

The International Confederation
of Midwives

MIDWIFERY LEADERS SHOWCASE





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Introduction

One thing is clear when you read these stories: midwives are taking the lead over their own work, their own training, their own registration, their own salary, their own environment, their own research. It fills me with pride and optimism to see midwives taking the lead over their own lives. Every woman deserves such a midwife by her side.

Much has been written about women and leadership. We are said to be empathic, open, intuitive, collaborative and a true asset if a problem needs to be solved. For me, the most inspiring and accessible description is the eight characteristics of women leadership described by Dr. Lorri Sulpizio, the director of the Women's Leadership Academy in the Department of Leadership Studies at the University of San Diego. She describes leadership as a choice and as a lifestyle. All the midwives featured in this Midwifery Leaders Showcase embody their leadership as a lifestyle, and have made conscious choices to bring their unique, authentic personalities into how they lead.

Optimism shines through in nearly every story, and especially that of Felicity Ukoko. Karen Guilliland champions a strong and powerful *voice*. *Persistence* hits you in the face reading Soo Downe's story. *Passion and purpose* shines through in every single story, and a strong *sense of self and confidence* comes across when we read Petra ten Hoope-Bender's journey. *Embracing change* can be found in the work and ethos of Gloria Flores, and the ability to *seek and receive support* is a defining quality of Nazgul Shadybekova. Last but not least: *authenticity* is a most crucial quality of leadership, and possibly the hardest to attain, because by embracing who we truly are, we need to let go of who we think we are supposed to be. That is what these midwife leaders do. They are willing to be the authors of their own stories and empower us to write our own.



Franka Cadée





Karen Guilliland: The Activist



It's said that true leaders represent the interests of the people who have invested in them moreso than they do themselves: a conduit, if you will. When Karen Guilliland, Chief Executive of the New Zealand College of Midwives (NZCOM), speaks of women and midwives in New Zealand – praising their sheer passion, resilience and tenacity in the recently respawned battle for the sexual, reproductive and maternal health services – that characterisation makes perfect sense.

And, like all effective leaders, she is quick to shrug off any praise.

“I was never particularly ambitious,” she says, “But everything changed when I became pregnant. I realised what a horrendous experience [birth] could be for some women. I had my children in a birthing unit and I was quite sure about how I wanted the process to be, but I realised other women didn't have these opportunities.”

It was 1978 when Karen, with her newborn in tow, began to advocate for patients' rights. At the time, midwives were not intuitively political in New Zealand, but their engagement in the womens' rights movement was a perfect fit in the debate for women to have bodily autonomy and access to contraception. Issues that now, Karen is quick to point out, are the same today as they were 40 years ago.

New Zealand is the home of one of the highest-quality midwifery services in the world, where a woman-centred community of maternity care model in primary health has enabled women to have continuous care from midwives within both community and medical settings. Evidence has found that this access empowers women to have the kind of birth they want, and mothers in New Zealand are rated amongst the most satisfied with their birth experiences in the world.

The implementation of this system over two decades ago was an uphill battle at times for midwives like Karen, who campaigned heavily alongside countless women who wanted this service. Acceptance was a triumph; implementation, a success. But the enabling environment around woman-centred midwifery care is becoming less pliable under a more right-wing government over the last 9 years. Midwives are working longer hours, underpaid, exhausted, and carrying unsustainable caseloads – all while challenged on their ability to provide care in the community and home. This has enormous ramifications not just for midwives themselves, but the mothers and newborns who rely on them. Karen sees this as an innately gendered issue.

“Though so much has changed, many people in the health sector still don’t believe a women’s profession is capable of being autonomous. Midwifery is a profession that other people feel needs to be supervised. We shouldn’t have to prove over and over again that midwives are capable and competent to practise wherever they’re needed.”

The professional respect midwives are demanding should be commonplace, but is not consistent with either policy or pay. In 2016, NZCOM launched a high-profile court challenge to the New Zealand Government, citing a pay equity gap of somewhere between thirty and sixty percent. It was a David and Goliath battle that led to an initial mediation agreement that could begin to bridge the equity gap. It came with an agreement from the Ministry of Health to work with NZCOM in co-designing a new funding model for midwives. That should have been the end of the battle but in 2017 – despite the Ministry being a co-designer – they failed to support or recommend the new funding model when providing its health briefing to the newly-elected Government. Accordingly, midwives have found themselves forced to reassert their value.

The movement was to encourage women to make their voices heard. Every single politician in New Zealand has been visited by at least one woman and her midwife to be educated on the importance of midwives in a functioning health system. The response from women was simple, grassroots and overwhelming: the ‘Dear David’ campaign, so named for Health Minister David Clark, began in March 2018 and joined in with the Colleges pay equity court and mediation work, Facebook and twitter campaign.

The Dear David letters capture the essence of midwifery – honest, human stories from midwives and mothers that reinforced the importance of this relationship. They detail the sacrifices of midwives in their professional practise – from the rural midwife who drove 600 kilometres in one week and earned only \$7 an hour, to the midwife who is forced to work part time at a café to supplement her vocational salary, to the midwife who wet herself after 3 hours of waiting for a fellow hospital staff member to relieve her during a complicated labour. And though all of the stories, it is clear that there is no bitterness nor resentment against the women – just frustration with working conditions that exploit their devotion to the people who need them most.

The media has been instrumental in providing a platform to midwives and women who are willing to stand up and be counted to share their stories openly. And the country is listening, in no small part, Karen believes, because of the intimate relationship between women and their midwives.

“We are hearing story after story from women saying: ‘My midwife saved my life’. The model of care is loved by both midwives and women, but it is neglected because successive Governments won’t establish structural support or income. This is why women’s voices are so important: they understand that advocating for women – from the highly-educated to the completely impoverished – is what a midwife does. Not every society has placed a value on that yet; there’s still a struggle to see a woman navigate a whole maternity episode and come out a strong woman and mother. But what keeps midwives going is that women do appreciate it, and they are saying so.”

Perhaps what makes midwives and women such a formidable pairing is their intuitive similarities: in many medical systems around the world, the capacity of midwives is dismissed despite incontrovertable evidence, and women are regarded as risk-laden incubators. The common thread, Karen believes, is gender.

“Midwifery is a feminist profession – it has to be if we are to keep women protected and in control of their experiences at such a vulnerable time in their life,” she says, “Our whole reason for being is to give women and their families the best maternity experience they can have, but we still fight the

same gender discrimination. It's not as overt, but it's still there. Birth is a profound life event and has enormous consequences if you get it wrong. Many health professionals see childbirth as a medical crisis waiting to happen, but midwives believe in the ability for women to give birth. We want to protect that."

The battle is not limited to just birthing centres and hospitals – it's interweaved throughout the entire medical system. Midwives are a female-dominated and female-oriented profession, and accordingly suffer the expected – and sometimes unexpected – discrimination. In New Zealand in 2018, Karen believes that the issues continue to centre around autonomy: both the woman's and the midwife's.

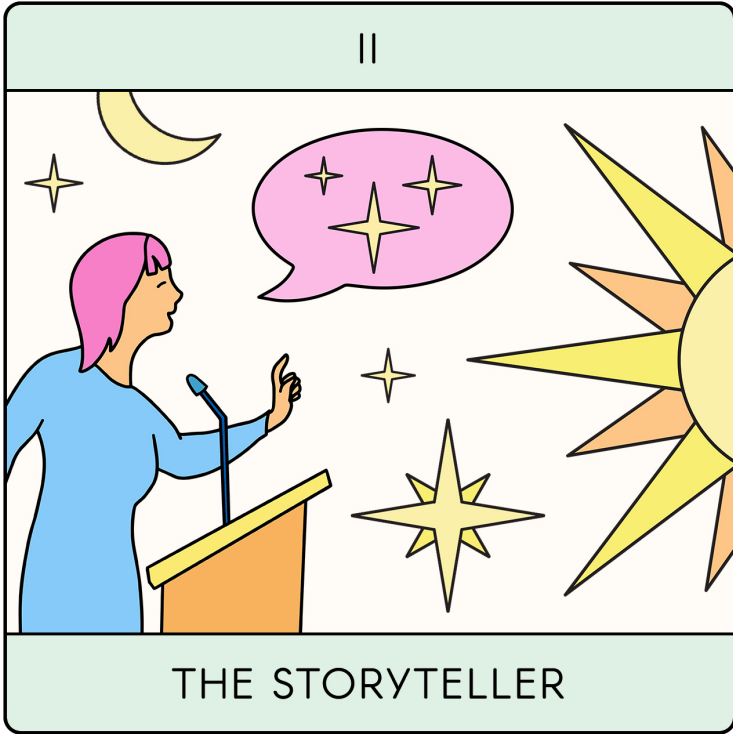
"It's quite a lesson in understanding the gendered nature of the profession, having it pointed out to you again in ten-year cycles and needing to keep fighting for it. The part we played 27 years ago is now being replayed, almost word-perfectly. It says to me that no matter what midwives achieve, if we can't fix the gender inequality in society, we'll never be able to achieve a sustainable midwifery workforce."

Ultimately, it seems New Zealand's midwifery crisis is an issue of perception versus reality: midwives are skilled and passionate, yes... but without an enabling environment, burnout is inevitable. But Karen says this new government is listening so she is confident that the situation can be turned around as long as fidelity to midwifery's core philosophy continues.

"Leadership has to be woman-centred," she says, "If the system doesn't work and a woman doesn't want to use a midwife's service, there's no way to persuade her otherwise. This campaign has made it clear that midwives in New Zealand offer a service that women want. Midwifery is a very successful model of care – it is reliable and competent. That's what makes me proud."

The mandate is ambitious, but when Karen says, "I'm not giving up", history shows, she means it.





Soo Downe: The Storyteller



Of all the midwives in all the world, Soo Downe may be one of the least likely to have wound up in the profession at all. A whimsical speaker whose reflections shift between academic terminology and no-nonsense brass tacks, her capacity to spin a story is enchanting. And no surprise, either: having studied Literature and Linguistics, Soo's vocation of midwifery came after a totally unexpected 'Road to Damascus' experience during a week working in a maternity unit in apartheid-era South Africa – a story (she says to my disappointment) for another time.

"It was a complete transformation," she says, effervescent in her enthusiasm even after all these years, "I felt like if we could get birth right, we could get the world right."

After some years working as a clinical midwife on a busy labour ward, she had many questions that she felt needed to be asked. At this point, she wanted to be a research midwife, but in the early 1990's in the United Kingdom, the concept did not really exist. After 15 years working in the National Health Service, during which the philosophy of midwifery continued to enchant her, Soo moved into a higher education system that was now ready to cultivate the curiosity of clinical practitioners like her. When speaking of qualitative research, Soo comes truly alive: her enthusiasm is contagious as she describes how human-oriented research has changed otherwise impersonal models of health care structure and provision.

"I really like to combine storytelling with research because audiences respond to stories," Soo says, "Qualitative research is one way to capture stories systematically – it has become much more acceptable to the mainstream. Researchers are increasingly aware that interpretation of data is a kind of story, but that, in academic research, you have to be clear about ensuring the story is rooted in the data. This is not the same as telling

an individual story. One of the reasons the World Health Organisation (WHO) now have guidelines for positive antenatal and intrapartum care is partly because, with the support of the WHO leads for the guidelines, we presented qualitative data from women to the WHO guideline development group and they saw women's stories reflected in the data. This completely changed the tone of the discussions, and influenced what was seen to be important about the recommendations made."

Soo, who co-authored "The Roar Behind the Silence: Why kindness, compassion and respect matter in maternity care" alongside Sheena Byrom, mentions the aforementioned values often. The kind of research she does requires substantial transparency and trust from the women and families she works with, and it is clear that this responsibility to do these people justice influences every story that is told about the research: the good, the bad and the tragic.

"There's an ethical obligation in this kind of storytelling to make sure the stories that emerge from research are rooted in – well, perhaps not absolute truth, since that's a fluid concept – but reality," Soo says, "Storytellers can make people believe the most extraordinary things. There's an ethical imperative to make sure stories are told compassionately, authentically, and, if they are about formal research, with constant reference to the underlying data."

The preservation of dignity is important to Soo. Aware of how easy it is to slip into hyperbole, she makes a point of checking with the source of any story whether it has drifted from the initial telling, to make sure that has not drifted from the initial telling. She also tries to maintain the delicate balance of talking positively about childbirth in a world that loves a bad news story – without diminishing the need for balance between both the joyful and the tragic, and keeping women at the centre.

“Women being a hero in their own story – and particularly in stories of birth – is important because women are rarely cast as heroic.”

“It’s the classic archetype of the Heroes’ Tale,” she says, “Women should be the hero in their own story – and particularly in stories of birth. This is important because women are rarely cast as heroic. Even in tragic situations, we need to acknowledge that some women feel they have grown as a result of the experience.. How do you acknowledge the depth of the tragedy without catastrophising it? It is possible for a woman to go through birth experiences that take her to the very edge of her capacity, and for her to emerge as something different, something more... without being scarred by the experience, if she has good support and care, from family members, and from midwives (and where needed, doctors and others), at every stage of the process”

The term ‘normal birth’ is one that many midwives staunchly defend because it empowers women to trust that their bodies are designed to labour and birth as a normal physiological process. However, a linguist can always be relied on to focus on the specific verbiage, and Soo is no exception.

