1 (1.4)
Commissioned review to inform government planning	2 (2.7)
Other	1 (1.4)
No reply	29 (39.7)
Total	73 (100.0)

[a] Following national planning guidelines.

Table 7
Benchmarks and tools used to support the midwifery planning process.

	Yes n (%)	No n (%)	Don't know n (%)	No reply n (%)
Geographical location	12 (16.4)	43 (58.9)	14 (19.2)	4 (5.5)
Levels of care[a]	10 (13.7)	46 (63.0)	14 (19.2)	3 (4.1)
Guidelines	23 (31.5)	33 (45.2)	13 (17.8)	4 (5.5)
Planning tool or software	7 (9.6)	42 (57.5)	20 (27.4)	4 (5.5)

[a] Including primary, secondary and emergency services.

'Planning is conducted at sub-national and particularly at hospital level'

Planning was conducted at sub-national level, particularly at hospital level – which was a hindering factor for the associations:

> *The government supports the hospitals, but the CEO of each hospital can decide, what sections of their hospital, for example the maternal and newborn section, he wants to close down.*

The staffing ratio of midwives is set by the local hospital authority.

'Financial issues influence the process of decision-making'

Planning was often based on financial issues, particularly at hospital level where most decisions were budget-based. Respondents mentioned the impact of the financial crisis on the recruitment and deployment of midwives:

> *Midwives are reimbursed in some areas, though in some hospitals, midwives are used to save money. We are a profit driven society and don't really have a national health care planning policy in place sadly.*
> *There is no real planning. In reality the maternity homes, clinics and hospitals take as many midwives at work as they can pay.*

'Planning is informed by midwives associations'

Respondents perceived that planning was informed by midwives associations and some have developed capacity to estimate midwifery needs through innovative approaches. For example:

> *As our government has not set out the standard for appropriate midwife positioning, our association is now working on calculating the numbers of the midwives needed.*
> *There is national guidance on numbers of births per midwife, but no minimum ratio advised. Our association advocates strongly for a national ratio of 1:28 and this is widely accepted.*

'Midwives' associations in low- and middle-income countries'

The associations in low- and middle-income countries identified three main categories, which illustrated their challenges in influencing planning and decision-making processes.

'Lack of recognition of the profession'

The lack of recognition of the profession and on its overall strengthening, rather the planning processes, through the improvement training, skills, best practices and regulation was highlighted as an issue. For example:

> *The government shows no interest in midwifery at all, but as an association we are trying to continue to have education sessions for*

midwives, whereby we can increase the knowledge and skill for midwives, as we strive to achieve MDG goals 4 and 5.

The association is only 4 years old and initially it had a very high resistance from the nursing council and association as well as the top most officials in the Ministry of health. It is only now that midwifery association is gaining recognition.

'Limited influence in the decision making process'

There were examples of limited but increasing influence in the decision making process:

We have not participated in the planning of midwifery services despite our advocacy for improved maternal and newborn services.

The Midwifery Association has not been always directly involved in planning provision of midwifery association. In recent years we approached the Secretary for Health and asked to be involved in stakeholders' meetings to do with midwifery issues thereafter, we are involved in such meetings and we are still working hard towards collaboration with the Ministry of Health and other stakeholders.

'A focus on capacity building and strengthening midwifery'

There was a strong focus on strengthening the midwifery profession through skills development and capacity building in the areas of regulation and education. This meant that there was less time available for policy development. For example:

The Association is performing different activities to insure the quality of midwifery education and care in the country … for example, we developed code of ethics and conduct for midwives, a scope of practice for midwives at all levels with the regulatory body and a standard of midwifery care practice to ensure quality of care.

The professional organisation is involved in setting up midwifery education and services, standards and policies.

In summary, while some issues faced by associations differed by income strata, there were also similarities especially the need for professional recognition to enable effective participation in policy and planning.

Discussion

This study described the involvement of ICM members associations in policy and planning approaches for SRMNH and specifically in midwifery services. Overall it showed that midwives' associations from countries of all income levels were involved in the policy-making processes for midwifery, usually under the leadership of the Ministry of Health. However, the degree of involvement was often limited by the lack of professional recognition or understanding of the role of the midwife.

The development of a workforce is both a political and technical process shaped by the characteristics of the countries and the strength of the professional associations. The selection of planning mechanisms and projection approaches reflect the countries' different political, economic and social characteristics and values, as well as their health systems structures (Dreesch et al., 2005; Dussault et al., 2010). Therefore, our findings may reflect different policy definitions of workforce development, or situations where our concepts of planning and estimating approaches do not apply to the national context. It is a limitation that the study only examined 'perceived' degree of involvement and knowledge from the perspective of the associations and not whether these processes were indeed used by governments at country level. Further research could cross-validate these perceptions and experiences with reality.

As a political process, governments, usually through the Ministry of Health, assume a leadership role in workforce planning, which is essential for the development of the health workforce (WHO, 2006). The capacity of professional associations to participate in the process of decision- and policy-making is influenced by how the government views external stakeholders and the nature of their relationship with them. A study conducted by the International Federation of Gynecology and Obstetrics (FIGO) involving its professional society members, showed that the nature, length and quality of the relationship established with the Ministry of Health shaped the capacity of professional associations to engage in policy dialogue and influence policy and strategy adoption and implementation (Andrews et al., 2014). Long-standing and respected relationships increased the capacity and empowered professional associations to influence decision-making through their stakeholder role and their involvement in the process from decision-making to implementation (Andrews et al., 2014).

Although these findings suggest that the number of years of existence and experience of professional associations are critical for successful engagement in the decision-making processes, our study seems to indicate that successful engagement is more related to whether workforce development is a priority defined by the associations themselves. This was found to hold true across ICM members associations regardless of their income group. Associations tended to be more focused on professional recognition and regulation as well as on their own internal strengthening, rather than on workforce planning processes.

Gender issues and public opinion may also influence the relationship that midwives associations have with authority and leadership. As midwifery is mostly a female profession, in some contexts, the lack of recognition of women as credible negotiation partners can constrain the involvement of midwives associations in policy dialogue and decision-making. If associations are visible and show commitment to the priorities of the general population, they will gain influence in the process of policy-making and may receive media attention and promotion (Chamberlain et al., 2003; Andrews et al., 2014).

The planning and development of the midwifery workforce requires information, expertise and technical competence (Sales et al., 2013). Professional associations are an important source of information, and when adequately strengthened can provide technical support and evidence (WHO et al., 2009). They benefit from 'direct' access to health workers, potentially contributing to a better understanding of who the midwives are, their qualifications, their capacities and performance and their in- and out-flows along the working lifespan (WHO et al., 2009). However, in our study we observed that midwives' associations had limited access to data either due to this being under the Ministry of Health's responsibility or due to a lack of capacity to hold the information required. This could also result from the limited capacity to effectively use the data and tools to generate knowledge on the best planning and policy approaches (WHO et al., 2009). As demonstrated in other studies, one of the main challenges for health care professional associations is the lack of workforce planning competencies and expertise resulting from limited resources and financial capacity of the associations to recruit staff with the needed skills (Chamberlain et al., 2003; Andrews et al., 2014).

The midwifery workforce planning processes are often developed under the umbrella of RMNH or National Health plans that lack specificity on the role of the midwife. Although joint planning of the national health plan can favour the integration of RMNH workforce requirements with health priorities in other sectors, it may also favour the most dominant health professional cadres (Dreesch et al., 2005), giving less space for the discussion of other cadres' roles. Sub-national planning was scarcely found, and if at all, then mostly in high-income countries. Health plans that consider basic health geographies, like regions or districts, seem to better fit the needs of the population (UNFPA et al., 2014). Understanding the

labour market dynamics and taking into account health care professional mobility at all levels could also support the process of planning current and future midwifery workforce needs (Ten Hoope-Bender et al., 2014; UNFPA et al., 2014).