“Some professionals consider a birth ‘normal’ even if it has had every intervention under the sun minus caesarian section,” she says, “Many women who experience multiple interventions perceive their birth as traumatic, especially if they were not supported by professionals, or if they also experienced labour as uncontrollably painful. Despite the trauma, if they give birth vaginally, they are still told their births are ‘normal’. It is hardly suprising that, having experienced this, these women do not want such a ‘normal’ birth next time and they tell stories of their trauma to their pregnant friends. These women then also do not want this kind of birth, and choose a cesearan section or an early epidural as protection.”

Some service user groups argue that using the term ‘normal birth’ means that women who need or seek interventions, as well as those who are exposed to them unnecessarily in the name of risk reduction, are all somehow intrinsically ‘abnormal’. But, Soo says, this is to make the error of mistaking the events that happen for the person they happen to. The complexity is understandable, and Soo emphathises with groups who advocate against the terms ‘normal’ and ‘abnormal’ on this basis.

“Many women experience interventions they or their baby don’t need, or

they do not feel supported when they do need interventions for themselves, and/or for their baby. Some of these women go into their first labour and birth with blind faith that everything we and our colleagues do will be for the best, but, for many, the interventions and attitudes they are exposed to in the name of risk reduction get in the way of their capacity to give birth positively. If women have previously experienced a birth called 'normal' that has left them feeling traumatised – or if they have heard stories of such births being considered 'normal' – it is hardly surprising that they demand interventions like elective caesareans: they don't really feel they have any other viable options. And if they have been exposed to a range of interventions that make their birth 'abnormal', they don't want to feel that they have failed to do birth 'properly'. To reduce this, it is really important that midwives are able to act as active advocates for circumstances in which women are able to labour and birth physiologically, powerfully, and joyfully, as far as they possibly can, and where – if interventions are needed – they can be experienced as helpful and empowering.”

During pregnancy, women are under heavy surveillance and subject to tests and treatments, which can lead them to believe that they cannot trust the baby is safe unless (for example) they receive ultrasounds at every opportunity. Soo believes that stories should be used to explain and challenge this approach.

“Sometimes women and babies need interventions – caesarians are lifesaving when needed, and epidural analgesia can be a profound relief for women experiencing unrelieved labour pain – but when these kinds of intervention become a 'just in case' norm, they can be harmful”, she says, “To counteract this effect, we tell positive birth stories, of joy, love, achievement and transformation. These include stories of women who labour and give birth normally with authentic and dedicated midwifery support, as well as those who have had some complications and who may have needed drugs, a drip or a caesarean, but who have been enabled by the support and encouragement of midwives and others to achieve as positive a birth as possible. If we enable a woman to do as much as she can herself whilst we do what we must to ensure the woman and baby are safe, we increase the chance of her having a positive labour and childbirth, and we maximise the opportunity for her to become a confident and competent mother.”

In light of global discussions to reduce unnecessary caesarean sections – an initiative supported by the World Health Organisation (WHO), the International Confederation of Midwives (ICM) and the International Federation of Gynecology and Obstetrics (FIGO) – the question of what solutions should be put in place are prudent.

“There’s a huge global push to reduce caesarean section rates to reduce short and longer term iatrogenic morbidity, but the proposed solutions often seem to be more interventions, such as routine induction of labour at 39 weeks’ gestation,” says Soo, “This solution itself is expensive, and many women don’t want to be induced (though some do) because it has potential for long-term adverse side effects for both mother and baby. It’s not that people want to do wrong by women and babies, it’s that they’re framing the solution in terms of what will help the few, but that could harm the many. The alternative is to look for solutions that are low cost, sustainable, and have no known or likely long-term adverse effects. For example, continuity of midwife-led care in pregnancy and during birth improves rates of normal birth, and women’s wellbeing. Similarly, companionship during labour reduces rates of caesareans, and is less expensive than routine induction of labour. However, a turn towards these kinds of inter-personal, social, midwifery solutions demands a seismic ideological shift.”

An ideological change of this nature is so immense as to be intimidating, but Soo believes it can happen.

“We’re trying to recount stories that say that maternity care should be framed around BOTH (safety) AND (positive wellbeing) for women, babies, and families throughout the maternity episode, rather than seeing it as a choice between EITHER ensuring safety (mainly of the baby), OR enabling women to have a positive experience,” she says, “If we can use storytelling to change the way maternity care is thought about and provided, towards this ‘both-and’ philosophy, staff, women, families, and the public will demand a different approach. They will reclaim ways of providing maternity care so that it is both a safe and a life-enhancing experience. The evidence shows that what matters most to pregnant women is to have a healthy baby, a normal experience of labour and birth, and the capacity to mother

effectively. The stories we tell are about women who are not just satisfied with labour, but who have a hugely positive and enjoyable experience, even if there are problems, so they can reclaim their self-belief as heroes, and maximise their capacity to effectively mother their children.”

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“Women being a hero in their own story – and particularly in stories of birth – is important because women are rarely cast as heroic.”

-SOO DOWNE



#MidwiferyLeaders #IDM2018 #RespectfulMaternityCare
#WomanCenteredCare #QualityEquityLeadership
#MidwivesLeadingTheWay #TheStoryteller

THE STORYTELLER





Felicity Ukoko: The Healer



Felicity Ukoko passed away unexpectedly at the end of 2017. In this Midwifery Leaders Showcase profile, an as-yet unreleased interview from 2016 has enabled us to remember her as a phenomenal midwife and friend, whilst hearing her story in her own words.

Though the word ‘midwife’ means ‘with woman’, there are many ways to be with a woman. No two midwives are the same in their practice: some are defined by gentleness, others by stoicism. Some are enthusiastic, assertive, any number of combinations – and for every midwife who provides respectful maternity care, there is at least one woman and one newborn who thrives as a result.

Felicity Ukoko’s midwifery style was apparent to even those whom she’d never provided care. With a wry, knowing smile and a measured voice, Felicity was the exact person – both soothing and authoritative – one would want to have with them during pregnancy and childbirth. She laughed often, championed the importance of compassionate midwifery care in her practise, and relished learning everything she could to promote better birth outcomes for mothers and newborns.

Felicity’s impact on the lives of others was profound and far-reaching. Born in Zimbabwe, Felicity trained as a nurse only to experience postpartum haemorrhage during the birth of her first child. Fortunately, she survived, but when she had her second child – this time in a London hospital – her experience was vastly more positive.

“The midwife was kind and respectful. She did little things that meant a lot, like sit down, explain things, and give information. She removed my sutures with care,” she said, “I made a decision then that this was what I going to do for the rest of my life: help other mothers.”

Felicity trained at St George’s Hospital in London, where she was deeply

inspired. Of this period of her life, she said: “It made me truly understand what it means to be ‘with woman’.” This passion for woman-centred care permeated her entire career, which spanned over 20 years. From working as a Specialist Midwife for pregnant asylum seekers at Guys and St Thomas Hospital, helping to deliver the Sure Start government programme in the U.K. which focused on providing a range of maternity services for vulnerable pregnant women and their babies, and being a founding member of White Ribbon Alliance Zimbabwe, Felicity always sought work that would enable her to help make a positive impact on the lives of as many people as possible – even receiving the British Journal of Midwifery’s Community Midwife of the Year award in 2005.

Felicity was a trailblazer in advocating for respectful maternity care in the U.K. She was a fierce proponent of the importance of midwives giving compassionate and well-informed care to women who, in some of their more vulnerable moments, are especially in need of kindness. As the Head of Midwifery Programmes at Wellbeing Foundation Africa, she developed the MamaCare Antenatal Education Programme, which provides education to expectant mothers and their partners on the realities of pregnancy and childbirth. Felicity believed that an informed mother would be better able to tap into her own intuition about her body and her baby, and make the best decisions for their health care.

Felicity was an effusive story-teller: She spoke with a cadence that made you feel like you were being invited to share a delicious secret. There was a sense of intimacy to the stories she told. In them, the women and midwives were always the protagonists through long labours and interventions and miraculous births. Even when it was clear – usually from a skimmed-over remark – that Felicity’s own quick action had saved a life, or many lives, she was quick to deflect praise. It was the work she loved – the women, the families, her fellow midwives, the beauty of pregnancy and childbirth – not the glory.

“So many births have inspired me,” she said, “But there is one in particular; a homebirth. I was the midwife on-call and when I walked into the woman’s house I was met by a room full of relatives and friends: uncles, aunties, a grandmother, a sister. They were all there, keeping the woman company. They said it was a way to distract her from the pain. It was an obviously a close-knit family. I examined her and she was [dilated to] 4 centimetres.

She asked me to run a bath. After an hour, she wanted to push. I told her to relax, breathe and pant as the head was delivered. The baby was delivered, placed onto her tummy and both mother and baby were fine.”

This story, she explained, stood out because it expressed the significance of a calm, relaxed environment during childbirth.

“A relaxed woman in labour, in tune with her body, is less likely to need pain relief or intervention and will have a shortened labour. I totally believe in that. Pregnancy and giving birth can be an overwhelming experience for most women; there is the feeling of anticipation, excitement, fear and joy. The midwife is the most critical person for effective care at the time of birth.”

This, she believed, was universal. Having worked in all settings, Felicity was firm that midwives today face more challenges than ever before. Though vastly different from Zimbabwe, the United Kingdom was not exempt from its own major issues in maternity services – namely, the overloading of midwives and increasingly complex births. In low- and mid-resource settings, midwives suffering from lack of resources, support and opportunities for professional development. The global shortage of midwives is a serious problem, and one that she felt needed a more collaborative approach between midwives, women and policymakers.

“We need to believe in the cause: Identify key players and decision-makers and work with them, galvanise support and ensure everyone understands what is to be achieved, be positive and have gallons of enthusiasm. When we all come together, we can do anything.”

Felicity was a proud advocate for partnership – she did not believe that anybody could make real impact on their own. She understood the importance of a united voice, with midwives supporting each other to influence others to action. Midwives had to stand for what they believed in and understand their right, with sound education and knowledge that could enable them to articulate a compelling argument with facts that could see them defend their positions when required. But for all her affability, she was not afraid to fight for her profession. When asked what her one decree would be if she were Prime Minister or President, she said: “Invest in the midwifery workforce. Equate the role of a midwife to that of a soldier going out to defend your country: ensure the midwives are trained, equipped and paid, and retain them so that our

mothers and babies survive.”

She believed in pushing for accountability, for being assertive, for leveraging the influence of social media, with the command: “Speak up, midwives. Let your voices be heard!”

Despite the numerous challenges the profession faced in the United Kingdom, Zimbabwe and beyond, Felicity was always very optimistic about the future of midwifery. She considered it a rewarding profession that needed more recognition and respect so that midwives could continue to save lives. She believed in the tenacity of midwives to make those changes possible.

One of my favourite stories about Felicity which captured the essence of who she was when, attending a conference, a colleague of hers broke their only pair of shoes on the second day of what was to be a whirlwind five. With limited time to purchase another pair, the colleague accidentally picked up a pair made with painful, stiff leather. Felicity politely – but firmly – insisted that she wear the shoes all day to break them in, and her colleague would borrow the pair she was wearing at that very moment. No matter how much the colleague protested, the day ended with Felicity triumphantly returning the shoes saying, “Now they are broken in.” to the pathetically grateful colleague. And I should know – the colleague was me.

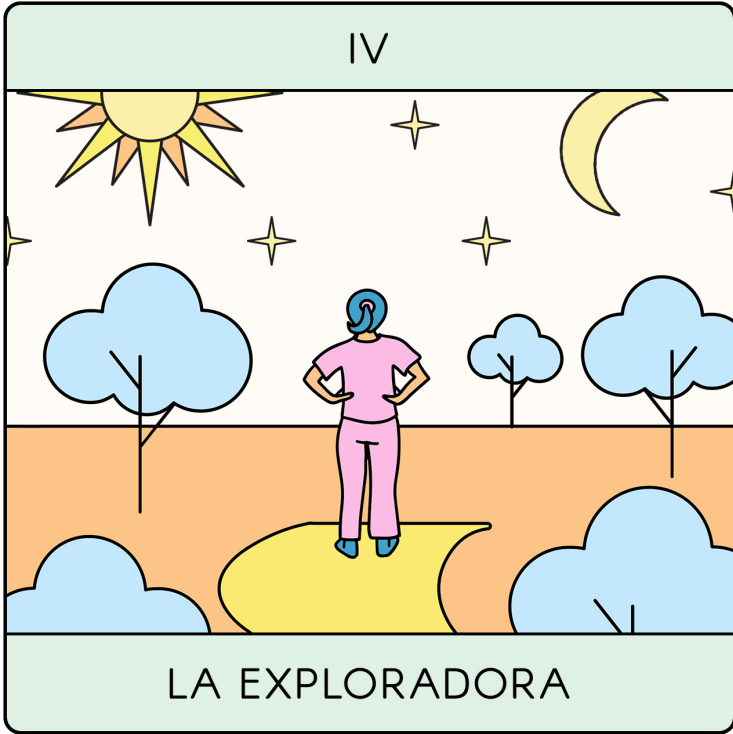
Such was Felicity’s way – she could convince just about anybody to do what she wanted with such graciousness that before long, they would almost thank her for allowing them to do so.