Midwives' associations are valuable actors in the development of the profession and for the delivery of quality SRMNH services. Robust planning and strong policies need to be in place to support and guide the path to UHC. The *Midwifery2030* vision in SoWMy 2014 details how a woman's pathway to health is supported by a midwifery workforce that is available, accessible, acceptable and providing quality care so that effective coverage can be assured (Shamian, 2014; UNFPA et al., 2014). The supporting pillars of this vision include a supportive and enabling environment for midwifery workforce; the role of data (collection and analysis) to inform decisions and professional development; and, the role of professional associations (UNFPA et al., 2014). Professional associations are important partners in national policy discussions and decisions about maternal and newborn health, however, our study shows that their roles in these planning processes are quite limited (Shamian, 2014). While midwives associations may not need to be full planning experts, they can make unique and important contributions if adequately enabled to use and understand data gathering and analysis for workforce development and planning, if they are regarded as a valued partner in these important national discussions.

The midwives' associations could actively participate in a range of policy-leadership processes. Anecdotally, however ICM have found that there is a lack of competency in advocacy, resource mobilisation and leadership and management skills within the member associations. ICM currently assists member associations with developing strategic action plans to address specific areas of need including data collection to inform workforce needs and policy. Using a wide network of consultants and partners, ICM builds the capacity needed for the association's staff (for example through, advocacy workshops, leadership programmes and twinning projects (ICM, 2014c)), to improve competence in the areas of advocacy, negotiation, planning and projection (ICM, 2011b) and has identified the areas that require strengthening to be advocacy competencies and leadership/management skills. Further research could help establish a profile of success factors for professional associations as stakeholders and partners in decision- and policy-making.

The three main principles for successful workforce strategies, planning and development are: act now, anticipate the future and acquire critical capabilities (WHO, 2006). These principles also apply to midwives and their associations as partners in this process. The capacity of midwives associations' to influence decision-making can be strengthened through focussed training and supportive measures that guide and establish their roles in workforce strategies. This can be done through Memoranda of Understanding with the Ministry of Health (Andrews et al., 2014) that identify their roles and collaborative activities, and the expected outcomes of their involvement. Also, capacity of midwives association can be built (for example through twinning projects promoted by ICM (ICM, 2014c)), to improve workforce planning and projection competence.

Conclusion

This study provided new insights into the roles and capacities of midwives associations in policy dialogue and decision-making and contributed to closing a knowledge gap on the process of planning and development of the midwifery workforce. Midwives associations can have a meaningful contribution to the achievement of the goals of universal health coverage only if are enabled to be involved in key decisions and contribute to policy development, with the support of data, evidence and knowledge for strengthening their capacity and roles.

Conflict of interest

The authors declare they have no competing interests.

Authors' contributions

SL contributed to data collection, analysis and write-up. PHB contributed for data analysis, interpretation and write-up. PT, MB and CH contributed to write-up. All authors read and approved the final manuscript.

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Appendix A. Supporting information

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References

Andrews, H., Perron, L., Vander Plaetse, B., Taylor, D.J., 2014. Strengthening the organizational capacity of health professional associations: the FIGO LOGIC toolkit. Int. J. Gynecol. Obstet. 122, 190–191. http://dx.doi.org/10.1016/j.ijgo.2013.06.002.

Campbell, J., 2013. Towards universal health coverage: a health workforce fit for purpose and practice. Bull. World Health Organ. 91, 886–887.

Campbell, J., Dussault, G., Buchan, J., et al., 2013. A universal truth: no health without a workforce. Forum report, Third Global Forum on Human Resources for Health. Recife, Brazil. Global Health Workforce Alliance and World Health Organization, Geneva.

Chamberlain, J., McDonagh, R., Lalonde, A., Arulkumaran, S., 2003. The role of professional associations in reducing maternal mortality worldwide. Int. J. Gynecol. Obstet. 83, 94–102. http://dx.doi.org/10.1016/S0020-7292(03)00185-1.

Clift, C., 2012. Is Universal Health Coverage Good for Health? Universal Health Coverage and the Post-2015 Development Agenda. World We Want 2015 [online].

De Vaus, D., 2013. Surveys in Social Research, Social Research Today. Taylor & Francis.

Dreesch, N., Dolea, C., Dal Poz, M.R., et al., 2005. An approach to estimating human resource requirements to achieve the Millennium Development Goals. Health Policy Plan. 20, 267–276. http://dx.doi.org/10.1093/heapol/czi036.

Dussault, G., Buchan, J., Sermeus, W., Padaiga, Z., 2010. Assessing Future Health Workforce Needs. WHO Regional Office for Europe, Brussels.