The passing of Felicity at the age of 51 was a grave loss to the midwifery community, the International Development sector, and her friends and family. The programmes she developed, the initiatives she spearheaded and the confidence she instilled in her fellow midwives and women lives on, where her influence continues to grow and spread as more people benefit from her teachings, her mentorship, her light. She was an authentic and earnest person with an inescapable allure: the ideal midwife to be with woman.

In the notes of her initial interview, there is just one concluding remark. It is unrelated to the answer that comes before it. Three words, no context, no embellishment:

Midwives are special.





Gloria Flores: La Exploradora



Se necesita determinación para liderar el cambio, coraje para cambiar las normas y compasión para hacerlo por una causa que afecta a muchos más que a uno mismo. Para convertirse en exploradora; en una persona que avanza y descubre o muestra a otros un camino o sendero, estos rasgos no son solo un requisito, sino herramientas. Herramientas que pueden usarse para lograr resiliencia y justicia. En el caso de Gloria Flores, una enfermera con título de licencia en medicina perinatal, su compasión hacia parteras, madres, recién nacidos y un sistema de salud general en descomposición en su estado de Morelos, México (en las afueras de la Ciudad de México), le ha capacitado para comprometerse con el cambio. Decidida y apasionada, la historia de Gloria surge de un profundo sentimiento de necesidad.

“Cuando comencé a trabajar en un Hospital General en mi estado, fui testigo de los pésimos niveles de atención que recibían las pacientes que necesitaban atención prenatal y posnatal, y me sentí profundamente motivada para crear un camino que me brindase la oportunidad de instigar cambios en la situación de estas personas”, explica Gloria, “Así que me matriculé para obtener un título en la UNAM [la institución nacional de educación superior más grande y más importante de México], especializándome en partería, sin embargo no fue tan fácil como lo anticipé. La fecha límite para comenzar el curso ese mismo año había pasado, el año siguiente me dejaron de lado porque no había completado un curso de inglés específico del que no tenía conocimiento, y en el tercer año insistí y fui aceptada al curso. Como decimos aquí, no quité el dedo del renglón”.

La experiencia de Gloria no es poco común. En todo México, las parteras alcanzan a cubrir apenas el 40% de las necesidades de atención

obstétrica y neonatal. Si bien el Ministerio de Salud de México tiene como objetivo mejorar la calidad y cobertura de los servicios de salud materna y aliviar la demanda excesiva de servicios de maternidad en los hospitales, Gloria vio el gran abismo entre estos objetivos y la realidad en que vivía cada día, por lo que tomó medidas para abrir el camino no sólo para ella misma sino para que otros lo sigan.

“Mi interés actual se centra en orientar y motivar a aquellos a los que puedo dirigir hacia el establecimiento de las condiciones adecuadas para que las mujeres embarazadas den a luz. Esta es mi pasión”, Gloria dice, “Sin embargo, desafortunadamente en el hospital en el que trabajo, se observa una importante desconfianza ante la perspectiva de que pueda llegar a haber suficientes parteras para ayudar a las todas las mujeres a dar a luz con acceso a las infraestructuras adecuadas. Idealmente, esto consistiría en paños sanitarios, un ambiente cálido, un baño relajante y, lo más importante, la presencia de sus seres queridos. Este es el objetivo para el que estamos trabajando, ya que actualmente todas las mujeres embarazadas que tratamos están apenas separadas por una delgada cortina..., si es que hay cortina”.

Pero la fuerza de voluntad de Gloria se mantiene fuerte y está ganando impulso. En colaboración con parteras de su lugar de trabajo y la Management Sciences for Health (MSH), una organización de asesoramiento en Cambridge, Gloria está ayudando a fomentar un ambiente propicio para la partería profesional y apoyar la contratación de parteras en el sector de la salud pública. El lanzamiento del programa Posada AME (Atención a la Mujer Embarazada), ha demostrado ser una iniciativa prometedora que puede llevar a resultados a largo plazo.

“En los próximos seis meses queremos implementar una mejor infraestructura para que las parteras puedan brindar los recursos adecuados y una atención suficiente a las mujeres embarazadas. En los próximos cinco años, veo más cambios positivos, ya que la ley está cambiando. La legislación para la prestación de servicios de salud maternal considera ahora a las parteras más inclusivamente, e incluye también las mejoras en la tecnología y la comunicación en todas las regiones. Nuestras voces se escuchan gradualmente y, lo que es más importante, están representadas”.

Puede que Gloria haya comenzado a abrir este camino en solitario, pero

ha ido encontrando aliados y adeptos en el camino. El contexto político de México presenta desafíos y oportunidades únicas, donde Gloria ha podido ayudar a desarrollar un programa específicamente diseñado para las estructuras institucionales y la voluntad política en su región. El programa AME se ha centrado en tres pilares principales, basados en los principios de la Confederación Internacional de Matronas: educación para proporcionar profesionales competentes y calificados, regulación de las actividades y de la mano de obra y una asociación colectiva de profesionales de la partería. Estos pilares abordan necesidades específicas, evaluadas como prioridades dentro del sistema de salud mexicano. Tales pilares no se pueden sostener solos y, desde febrero de 2018, este programa ha recibido el apoyo de la Fundación John D. y Catherine T. MacArthur, una Fundación con sede en los E.E.U.U. que, desde su creación en 1978, ha otorgado más de \$6 mil millones en subvenciones. Aún así, el camino es arduo y queda mucho por hacer.

“Hay una distinción en el mundo de la partería en México”, describe Gloria, “Entre las que se consideran parteras tradicionales y las parteras profesionales que han obtenido un título avanzado de partería. Mientras que las parteras profesionales están cada vez mejor formadas para alcanzar los estándares internacionales de salud y atención materna, allanando el camino a través de legislación, colaboración y orientación, las parteras tradicionales se vuelven cada vez más marginadas, carecen de acceso e incentivos para convertirse en parteras profesionales y por tanto no proporcionan el número necesario de trabajadoras para cubrir la creciente demanda de mejores cuidados, infraestructura y atención a nacimientos y mujeres embarazadas”.

Por lo tanto, en algunos aspectos, la batalla acaba de comenzar y lo que se encuentra en el horizonte sigue siendo incierto. Gracias a talleres ofrecidos por el programa Posada AME, a los que asisten parteras de todo México, se han desarrollado recomendaciones sobre cómo avanzar la partería en los respectivos estados y dentro de su contexto institucional y socioeconómico. En la región de Morelos, donde se encuentra Gloria, la situación necesita mejorar en términos de incentivar a más parteras para que estén presentes en las instalaciones de atención primaria de salud y haciendo que las barreras existentes desaparezcan. En gran parte, los médicos de atención primaria todavía se oponen significativamente a alentar esto por temor a sobrecargar aún más un sistema de salud pública

ya demasiado tensado, pero Gloria explica cómo el papel de las parteras se ha pasado por alto en términos del alivio y los beneficios a plataformas de salud que conlleva.

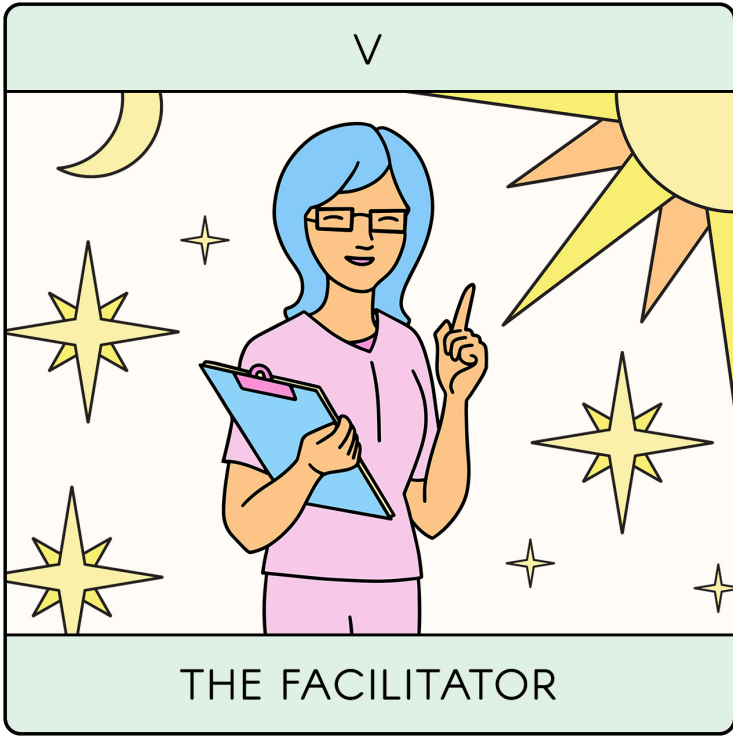
“Es esencial distinguir las responsabilidades de manera efectiva. Donde las parteras intervienen es donde los médicos no pueden, al ayudar a la planificación familiar, evaluar las necesidades específicas de una madre, su recién nacido y su familia, y – quizá lo más importante – examinar rápidamente las necesidades y recursos específicos en el caso de cada mujer que asiste al hospital”, dice. “La semana pasada, cuando entró una niña de catorce años, embarazada, debemos estar en una situación de poder brindarle atención, cuidado y herramientas para manejar mejor sus circunstancias. Este es mi objetivo: crear el camino para aquellos que necesitan tener acceso a información y recursos, y defender a aquellos cuyo camino ha sido bloqueado por factores externos”.

Gloria no muestra signos de desgaste en su compromiso hacia mejorar la situación. Ella continúa buscando los mejores tipos de solución, con la asistencia de aquellos que ha reclutado en su camino o los que ha encontrado caminando junto a ella:

“Actualmente, el gobierno mexicano ofrece una beca para alentar a todas las niñas a estudiar. Esta beca implica una visita mensual a un centro público de salud para un chequeo médico, donde un trabajador de salud, ya sea una enfermera o un médico, puede facilitarle información sobre salud reproductiva y sobre todos los asuntos relacionados con sus inquietudes sexuales. Esta colaboración es esencial, y debemos caminar cada vez más unidos para construir este camino”

El enfoque paso a paso de Gloria ha demostrado ser firme, y si bien algunos de los pasos más importantes aún están por venir, el camino abierto por ella está sembrado con semillas de esperanza, superación y éxitos de colaboración para las parteras en todo México.





Petra ten Hoope-Bender: The Facilitator



Petra ten Hoope-Bender is as intersectional an advocate as they come. It seems no matter where you turn in the civil society space, if a conversation can generate benefit from women of all walks of life, then Petra – who has been profiled by the Lancet as “the midwife’s midwife” – is probably already involved. In the International Development sector, where every stakeholder is eager to yield the highest impact with their funding, Petra’s expertise has made vital resources, support and capacity development to people who might otherwise miss out.

Accessibility is important to Petra: at the core of everything she does, she believes in balancing the scales of gender inequality. Wherever an opportunity arises to create a safer, healthier and kinder world for women and girls, Petra gravitates towards almost as if from some greater, subconscious calling.

“Compassion is needed
to take the world out of a downward spiral.”

“Compassion is needed to take the world out of a downward spiral,” she says, “It’s the word that best counterbalances everything that’s happening at the moment.”

She’s not wrong. As a Technical Advisor on Sexual and Reproductive Health at the United Nations Population Fund (UNFPA), Petra’s perspective is informed by decades of experience and, most recently, the findings of UNFPAs State of the World’s Population report, launched last year. Through analysis of inequalities all over the world – not only economic, but

within social, racial, political and institutional dimensions also – the report found that the two greatest hindrances to equity and equality were gender inequality, and inequalities in realising sexual and reproductive health and rights. A former Secretary General of the International Confederation of Midwives (ICM), Petra believes that this is where midwives can make a significant impact.

“Midwifery is a very good model of care that can show the power and return on investment of compassionate support for women, rather than rules and regulations and aggression [around sexual and reproductive health]. We don’t need to have the bigger fist to slam on the table,” she says.

Midwifery has been a subject on the lips of many civil society leaders – since UNFPA’s second State of the World’s Midwifery report, released in 2014, the case for midwifery has been further reinforced by compelling evidence: the return on investment in a midwifery cadre that is trained and educated to the standards set by the International Confederation of Midwives can manage up to 87% of essential maternity care in non-emergency situations, and yields a sixteen-fold return on investment for funders.

“You have to make the economic argument because that’s what people understand,” says Petra, “We need to have a strong profile and business case for what midwifery does and what midwives can do. People question what evidence exists, but even from 2014, you can see the cost-benefit of educating a midwife against the number of lives saved and unnecessary interventions prevented. The bit that we can’t really count is the impact of a positive birth experience over the rest of the life of a woman. That is such a grounding experience of a start of life in a way – it’s where the return on investment is – but many countries don’t see the importance of that or the value of women. Birth is significant in this way; it shouldn’t be overlooked. It is a strong moment in the life of women that gives them the capacity to recognise their own strength and community.”

An increased commitment to and promotion of midwifery does not only affect the women and families involved – it has a positive ripple effect through the midwifery cadre as well. In settings where skilled work may be difficult to access for many women, the inevitability of pregnancy and

childbirth represents a great economic and social opportunity.

“If there’s a case to be made – and there is – for empowering women by giving them an opportunity to do work that is very much needed and has a level of autonomy that doesn’t exist in a number of other caring professions, it is midwifery,” Petra says, “An issue though is that midwives are at the bottom of the rung in health systems and international organisations even now – there’s not a lot of understanding of the value of midwives, though the value is evidenced. We need to make it as a business case because investment has a multiplying effect for women’s rights – particularly because the majority of midwives are women.”

However, unfavourable perceptions of midwifery can at times work against its ability to succeed. Midwifery doesn’t fit a traditional medical framework. Midwives do not always have the ability, nor desire, to clock out when their shift ends; many remain with pregnant women through the birth experience for however long it takes. This, of course, seldom aligns with risk-prevention-oriented, bureaucratic medical systems. Accordingly, midwives can be seen as defiant, or renegades. And whilst there’s a certain romance to those terms, it’s taken less pleasantly when applied to a profession that is dominated by women and works for the benefit of women.

“The profession is not always put in a very favourable light,” says Petra, “The role of the midwife and the capacity of midwives to provide the care that strengthens women’s own capacity is reduced by all the procedural things and the prevention of liability. The profession is really pushed into a box that it doesn’t fit in. There needs to be space for the individuality of the women we care for – not all of their needs are the same and so a midwife needs to dedicate all of their senses and capacity to keep pregnancy and childbirth safe. It’s not a tick-box kind of job.”

Though midwives seem – almost universally – to describe their work less as a job and more of a vocation, the dissonance with medical hierarchies and unpredictable hours can make it difficult to promote to young people considering a health science career. Doctors sit at the top of the medical pecking-order and the subsequent tier, nurses (who, blessedly, have seen the pervasive pop culture caricature of being ‘sexy sidekicks’ to doctors finally limp away to die), report experiencing significantly less professional

respect and job satisfaction than doctors. When these issues ripple through the rest of the hierarchy, midwives – who are skilled to work both in medical settings and the community itself – are somewhat dissonant with the system at large: too autonomous to be truly medical, but too highly-skilled to be disregarded as an unregulated, alternative health worker.

The World Health Organisation (WHO) *Midwives' Voices, Midwives' Realities* report of 2016 surveyed and analysed 2470 midwives in 93 countries and describes, from their perspective, the barriers they experience to providing quality, respectful care for women, newborns and their families, and found – perhaps unsurprisingly – that endemic subordination and disrespect from senior medical staff significantly inhibited their job satisfaction and ability to deliver the highest standards of care. All of these factors conspire to create difficulty in attaining the next generation of midwives.

“It’s difficult,” Petra says, “There’s growth happening in midwifery units and in the Respectful Maternity Care space, but it’s hard to make midwifery attractive to 15–17 year-olds, particularly, when caring professions aren’t always that highly valued by that age group anyway.”

But Petra believes that the issues that have hindered the uptake of midwifery – in policy, programming and promotion to young people – can be overcome. The avenue, she is adamant, can only come through partnership, and not only partnership at a global level. Bridging systemic inequalities requires buy-in from leaders at all levels to create the kind of impact that is needed to bridge the gender divide. Petra, who has worked with and for many of the leading sexual, reproductive, maternal, newborn, child and adolescent health stakeholders in the world, is quick to point out synergies that can be harnessed to push the entire world towards the common goal of improved health care quality, resourcing and accessibility for women.

“Even now, I still work with the United Nations Partnership for Maternal, Newborn and Child Health (PMNCH),” she says, “I’ve always thought that the only way to go is through doing things together that are not competitive but adds value to the work of others as well: to use ICM’s Essential Competencies for Midwifery Practice and its pillars of Education,

Regulation and Association to further midwifery and then spread the message through White Ribbon Alliance's (WRA) Citizen's Voices; bring in the WHO for standards and guidelines, UNFPA for implementation of midwifery programs and care in humanitarian settings and through gender lens," she says.

And stakeholders are coming together. Midwifery is a word increasingly finding its way into high-level meetings, on panels, and in strategic documents. And despite the challenges the profession faces in general, its fundamental woman-centred focus makes a sympathetic case. It comes through even now with Petra, who has participated in most likely hundreds of these same conversations over and over again to change misperceptions around midwifery.

"What really drives me is giving women the opportunity to use their pregnancy and childbirth as a way to strengthen and find themselves. It's so enormously empowering if women can be in charge of their pregnancy and childbirth and find support in health providers and their community to grow from new situations," she says. "That's been in my drive for everything – to be part of that amazing moment where a woman whose birth is a clinical challenge become an opportunity for her to find the strength inside herself."

It seems that when it comes to making the case for midwifery – for the women, their newborns, their families, and their midwives – Petra ten Hoop-Bender is tireless. Which inspires the rest of the world to be also.



V

“Compassion is needed
to take the world out of a
downward spiral.”

-PETRA TEN HOOPE-BENDER

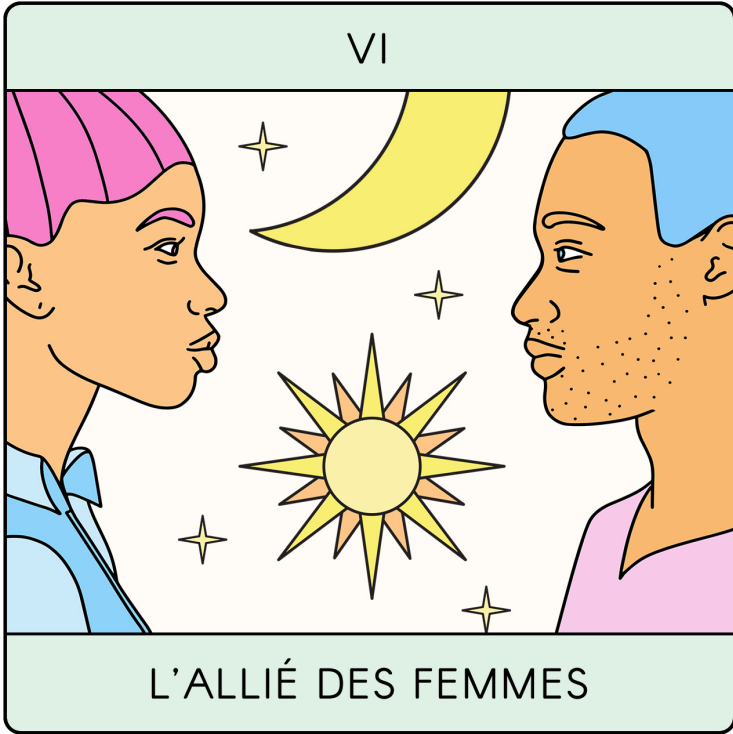


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#MidwivesLeadingTheWay #TheFacilitator

THE FACILITATOR







Ambrocckha Kabeya: l'Allié des femmes



Etre un leader est un art. Pour Ambrocckha, exercer la pratique sage-femme l'est tout autant.

Ambrocckha est Président de la Société Congolaise de la Pratique sage-femme de la République Démocratique du Congo (RDC). Il enseigne la pratique sage-femme à l'Institut Supérieur des Techniques Médicales de Kinsasha. C'est un leader qui puise son inspiration dans sa passion pour la pratique sage-femme et son dévouement à rendre aux femmes, leurs droits à une santé reproductive et génésique.

« La pratique sage-femme a été un appel » dit Ambrocckha. Son premier cours d'anatomie à l'école primaire l'a passionné, il veut alors travailler dans le domaine de la médecine, mais sa vision est encore floue. Sa grande sœur, qui est accoucheuse, va déclencher cet appel en lui et éclaircir sa vision. Il se souvient que, suite à son accouchement, elle a eu un problème de santé, et a eu besoin d'aide, besoin d'être accompagnée, besoin de soins. Si elle, accoucheuse, en a eu besoin, alors qu'en est-il des autres ? Ambrocckha comprend alors qu'il veut se dévouer à l'accompagnement de la femme avant, pendant et après sa grossesse et être au service de la santé de la mère et de son enfant. Un an après cet événement, il s'inscrit à la formation d'accoucheur auxiliaire et obtient son diplôme en 1987.

Dès ses premiers pas en tant qu'accoucheur, il découvre l'état de santé des femmes et prend conscience de l'ampleur des besoins de services de sages-femmes de qualité pour les femmes et leurs nouveau-nés. Il décide alors de poursuivre ses études pour développer ses compétences et fournir des soins mieux adaptés. Il obtient son diplôme d'infirmier en 1992 et celui d'accoucheur sage-femme en 1998. Il complètera sa formation de sage-femme au Japon en 2009. Malgré sa licence en Enseignement et Administration de soins et ses études en Médecine, Ambrocckha a

préféré répondre à l'appel à la profession sage-femme dans son cœur, en s'engageant dans la pratique sage-femme dans son pays.

« Malgré une réalité difficile, où la situation socio-culturelle dans mon pays prive la femme de ses droits en matière de santé sexuelle et reproductive, rien n'a réussi à me faire regretter mon choix » dit Ambrocckha.

En effet, c'est son amour pour la profession qui le motive à combattre la discrimination et la violence à l'encontre des femmes dans son pays. Là où elles manquent d'éducation, d'autonomie financière, de revenu et de justice, ces femmes ont besoin d'une sage-femme plus que tout. « La femme a une mission biologique » dit Ambrocckha, mon but est de l'accompagner elle et son enfant, dans cette étape de la vie, afin qu'ils soient tous les deux en bonne santé. Je le fais avec mon cœur, sans être poussé, car l'accomplissement de la femme, c'est l'accomplissement du foyer ».

Ambrocckha est l'un des principaux pionniers de la réforme du programme de formation de sage-femme en RDC qui s'est opérée en 2013. En effet, c'est suite à ses études théoriques et à ses stages sur la pratique de sage-femme au Japon en 2009, que sa priorité a été d'orienter le gouvernement sur cette réforme. Grâce à des efforts de plaidoyer, il parvient à ce que l'UNFPA soutienne la mise en place de cette réforme, en collaboration avec le Ministère de l'Enseignement Supérieur, Universitaire et de la Recherche Scientifique. « J'ai parcouru les différentes provinces de la RDC pour vulgariser les bénéfices de cette réforme et promouvoir la profession de sage-femme et la dénomination « sage-femme ».

**« C'était la profession la plus oubliée.
Aujourd'hui les sages-femmes se réveillent,
prennent conscience et s'engagent partout dans le
monde »**

Grâce à cette réforme, le programme de formation de sage-femme est désormais aligné aux standards internationaux et fait rayonner la profession. « Dans mon pays, on commence à parler et à s'intéresser à la sage-femme, chose qui était impossible il y a 2 ans. C'était la profession la

plus oubliée » explique-t-il, « aujourd'hui, les sages-femmes se réveillent, prennent conscience et s'engagent partout dans le monde ». Ambrocckha a sillonné les maternités pour aller à l'encontre des sages-femmes et réveiller leur conscience sur leur identité professionnelle. Selon lui, l'avenir de la profession sage-femme est prometteur. « Les sages-femmes continuent à démontrer aux yeux du monde qu'elles sont des héroïnes de la santé maternelle, qu'elles peuvent améliorer très sensiblement la santé maternelle et néonatale en réduisant les taux des mortalités maternelles et néonatales où elles sévissent ».

« Renforcer les capacités des sages-femmes en matière de soins de maternité respectueux, et de droits de la femme à décider de sa santé génésique et reproductive est une priorité en RDC » explique Ambrocckha. Il souligne également l'importance d'humaniser l'accouchement. Pour cela, il convient de faire un plaidoyer en faveur de l'amélioration de l'environnement de travail permettant de garantir l'humanisation de soins de la pratique sage-femme. « La réglementation de la profession de sage-femme dans mon pays est l'urgence des urgences pour assurer la protection du public (les femmes) qui a droit de bénéficier des soins d'une sage-femme compétente » dit Ambrocckha.

« Il est important que les sages-femmes contribuent avec les autres professionnels de la santé à l'amélioration de la santé maternelle ». Il explique ainsi comment les sages-femmes, en collaboration avec d'autres professionnels, ont tracé ensemble les soins obstétricaux et néonataux d'urgence adaptés à leur champ de pratique. « Nous entretenons une bonne relation et collaboration avec la Société Congolaise des Gynécologues Obstétriciens (SCOGO) pour tout ce qui se rapporte aux prestations de soins ou aux formations autour des thèmes de santé maternelle et néonatale ».

Ambrocckha nous confie que le statut des sages-femmes s'élève de plus en plus grâce aux efforts des sages-femmes et de ceux qui les soutiennent. Si un grand travail a été accompli, il reste encore beaucoup à faire, surtout dans certains pays en développement. Il donne le cas concret du sien, « le statut des sages-femmes n'est pas ce qu'il était hier, il n'est pas non plus ce qu'il doit être. Il est quelque part ».