Hsieh, H.-F., Shannon, S.E., 2005. Three approaches to qualitative content analysis. Qual. Health Res. 15, 1277–1288. http://dx.doi.org/10.1177/1049732305276687.

ICM, 2011a. Member Association Capacity Assessment Tool (MACAT).

ICM, 2011b. Member Association Capacity Assessment Tool (MACAT) Guidelines.

ICM, 2012. International Confederation of Midwives: Vision and Mission [WWW Document]. ⟨http://www.internationalmidwives.org/who-we-are/vision-mission/⟩.

ICM, 2014a. Education, Regulation and Association [WWW Document]. ⟨http://www.internationalmidwives.org/what-we-do/education-regulation-association/⟩.

ICM, 2014b. Why and How to Create a Midwives Association [WWW Document]. ⟨http://www.internationalmidwives.org/who-we-are/midwives-associations/create-a-national-association.html⟩.

ICM, 2014c. Twinning Programmes [WWW Document]. ⟨http://internationalmidwives.org/projects-programmes/twinning-twinning-projects-programmes.html⟩.

ILO, 2009. ISCO-08 Definitions.

PMNCH, 2012. Women and Children's Health in the post-2015 Development Agenda [WWW Document]. World We Want 2015 [online]. ⟨http://www.worldwewant2015.org/node/300588⟩ (last accessed 10 January 2013).

Renfrew, M.J., McFadden, A., Bastos, M.H., et al., 2014. Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care. Lancet 384, 1129–1145. http://dx.doi.org/10.1016/S0140-6736(14)60789-3.

Sales, M., Kieny, M.-P., Krech, R., Etienne, C., 2013. Human resources for universal health coverage: from evidence to policy and action. Bull. World Health Organ. 91, 798–798A. http://dx.doi.org/10.2471/BLT.13.131110.

Shamian, J., 2014. Interprofessional collaboration, the only way to save every woman and every child. Lancet 384, e41–e42.

Sheikh, M., Cometto, G., Duvivier, R., 2013. Universal health coverage and the post-2015 agenda. Lancet 381, 725–726. http://dx.doi.org/10.1016/S0140-6736(13)60580-2.

Shetty, P., 2014. More midwives needed to improve maternal and newborn survival. Bull. World Health Organ. 91, 804–805.

Ten Hoope-Bender, P., de Bernis, L., Campbell, J., et al., 2014. Improvement of maternal and newborn health through midwifery. Lancet 384, 1226–1235.

UNFPA, ICM, WHO, 2014. The State of the World's Midwifery 2014: A Universal Pathway. A Woman's Right to Health. United Nations Population Fund, New York.

WHO, 2006. Working Together for Health. The World Health Report, 2006. World Health Organization, Geneva.

WHO, 2008. Establishing and monitoring benchmarksfor human resources for health: the workforce density approach. Spotlight Health Workforce Stat. 6 ⟨http://www.who.int/hrh/statistics/Spotlight_6_Nov2008_benchmarking.pdf⟩.

WHO, 2010. Models and tools for health workforce planning and projections. Hum. Resour. Health. Obs. 3 19 pp ⟨http://apps.who.int/iris/bitstream/10665/44263/1/9789241599016_eng.pdf⟩.

WHO, 2012. Positioning Health in the post-2015 Development Agenda: WHO Discussion Paper [WWW Document]. World We Want 2015 [online], WHO Discussion Papers. ⟨http://www.worldwewant2015.org/node/279357⟩ (last accessed 10 January 2013).

WHO, 2013. Nursing and Midwifery Progress Report 2008–2012. World Health Organization, Geneva.

WHO, World Bank, USAID, 2009. Handbook on Monitoring and Evaluation of Human Resources for Health: with Special Applications for Low- and Middle-Income Countries. World Health Organization, Geneva.

World Bank, 2014. World Bank Countries Classification [WWW Document]. ⟨http://data.worldbank.org/about/country-and-lending-groups⟩.

World Health Organization, 2014. What is Universal Health Coverage? [WWW Document]. ⟨http://www.who.int/features/qa/universal_health_coverage/en/⟩.