VI

« C'était la profession la plus oubliée.
Aujourd'hui les sages-femmes se
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-AMBROCCKHA KABEYA

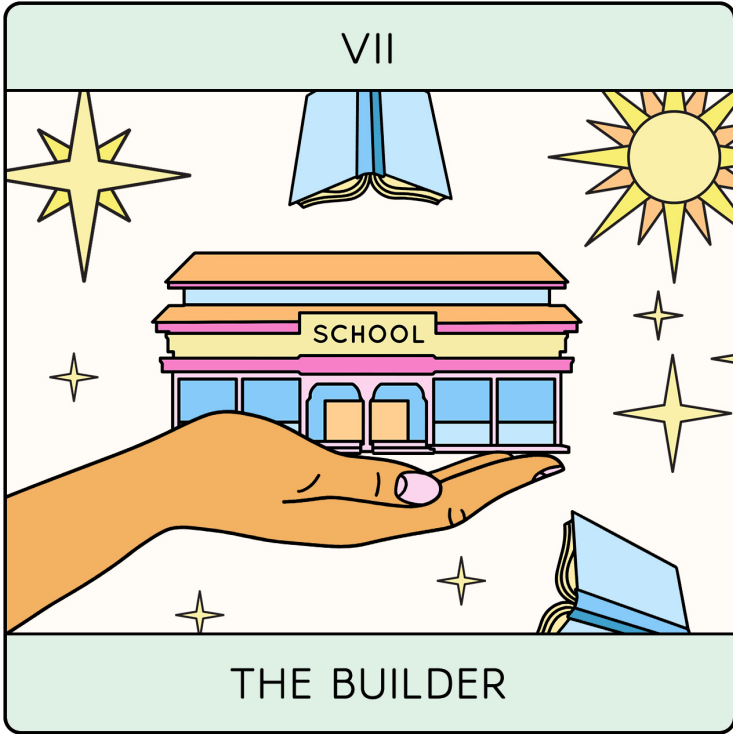


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L'ALLIÉ DES FEMMES







Htay Htay Hlaing: The Builder



Myanmar is a country that has undergone great changes from the last century during its rapid change to democracy. With its borders opening formally to tourism in 2013, the world has been granted an insight into one of the most beautiful and interesting countries in the world. With 7 Regions, 7 States and 1 Naypyidaw Union Territory, 135 ethnic groups and enormous geographic spread, Myanmar is a country where improvement of maternal and newborn health outcomes can be rapid and significant.

Htay Htay Hlaing has been a midwife since 1988 and is as enthusiastic about her career as she was when it began.

“Since I was young, I have aimed to become a nurse–midwife,” Htay Htay says, “I wanted to deliver healthcare from womb to tomb. I love midwifery and ante-, intra- and post-natal and newborn care, and also attending to their families.”

Though based in the country’s capital of Naypyidaw, Htay Htay acknowledges the enormous need for midwives across the country.

“Midwives work mostly in villages or people’ homes,” she explained, “Many are based in rural and also hard–to–reach areas.”

This means that the demands on midwives are considerable, and many are required by necessity to blend their maternity care role with others. When Htay Htay first qualified, Myanmar’s maternity health services included care of women during the pregnancy, labor and postpartum periods, as well as care of newborns and family planning.

“Nowadays, Midwives play a critical role in ensuring that women, adolescents, child and newborns survive and thrive,” she explains.

Midwifery services are delivered at the primary levels where standard care, basic emergency care and outreach services are the main priorities, to the secondary and tertiary levels – the latter of which also serve as referral centers for comprehensive care.

“We provide midwifery services according to National Standards, World Health Organisation (WHO) and International Confederation of Midwives (ICM) guidelines,” Htay Htay says, “There is more emphasis now on preventing health problems in pregnancy and the early detection of abnormal conditions.”

Education is a subject of which Htay Htay is clearly enthusiastic: she is currently responsible for academic affairs, administration and financial management of all 50 nursing and midwifery schools across the country. Building the capacity a country to ensure all women, newborns and families have access to a competent and well-resourced midwife is not an easy task, but Htay Htay is diligent. By ensuring that all maternal and newborn health policy is informed by evidence, the quality of midwifery education (and that of nursing) is improving considerably.

“This year, the two-year Midwifery Diploma curriculum has been upgraded so it is in line with both Association of South-East Asian Nations (ASEAN) and ICM standards,” she says, “Our two-year Bachelor of Midwifery Science (Bridge) Program will be implemented in the 2019-2020 academic year.” Its focus, she explains, is to improve midwifery education and ensure that the careers of midwives can be developed further. At the core of it all, it is clear that Htay Htay’s true passion is to help build a system that can reduce maternal and newborn mortality in her country with the help of midwives.

“We want to improve the health of women and their families and progress towards the United Nations Sustainable Development Goals,” she says, “This is such a wonderful job: catching gorgeous, healthy babies and helping mothers facilitate a natural part of their lives.”







Hanane Masbah: l'Humaniste



« C'est la nature de la profession qui m'a toujours attiré. Etre sage-femme, c'est apporter la joie et apaiser la souffrance des femmes, cela me donne de l'énergie pour surmonter les obstacles » confie Hanane Masbah, sage-femme marocaine. Son amour pour la profession remonte à l'enfance. Sa grand-mère était accoucheuse traditionnelle. « C'était la sage-femme de la famille » raconte Hanane, « une femme forte, une femme autonome, un leader, un modèle ».

Lors de la première réunion des sages-femmes de la région Moyen-Orient et Afrique du Nord, en 2012 à Dubaï, Hanane rencontre les membres du bureau de la Confédération Internationale des Sages-Femmes et des autres associations de sages-femmes de la région. Elle prend alors conscience de l'intérêt du travail associatif et de son rôle dans le soutien au développement de la profession. « J'ai su que c'était ce que je voulais faire » dit Hanane qui préside aujourd'hui l'Association Marocaine des Sages-femmes (AMSF), et coordonne également les activités du Comité Fondateur du Réseau des Associations de Sages-Femmes des États Arabes.

C'est auprès du gouvernement et des parlementaires mais essentiellement auprès de la population marocaine que Hanane prône les qualités de la sage-femme et sa capacité à contribuer de façon efficace et durable à l'amélioration de la santé et du bien-être des femmes et de leurs nouveaux-nés. « Nous devons créer un partenariat avec la population si nous souhaitons avoir leur soutien et renforcer la profession. C'est ce à quoi nous travaillons », dit-elle, en se référant aux Associations de Sages-Femmes membres du Réseau dont elle coordonne les activités. « Il est important d'expliquer aux femmes, à leurs familles et à la communauté, que la réduction de la mortalité maternelle et néonatale repose essentiellement sur le rôle de la sage-femme » dit-elle. « On doit faire du lobbying social, aller vers

les parlementaires, obtenir des données scientifiques et convaincre la population du rôle capital de la sage-femme » affirme-t-elle.

« Les sages-femmes doivent agir avec humanisme et assurer un accompagnement respectueux de la fille et de la femme, et prendre en compte leur diversité socioculturelle et idéologique »

Sa priorité en tant que sage-femme et leader est de renforcer les compétences de la sage-femme en matière de soins respectueux et de communication avec la femme et sa famille. « Les sages-femmes doivent agir avec humanisme et assurer un accompagnement respectueux de la fille et de la femme, et prendre en compte leur diversité socioculturelle et idéologique ». Hanane souligne l'importance d'agir avec professionnalisme selon les règles de l'éthique et de la déontologie, et d'être responsable de ses actes et de ses décisions ». Hanane veut mettre les besoins de la population et plus particulièrement de la femme, au centre de la pratique de sage-femme. A titre d'exemple, elle encourage les Associations de Sages-femmes à impliquer les femmes lors de la journée internationale des sages-femmes le 5 mai.

Ses convictions la mènent à engager et à s'engager dans des chantiers importants dont celui de la révision du programme d'études de sage-femme pour en renforcer les compétences transversales en rapport avec l'humanisation. « La formation est purement technique, nous devons mettre l'accent sur le volet relationnel et humain ». Membre du comité de révision du curriculum de sage-femme, Hanane explique que ce dernier sera mis en œuvre prochainement et va ouvrir des perspectives aux sages-femmes en leur permettant d'élargir leur champ d'exercice et protéger leur identité.

Si d'après Hanane, la sage-femme doit mettre la femme au cœur de son travail, elle doit aussi être capable de collaborer avec la société civile qui œuvre dans la santé de la femme, afin de rendre son travail et ses actions plus efficaces. Hanane considère que la profession de sage-femme au Maroc occupe la place qu'elle mérite et cela, grâce à la consolidation des efforts de toutes les parties prenantes : les associations, le gouvernement, les parlementaires et les médias. « Ils ont soutenu la profession, notamment

durant la phase de création de notre nouvelle loi réglementant l'exercice de la profession sage-femme au Maroc. « Cependant, d'autres choses restent à faire », explique Hanane. Malgré les chantiers en cours pour normaliser la réglementation de la profession et consolider la formation, elle rappelle que les conditions de travail dans son pays continuent d'être défavorables à une pratique de qualité et nuisent à l'image des sages-femmes. « Une jeune lauréate se retrouve seule dans les maisons d'accouchement, sans accompagnement » explique-t-elle. L'effectif des sages-femmes est généralement insuffisant dans les maternités provinciales et régionales. Ces conditions aboutissent à une charge de travail importante et se répercutent sur le bien-être de la population.

Hanane réclame une reconnaissance du travail et des compétences des sages-femmes. Elle confie que, depuis des années, la sage-femme travaille entre quatre murs et n'a pas d'ouverture sur l'autre et sur la société. « Nous sommes connues via des cas de décès maternels » dit-elle. Elle ajoute : « il est urgent de soigner l'image de la sage-femme et d'expliquer au monde que plus de 90% des accouchements sont pris en charge par les sages-femmes. Nous faisons notre travail du mieux que nous pouvons, malgré des conditions difficiles et un manque de ressources ». Pour remédier à ce manque de reconnaissance, elle préconise des efforts à l'échelle nationale, régionale et internationale afin d'obtenir un statut qui protège et revalorise l'identité et les compétences de la sage-femme. « Ceci peut être obtenu à travers un système de formation, un arsenal juridique qui répond aux normes de l'ICM et une sensibilisation de l'opinion publique » argumente-elle.

Hanane aime servir les femmes et se sentir utile. « Mon rêve est que la femme marocaine puisse être servie par les sages-femmes avec amour, dignité et respect de ses droits fondamentaux. »



VIII

« Les sages-femmes doivent agir
avec humanisme et assurer un
accompagnement respectueux de la fille
et de la femme, et prendre en compte leur
diversité socioculturelle et idéologique »

-HANANE MASBAH

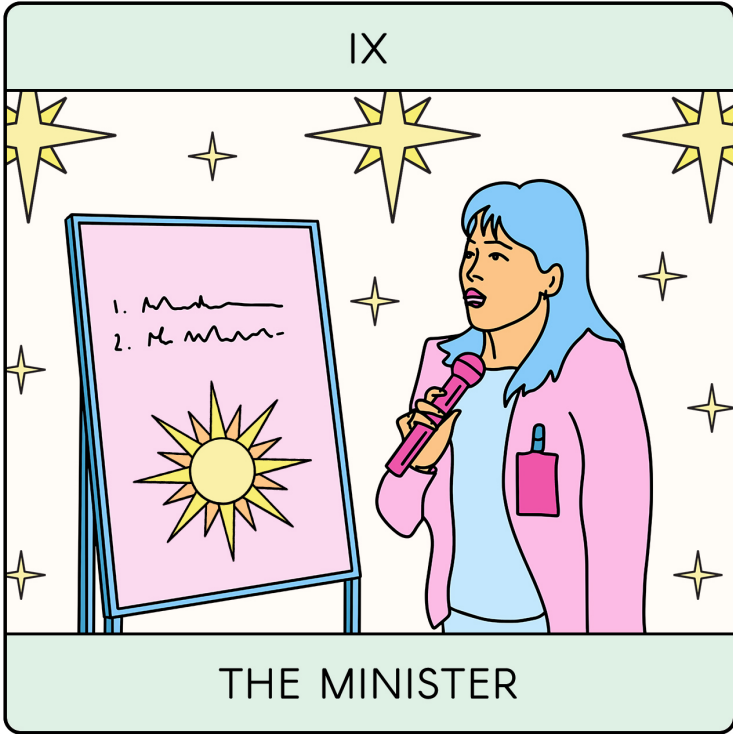


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L'HUMANISTE







Nazgul Shadybekova: The Minister



When she was a young girl, Nazgul Shadybekova was a dreamer. She fantasised about learning languages and travelling all over the world; a natural-born adventurer. She hadn't planned to become a midwife initially, but the enthusiasm and wisdom of her mentors was infectious. These midwives loved their work and, despite the low wages, gave their whole soul to it – and so Nazgul followed.

“The ability and desire to help a person, participating in a significant event in the life of a person, the possibility of self-improvement – all this inspires us to work,” she says, “The love for this profession probably originates from the depths of the soul.”

Born and raised in Kerben in the Jalal-Abad oblast of Kyrgyzstan, Nazgul worked autonomously quite early in her career due to the absence of any obstetrician-gynaecologists in the region. This enabled her to develop an advanced understanding of the needs of women, newborns and their midwives. The accessibility of vital maternity services is a subject she is passionate about given that the expansive, mountainous geography of the Kyrgyz Republic. In places like this, medical centre placement is never quite perfect; care can feel very far away during an emergency.

Kyrgyz Republic is afflicted by a high maternal mortality rate, and midwives face difficulty to reduce it because they are not formally defined within the health system, lack official core standards or competencies for practice. The Ministry of Health, informed by Nazgul's expertise, has made a commitment to resolving all of these issues and establishing regulatory systems to ensure accountability.

“The protection of mother and child health is an important direction in our republic,” Nazgul says, “Through the development of manuals, protocols,

Standards Operation Procedures for midwives, programs for the protection of mother and child health are being actively introduced.”

The process is collaborative: “The closest approach to international health standards is with the support of international organisations.” A key component of this success, she says, is linked to capacity development through both health system strengthening and midwifery education.

“The Ministry of Health, with development partners, and the Kyrgyz Midwifery Alliance are holding trainings and seminars to increase the knowledge and practical skills of midwives,” she says, “In these trainings, midwives are involved, and training is conducted on a peer-to-peer basis ... One of the priorities is pre-diploma training for midwives, which requires changes in terms of teaching and training programs that meet international standards.”

Nazgul is considerate in her approach, ensuring special acknowledgment is given to every stakeholder who has helped her country begin its journey towards leadership in midwifery at a national level. She gives thanks to them all: The German Society for International Cooperation (GIZ) who has provided technical and advisory support since 2011, United Nations Population Fund (UNFPA), United Nations International Children’s Fund (UNICEF), World Health Organisation (WHO) and the Aga Khan Foundation, to name a few.

The International Confederation of Midwives has embarked on a partnership with the Kyrgyz Republic Ministry of Health, the Kyrgyz Midwifery Alliance and the Bill and Melinda Gates Foundation to launch the Midwifery Services Framework programme, which is an analytic tool that guides governments in the development and strengthening of midwifery services through focus on a quality midwifery workforce. It aligns neatly with the larger commitment to midwifery that the Kyrgyz Republic government has made.

“The status of midwives in our country has now significantly increased. A lot of activities are carried out in the republic to increase the capacity of midwives and delegate functional duties,” Nazgul says, “Numerous trainings and seminars are held in all areas ... where participants gather

from all over the republic. Every year, the Kyrgyz Midwifery Alliance holds a congress of midwives at the level of the republic, where the most active members of the Association of Midwives are gathered; this also motivates and enhances the potential of midwives. Also, annually, together with the Ministry of Health and the Kyrgyz Midwifery Alliance, the awarding of the best advanced midwives is held.”

It is perhaps no surprise then that Nazgul is optimistic about the future of midwifery in her country. She sees the successful investment today multiplying in a short window – and given that this was the same conclusion as UNFPA’s own in their State of the World’s Midwifery report in 2014 (which concluded that investment in midwifery yielded a sixteenfold return), she is likely correct. When asked what the coming five years hold for midwifery in Kyrgyz Republic, her response leaps from one triumph to the next: first, improvement of the regulatory framework based on the recommended international standards, then the improved role of midwives which will, in turn, improve the provision of services to pregnant women, newborns and women of childbearing age, and ensure better health outcomes for the whole family.

“I worked as a midwife for 17 years,” Nazgul says, “And still, I do not see myself in another profession.”



IX

“Love for this profession
probably originates from the
depths of the soul.”

-NAZGUL SHADYBEKOVA

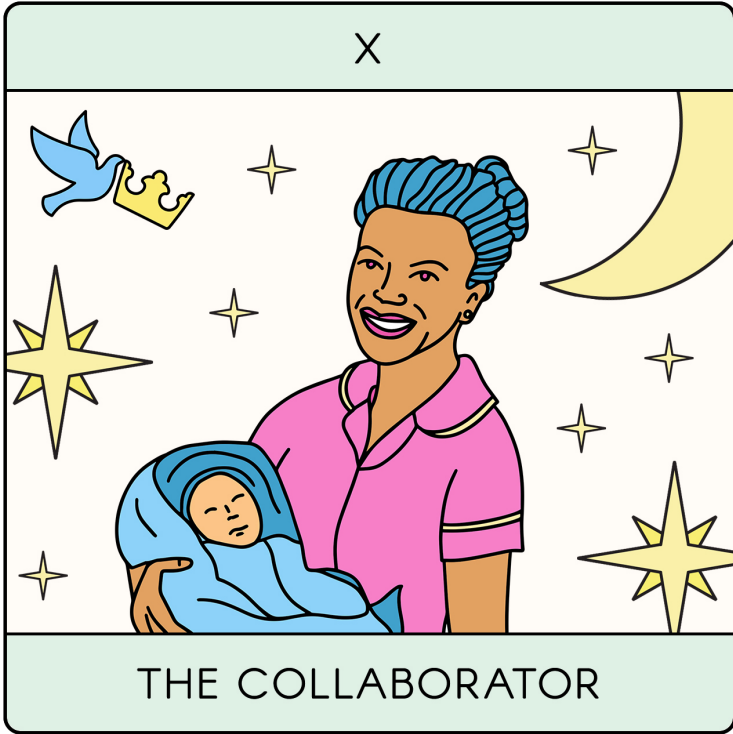


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THE MINISTER







Jacqueline Dunkley-Bent: The Collaborator



Professor Jacqueline Dunkley-Bent is a woman who knows how to hold a person's attention. Even as she bustles through the streets of London during what is clearly neither the first nor last busy day during her storied career, her phone manner is succinct, yet eloquent.

"I'm in a very privileged position," she says, right off the bat, "Because whilst I still work clinically as a midwife in the birth centre with women, I can influence the pragmatic nature of policies so the policy fits the purpose."

With a career in Midwifery that began in 1988, Jacqueline – who is currently the Head of Maternity, Children and Young People at National Health Service (NHS) England and is known in national policy circles as the midwifery influencer – laughs when asked how she came to find her calling in the profession.

"Frankly, I considered midwifery to be the next step in my career so I am currently dual registered as a nurse and a midwife. In the UK, midwives and nurses are on different parts of the professional register. But in many countries, there can still be difficulty in knowing the difference between midwives, nurses and nurse-midwives."

Midwives in the UK are autonomous practitioners, and she's quick to point out this benefit. Their other selling point is that they work where necessary in a multidisciplinary team with obstetricians, neonatologists, paediatricians, physiotherapists, support staff and many others.

Jacqueline is one of two National Maternity Safety Champions working

to the Secretary of State for Health. Her co-Champion is a doctor, and the two are ambassadors for maternity safety in England. This type of collaboration in the health sector is atypical, though Jacqueline remarks on it without fanfare: it is, evidently, not so much an innovation as it is a preservation of common sense.

“It’s really about taking down these barriers and boundaries and saying that care should be personal, and safe.”

This philosophy has seen Jacqueline support countless women through pregnancy and childbirth across all walks of life. Though her association with British royal circles – and, in particular, the Royal babies – is known, Jacqueline also has a passion for supporting women from more vulnerable populations, such as those from low socioeconomic backgrounds, pregnant teenagers, and survivors of assault and gender-based violence.

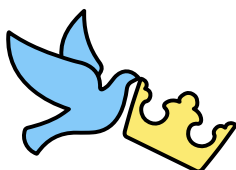
She shies from the word ‘barrier’ when discussing why women might struggle to access the midwifery care they need because of the subtext: that in some way, the responsibility for lack of service uptake is the fault of the women themselves. Jacqueline firmly rejects this notion.

“We [in healthcare] need to work harder. Barriers are created by us, not the women – we need to be able to reach out to women; to provide them with the care they want.”

Jacqueline was introduced to the concept of Respectful Maternity Care many years ago by close friend and colleague, Felicity Ukoko. This influence has permeated much of Jacqueline’s work since, which today places the right for women to have more control over how their maternal and newborn care is delivered, rather than feeling beholden to their care providers. It may seem a common sense approach, but the official advocacy of Respectful Maternity Care is quite a recent initiative – one, Jacqueline makes clear, is non-negotiable.

“Our vision for maternity services across England is for them to become safer, more personalised, kinder, professional and more family friendly; where every woman has access to information to enable her to make decisions about her care; and where she and her baby can access

support that is centred around their individual needs and circumstances and for all staff to be supported to deliver care which is women centred, working in high performing teams, in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries. This is the vision for maternity care in England outlined in Better Births the report of the national maternity review.”





X

“We need to work harder.
Barriers are created by us, not
the women.”

-JACQUELINE DUNKLEY-BENT

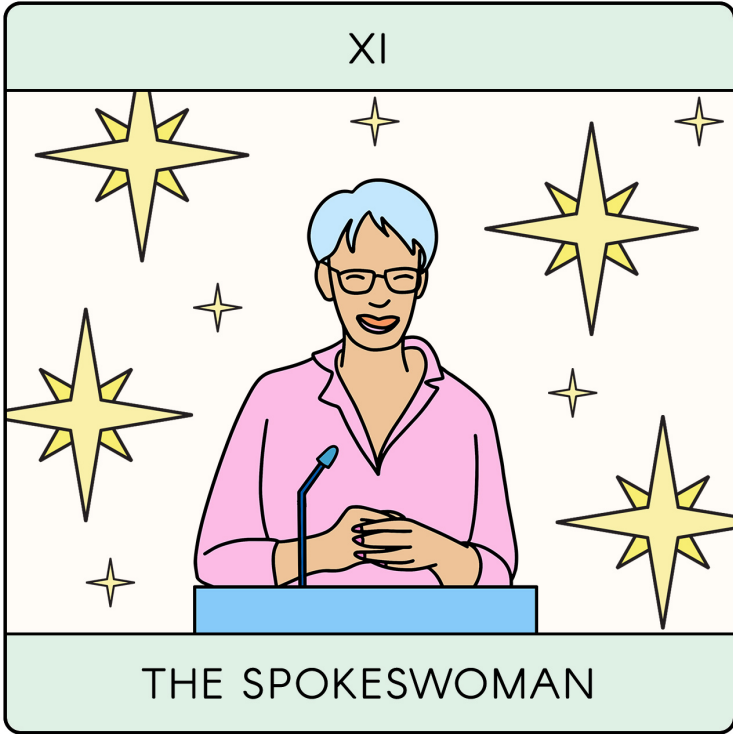


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THE COLLABORATOR







Lillian Bondo: The Spokeswoman



Lillian Bondo is the kind of woman who goes wherever she is needed: versatile, confident and capable, there is no shortage of spaces where she can make a positive impact on the lives of others. And so, it seems, she is everywhere. A midwife since 1984, Lillian continues to practise whilst maintaining other roles as a political activist and advisor and Chairperson of the Danish Midwives' Association. This workload that is compounded by her relentless pursuit of further education.

"I became a midwife for the same reason as many many other women: discovering the field when having my first babies," Lillian says, "I was deeply in love with my babies, the process and the care I received from midwives. I was thrilled by their world, their ability to support me no matter what prior knowledge they had of me and my husband, and I knew that I would go into this field if I could."

Denmark is a country in which the midwifery profession is highly respected. The degree of midwifery is 3 ½ years long, direct entry and its entry requirements are among the highest. A large number of midwives go on into university Master of Science degrees in PH, Health Science or Midwifery. Accordingly, midwives' visibility is high in Danish society.

"And we strive to make our influence match the visibility," Lillian explains.

In the late 1970's, when Lillian began having her babies, she had considered midwives to be a somewhat outdated profession; perhaps even obsolete. However, she was soon corrected of that presumption in seeing the way midwives quickly became integral to the women's rights movement.

"Women decided they wanted better births, and it helped midwives find their feet again," she said, "I, too, was a woman who had a plan for my

birth that I thought I had to fight for – and then my midwives said, ‘You want this? You want that? Then that’s what we’ll fight for.’”

Lillian’s ascent from the clinical setting to representing the midwifery profession – and women’s sexual and reproductive rights – was an organic one. Public cutbacks in midwifery saw her begin to argue in newspapers that policymakers had failed to understand the importance of midwives in facilitating the best chance at a happy and healthy start to life. She advocated for a reframing of birth as a healthy and fulfilling experience when done right, rather than a highly invasive process that left women weak or vulnerable to unnecessary intervention. She was dynamic, bold and unafraid of the spotlight, forging connections with politicians and the media upon taking on leadership within the Danish Midwives’ Association.

“Since the 1700’s, midwives have been recognised as the key health professional for women in the Nordic region – we were licensed by law even before medical doctors were,” Lillian explains, “It runs in the backbone of our society and its early moves towards a welfare state that women’s health and that of families were essential – and this makes it natural for us to approach a Minister, to get the ear of the politicians, to tell them, ‘If you do this, you change the ground on which the population and its health stand.’ And we have the ear of the politicians in this field now.”

Despite the power of midwives in Denmark, they are not exempt from the risk of erasure in any country. New public management seeks to create a one-tier health system that will see midwives answer to heads of administrations not necessarily with a midwife background. Lillian considers the absorption of midwifery into what she calls ‘the hospital solution’ to be a difficult issue.

“Hospitals are primarily for treating illness – so a prophylactic and health promotion approach as that of midwifery may sometimes have a hard time standing its ground. Our patients may be called just that – but the majority is a group of strong and well women and their partners,” she says, “I am happy to say, that our National Board of Health always considered this true of perinatal care: that pregnancy and childbirth is about becoming a family. It is not only a medical event, it is also a psychological and sociological change. Birth is a kind of diving into human life; it is a life experiment. Supporting people through the journey towards becoming a

family – providing emotional support, giving them resources, connecting them with the right medical professional if needed – is what midwives do.”

The unifying role of midwives extends beyond the dominion of women, newborns and families. As Denmark’s government continues along a protracted public sector enterprise bargaining agreement that has become increasingly fraught with tension, midwives have again stepped forwards to pledge their support to others. The public sector is in uproar, with threats of strike being met with threats of lock-outs. The Danish Association of Midwives is a member of the Health Cartel, which represents the interests of 112,000 members from 11 healthcare organisations alone. The collectivism is important.

“This goes beyond midwives,” she explains, “We are not as significantly affected by the terms of the proposed agreement as others – the people who control our borders, veterinarians, pilots – but we stand with them.”

This is the second instance of Industrial Action that Lillian led in her time with the Danish Association of Midwives, and although her voice is animated and energetic as she describes the highs, the lows and the victories snatched from the jaws of defeat, she is quick to point out that it is a joyless experience. She recalls the previous instance, in 2008, when mid-level health professionals such as bio-engineers, nurses, midwives and physical therapists were forced to strike.

“All the health professionals with Bachelors degrees stood together, but we were the only ones,” she explained, “That left us feeling very forlorn and very lonely, because there was emergency coverage so the employers let it go forever. We struck for 8 weeks and it was awful. We won by a very narrow margin but we were all of the same sense that we would not do this again. And it really is different this time – there are many of us and the Government will have to concede or they will have to use power. Either way, they will lose because there is an election coming up, and families are telling them: “We don’t want to lose our midwives, our nurses, our teachers.” Eventually the employers and the employees came to an agreement – “One of the best in my time,” Lillian adds with a smile, “That we stood together for so long, did pay off.”

When Lillian speaks of midwifery, her entire voice sings. Even after decades (and the obligatory reference to tough, overworked, poorly-compensated clinical conditions that are common amongst all midwives), Lillian remains utterly besotted with her profession.

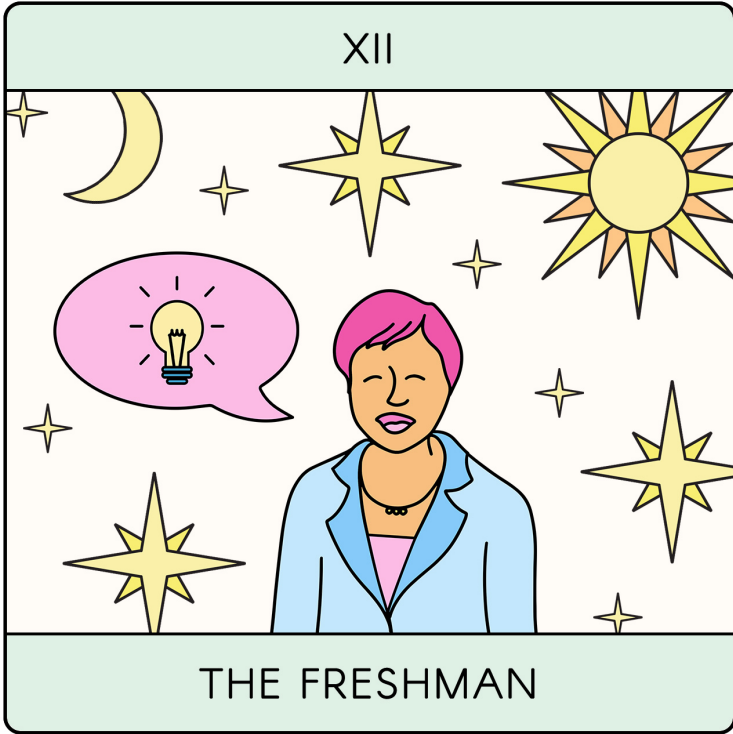
“Midwives work hard,” she says, “But we in Denmark have so many better conditions than a lot of other midwives do. Only 10% of women here aren’t satisfied with their birth, and we have a 20% caeserean section rate. These rates creep up unless we work all the time to make every woman – a sick woman, a woman with huge challenges in her life – feel that being pregnant, going through pregnancy, having an abortion or using contraceptive care, whatever – happens in a way that makes her feel respected, that her words are listened to and that she can trust a midwife to listen to her and strengthen her through the journey.”

This is not, to her mind, so much of an evolution as it is a natural continuation of a midwife’s role: to be the informed supporter and spokesperson for the women they serve.

“In the Nordic region,” Lillian says, “Midwives stand for women.”







Kiyoko Okamoto: The Freshman



When Ms. Kiyoko Okamoto describes herself as ‘a freshman’, it’s hard not to blink in surprise. With decades of experience as a midwife – including 22 years of service to the Japanese Midwives Association in every role from chairperson to Secretary General – Ms. Okamoto’s shining characteristic is her considerable wisdom about pregnancy, childbirth and midwifery itself. However, it quickly becomes clear that Ms. Okamoto’s wisdom is bolstered by a sense of wonder and curiosity.

“One of my mottoes is: I am always a freshman,” she says. “I always want to convey a new idea to a student or to women whenever I teach.”

With a long and storied career as a midwife educator at some of Japan’s most esteemed midwifery schools, this approach is highly successful. This willingness to see the world from a new perspective has had a significant impact on the way midwifery exists in Japan. 23 years ago, Ms. Okamoto resigned as an educator to sustain a midwifery system that recognised midwives as their own profession – not a hybrid role mixed into the professional identities of nurses and community health workers.

“I really wanted to help sustain the midwifery system, and to also maintain the business right of practice which had been in place since the era of Emperor Meiji in the late 19th Century,” she explains.

There is a nurturing role of midwives in this system, one which Ms. Okamoto deferentially describes as an important daily duty for all midwives. It is, however, a responsibility that risks being lost as new graduate midwives increasingly work to the instructions of a physician, rather with an autonomous identity that places the individual woman’s wellbeing at the core. Integral to this is the belief that women should enjoy, rather than fear, a natural birth experience.

“I wanted to protect natural delivery for women who want to give birth [without intervention],” Ms. Okamoto explains, “Young women tend to have a fear of labor pains. Thus, painless delivery applications are increasing among young pregnant woman ... In this framework, women who give birth naturally have been decreasing.”

The framing of birth in terms of risk, danger or medical crisis is something that midwives work tirelessly to resist. The belief that women should not fear birth because it is something they are biologically made to experience is more than just philosophy – it is about preventing unnecessary, invasive medical procedures that leave women feeling distressed as a result of birth, rather than euphoric. Ms. Okamoto sees education as one of the key safeguards against this.

“As well as supporting young pregnant women, it is necessary for midwives to promote natural birth even in puberty education,” she says, “[We should] convey the message from the age of puberty that ... females have the power and ability to give birth naturally.”

Japan’s aging population and a declining marriage rate – consequently affecting the national fertility rates – has seen the average age of pregnant Japanese women rise. It is not rare for women to have her first baby in her late thirties or in her forties. Unsurprisingly, rates of caeserian section and medical intervention during birth are both on the rise. Health guidance from midwives, Ms. Okamoto states, can promote better health outcomes.

“There are issues that are common toward all generations in the life cycle,” she says, “Good balanced diet, moderate exercise, enough sleep, maintaining a mental status without excessive stress are all important. A midwife must be a good supporter for mother and child, women, and their families.”

The low social status of midwives is, however, a barrier to success. Midwifery education levels in Japan are low and confusing: there are several programs of midwifery training in each school, which include as postgraduate schools, non-degree graduate programs and special courses at university level, amongst others.

“The system of choice is university, technical schools or junior colleges,” Ms. Okamoto says, “That’s why I think that it is necessary to promote midwifery education curricula in graduate programs, so that they will better fit the criteria of the International Confederation of Midwives standards and clinical competencies.”

Three years ago, an evaluation system for the competencies of midwifery clinical practice began. It is now in need of promotion against a postgraduate training system which can strengthen the capabilities of midwives who have already graduated.

“In five years, the postgraduate program will be promoted in midwifery education,” she says, “The number of schools will be about twice the current number (32 institutions at present). It is my wish that the independent leaders in advanced education become more active in various areas and globally, and a midwife may be elected to the Japanese government.”

It’s the kind of idealism that matches perfectly with a freshman – one who intends to change the world, mobilise for a common cause and reinvent the world as it should be. Though Ms. Okamoto will be turning 70 years of age this year, it’s easy to imagine her in this way.

“I think that an ideal age is to subtract 40 from real age,” Ms. Okamoto says with characteristic wisdom, “For the reason, I feel like I’m just becoming 30 years old.”





XII

“I always want to convey a new
idea to a student or to women
whenever I teach.”

-KIYOKO OKAMOTO



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#MidwivesLeadingTheWay #TheFreshman

THE FRESHMAN







Mary Renfrew: The Evidence-Seeker



Although research has had a transformative effect on midwifery practice and policy, it has not always been seen or valued, even by midwives. However, midwives like Mary Renfrew are not simply improving midwifery research in the academic space... they are revolutionising how it is perceived and used.

When Mary became a midwife in the United Kingdom in the 1970s, she found the way maternity care was structured virtually impossible to work within. "It was very intervention-driven," she explains now, "There was a lack of evidence for what was considered best practice at the time; almost a lack of humanity."

She describes herself as being "perilously close" to leaving midwifery altogether at that time – until a job in research transformed her relationship with the profession. Being able to view the system's shortcomings through the lens of evidence gave her a cause to champion and the tools with which to do it. Research empowered her to challenge the routine use of unnecessary and sometimes harmful practices in a constructive way and, in turn, helped the system improve.

"The first research I did was looking at aspects of breastfeeding and working with women and babies to figure out what worked for them," she recalls, "That resulted in a range of studies that challenged the routine practices at the time and helped to change them. These included practices such as separating mothers and babies after birth, timing feeds and giving formula supplements to breastfed babies. What the research enabled us to do was listen to women's own voices about the problems and solutions, and build an evidence-based case to challenge harmful practices."

The findings were significant, influencing national and global policy throughout the 1980s. This, Mary acknowledges, explains much of her determination to conduct and implement good quality research ever since – in midwifery and maternal and reproductive health more broadly, as well as infant feeding.

In the academic world, women's and children's health – and, as a subset of that, midwifery – has not always been granted the attention it deserves. The intervention-focussed model of care and the near-total dominance of the medical profession in health research also created serious barriers to the involvement of midwives in research. Mary found that for many years funding proposals and ethics applications all had to be signed off by doctors, and research funding was very limited for the sorts of questions that midwives ask. Midwives still often find their perspectives dismissed, yet at the same time these are often the questions that women need to have answered. Even midwives do not always value research – some see a sharp divide between heart and head. Mary has had to pioneer ways to overcome these and other serious barriers as her work has developed, and she has had to argue the case with colleagues, universities, funders, and professional organisations to be able to set up her research programmes. From the start, though, she was fired up by recognising how important good evidence is.

“The things I'd been taught about practice by very good colleagues – well, a lot of them turned out to be wrong when examined by research. I've learned that humility is important – not being too certain about what we know. We have to be very careful before we tell anybody what is right and what is wrong if we don't have good evidence. A key part of the answer to research questions lies in listening to women and families and always being open minded. Our work must be hand-in-hand with women and families so we're answering the questions that matter, together, and not imposing our answers on them.”

Now that midwifery researchers are building a greater body of evidence that demonstrates the key contribution of midwifery, the visibility of the profession, as well as perceptions of its legitimacy, are both on the rise. The Lancet Series on Midwifery – for which Mary was the academic lead – used innovative approaches to demonstrate for the first time how critical midwifery is to survival, health, and well-being for all women and

babies. This evidence is being used widely to strengthen midwifery, and is contributing to the increasing recognition of midwives internationally. But there's still a world of research needing to be done – both on individual practices and whole packages of care.

“We need what I call an explosion of research,” Mary says, with what is quickly becoming recognisable as her characteristic enthusiasm, “There are a lot of important questions, so we have to do a lot of studies. And we need good, well planned research that is then used to inform change, not ignored’.

Mary's research program for several years has focused on tackling inequalities and ensure care and services for the most vulnerable women and families. From this, she's come to believe that more research is needed on how to implement good quality midwifery even in very challenging settings where there are as yet no midwives or where midwives cannot work to their full potential.

“Things other than evidence influence the delivery of services for women and babies – government priorities, commercial forces, professional dominance, even gender bias,” Mary explains. The varying investments in midwifery research from country to country represent both an opportunity and a hurdle to tackle this.

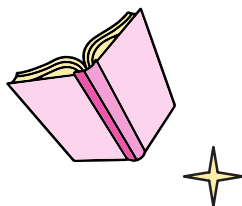
“In the nearly 40 years since I began research, we have a lot more midwives around the world with PhDs, lots of important research being funded where there once wasn't any, and many interdisciplinary studies,” Mary says, “But much more is needed to help midwives become research leaders and tackle the most important issues.”

In many countries, midwives themselves aren't involved in research because there hasn't been sufficient education and capacity building for them to do so. In those settings, other health professionals undertaking research aren't likely to consider midwifery a viable research subject because they don't know how important it is. Mary affirms the need both to build midwife capacity and develop interdisciplinary collaborations – with epidemiologists, social scientists, economists and others – to examine the questions that matter to women, babies and families.

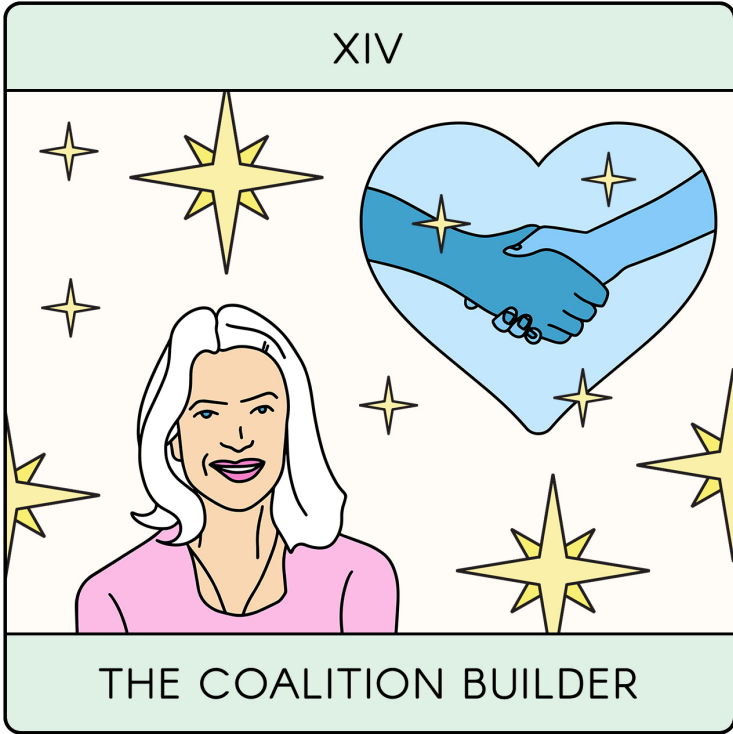
Midwife researchers don't just have relevance in midwifery; they can also demonstrate midwifery's wider impact on health and the health services.

Although her work as a researcher and as a global leader in evidence-informed policy and practice has been challenging, it has also been deeply rewarding. For Mary there is no greater satisfaction than working out rich answers to challenging questions alongside fantastic people. As she heads towards retirement, Mary feels optimistic about the new generation of midwife researchers with a far more expansive foundation of knowledge than she started with.

"People sometimes say 'I feel hugely privileged' without giving it a lot of thought, but I mean it completely," Mary says, "The rich tapestry of collaboration and joint learning and the collaborative relationships that you build with people who work in this way... it's just fantastic to do this work that matters and makes a difference to women, babies and families."







Rima Jolivet: The Coalition Builder



Midwifery is often perceived through a defined scope: one woman, grunting and pushing with sweat beading her brow as an assertive – yet compassionate – health professional dressed in scrubs crouches at the ready, gloved palms splayed, ready to ease a newborn into the world.

It's a beautiful and triumphant image, but an overly simplistic one. This image does not depict the months of consultations that midwives provide beforehand to ensure the woman has the information and care she needs to plan her pregnancy, and that once pregnant she continues to have frequent contact to reassure her that her pregnancy is moving along well – eight, as is recommended in the new [2016 World Health Organisation \(WHO\) guidelines](#). It also does not depict the limiting factors, the system variables. Maybe there are no scrubs. Maybe there are no gloves. Maybe the midwife doesn't have the kind of support she needs to manage complications or the enabling environment required to consult, collaborate, or refer the woman for a necessary emergency intervention.

And maybe a midwife is not practising in this space at all, and is instead working at a policy level to widen this scope, inch by inch. This is where midwives like Rima Jolivet make an invaluable contribution to midwifery and health policies at the global level. Rima, who has been a midwife since 1999 and holds a doctorate in public health, represents a fascinating intersection of midwives who are setting a woman-centred agenda for maternal and newborn health. And it began with her own story as a pregnant American woman confronted by the limitations of her country's health system.

"I was employed but I didn't have health insurance," she says, "My partner was European and had spent years living in London, so we

came to the United Kingdom where there is Universal Health Coverage, seeking access to affordable health services for the birth. I wasn't aware that midwifery was the standard of care when we moved, but as luck would have it, I was assigned to a midwife-led care team and I had an incredible experience of care that was very women-centred and family-centred. I found that this was rather exceptional when I compared the care I received to the experiences of my pregnant friends in the U.S. and I decided that I wanted to make that kind of experience available to more people."

However, Rima did not come from a scientific background and so, with fluency in both French and Spanish, she got her feet wet volunteering as an interpreter for women in labor and birth who did not speak English, while taking prerequisite courses and studying to become a midwife. Through a lengthy six-year process, Rima ultimately qualified to become a certified nurse-midwife... one whose expertise has centred around the multifaceted needs of the women she has supported over the years to use their voices and determine their own birth experiences.

"What drew me to midwifery in the beginning was the experience that I had of the midwifery care model that was so different from the mainstream models of women's health care that I'd experienced," Rima says, "I wondered 'Why do we do things this way when they don't seem to be in the interests of the beneficiaries of the system and don't protect the fundamental humanity of the birth experience? Pregnancy and childbirth are deeply human social and psychological experiences, so why don't we cherish and protect them?'"

Over time, this orientation toward quality improvement led Rima to what she calls "macro-midwifery", helping to support the development and genesis of improvements to maternity care systems. In this capacity, she has facilitated multi-stakeholder consensus and contributed to the development of invaluable frameworks for maternity care system strengthening, including the *Blueprint for Action (Transforming Maternity Care, 2009)*, a national policy project Rima directed that developed a multi-stakeholder framework for comprehensive maternity care system strengthening in the US, the *Strategies toward Ending Preventable Maternal Mortality (EPMM) (World Health Organisation, 2015)*, and the

[Respectful Maternity Care Charter: The Universal Rights of Childbearing Women](#), which was issued by the Global Respectful Maternity Care Council, which she helped to found. Currently, Rima serves as a Senior Research Associate at the Women & Health Initiative of the Harvard T.H. Chan School of Public Health. There, she is the Maternal Health Technical Director for the Maternal Health Task Force (MHTF) and directs [the Improving Maternal Health Measurement Capacity and Use \(IMHM\) project](#), which aims to advance measures that can address the full spectrum of determinants, including social determinants, of maternal health and survival.

The United States is the only high-resource country with a rising maternal death rate. [Fragmentation of care and disparities by race in both access to and quality of care are contributory factors](#). Midwives attend [only a small percentage of births in the U.S.](#), and thus midwifery is seen by many as an alternative rather than the mainstream model in the U.S. health care system. But in the context of increasing mortality, [the need for quality maternal newborn care is urgent](#). As an expert coalition builder, Rima sees effective partnership as a key driver of change to this status quo.

“Evidence supports midwife-led care teams as the optimal configuration for the delivery of quality maternal and newborn care,” Rima says, “But we as midwives are frequently overworked and understaffed. We don’t need to get into skirmishes with those playing complementary roles or with other cadres of providers, particularly when each member of the care team serves such a good purpose: the optimal provision of care to support positive experiences and optimal outcomes of care for mothers and babies. But sometimes it seems that we work at cross-purposes.

“In the United States (and elsewhere), you can sometimes encounter ideological tensions and a deep-seated distrust of the birth process that can lead to overmedicalization of birth. If the model is pathology, it can lead one to view pregnancy and birth as an emergency waiting to happen, rather than what is usually a state of wellness and a normal life experience,” Rima explains, “Payment systems can also influence the way pregnancy and childbirth are managed. There are around 4 million births in the U.S. annually, and over 30% of them are caesarean

births. On average, the total costs of care for mothers and newborns having cesarean births were about 50% higher than average payments for vaginal births, [both for private and public payers.](#)”

When asked about the role of doulas in America where the doula movement is most prominent, Rima explained, “Continuous labour support is associated with significantly improved birth outcomes for women. The presence of a birth companion who can support and advocate for a woman during birth is of great importance. The right for women to have a birth companion of their choice is a cause that midwives have championed for decades. However, sometimes people confuse the role of doulas and midwives. Doulas are not clinical care providers and they do not have the training to manage or provide care, but rather provide emotional support and encouragement to women during childbirth. In contrast, midwives trained to international standards are skilled to provide up to 87% of all essential care during pregnancy and childbirth, and have the necessary skills to identify and manage emergencies. I believe that there is a part to play for everyone on the care team and there is no reason why women who wish to cannot integrate both midwives and doulas into their team. I also think that being a doula can be a great path to a career in midwifery. In fact, I often recommend to prospective midwives that they undertake a doula certification program so they can attend births and see what it is like to provide emotional support and education to women in labor, as these are also key parts of midwifery practise and can give you a taste of what birth is like.”

Fostering midwives to practice to the full extent of their professional scope and improving supportive collaboration and teamwork between midwives and other professionals is invaluable to improving health indices at all levels. Rima considers investment in a skilled midwifery workforce critical to attaining Universal Health Coverage, and in turn, contributing to achievement of the United Nations Sustainable Development Goals.

“Successfully ending preventable maternal mortality will depend on the investments made in a competent workforce,” she says, “Women need to have access to care where their lives take place in order to achieve Universal Health Coverage. They need to have effective referral systems. Many current systems around the world are inadequate to meet

even basic emergency needs, let alone provide good holistic care for supporting optimal wellness and addressing preventable health issues. How investments are made to achieve high performing maternal health systems depends a lot on how women's lives are valued. Since women also make up most of the midwifery workforce, how women are valued in societies, in turn, reflects directly on the investments made in the maternity care health workforce."

This is where macro-midwifery can create a positive, lasting and far-reaching impact to improve maternal and newborn health indices, reduce costs and improve lives. Though Rima relishes the work, she acknowledges that it is quite far from where her midwifery career began.

"I do miss being at the bedside and being in the lives of women and families," she says, "I loved practicing clinically with one person and one family at a time. But I also love the work I do to help ensure that midwives have the system support they need to practise under optimal conditions. I hope that macro-midwifery has a compounding positive impact on women and their families in a number of sociological, political and humanitarian ways."

But as Rima continues her work on this level, she offers a common message to her fellow midwives that reflects on the importance of quality, equity and dignity in service delivery, and good leadership.

"One of the things that midwifery stands for is excellence, and we – both prospective and current midwives – need to really protect that reputation fiercely. Sometimes that means advocating very strongly for the improvement at the system level, because if it's not possible to sustain, our reputation suffers. The conditions in which midwives work are often suboptimal – unacceptable, or even abusive – and in those situations, our own professional respect and dignity requires us to rise up to the occasion. We have to advocate. We have to be united. We have to be change agents."



XIV

“A midwife-led care team is the optimal configuration. Evidence supports that.”

-RIMA JOLIVET



#MidwiferyLeaders #RespectfulMaternityCare
#WomanCenteredCare #QualityEquityLeadership
#MidwivesLeadingTheWay #TheCoalitionBuilder

THE COALITION BUILDER







Sisters of Solidarity in Nigeria: the MamaCare Midwives Family

Every pregnancy is unique. Every delivery is unique. Every child is unique. This awareness is commonplace amongst midwives across the world who work to empower and educate pregnant women and babies, and to one another as healthcare providers and advocates for reproductive and maternal health. In the context of the Wellbeing Foundation Africa's (WBFA) MamaCare Midwifery team – comprised of Mrs Patricia Komolafe, Rita Momoh and Eunice Akhigbe – this empowerment is at the core of their roles.

Based in Nigeria, the MamaCare midwives are a unified trio with complementing strengths – a sisterhood of solidarity who support one another in their shared service of women and newborns. With a longstanding career behind her, Mrs Komolafe is the 'older sister' figure, confident from her ample experience. Rita is resourceful; dynamic – always available to empower and inspire the pregnant women who see her as a gust in the sails and a source of knowledge; while Eunice completes the team by providing personalised care at an individual level, with a youthful curiosity in her work that embodies the very spirit of working within a midwifery family.

The MamaCare midwives work with a consistent mindset dedicated to a simple ethos: providing antenatal education to pregnant mothers, as well as serving the wider communities. Their ambition is to reduce maternal and newborn mortality indices across Nigeria, and education is their tool to achieve it.

"Midwifery teaching is as practical as it is about theory," says Eunice, "We use mannequins and even sometimes our own bodies to demonstrate key danger signals during pregnancy."

Through their classes, these midwives teach groups of pregnant women and maintain consistent contact for any queries or behavioural doubts they might have. At any given time, the online groups these midwives host can contain

up to 250 active members. Still, the MamaCare midwives face a variety of obstacles – ranging from limited access to key resources to undervaluation of their socioeconomic contribution to the community. There is a global call for investment in the midwifery workforce that is based on a significant body of compelling evidence that this is one of the most cost-effective ways to improve sexual, reproductive, maternal and new-born health outcomes. However, the strategic opportunity midwifery represents for government investment is often neglected, and consequently, midwives are not valued commensurate to their work. Rita is very much aware of this in daily work, where even a moderately greater provision of information could make a positive impact in the community.

For the MamaCare midwives, so much comes back to Water, Sanitation and Hygiene (WASH). WASH is a key element in preventing the effective and healthy provision of services from midwives to pregnant mothers in healthcare facilities. However, there are a number of hindrances to making WASH ubiquitous.

“When there is a spread of disease such as dysentery, Lassa fever or Ebola, the outbreak could be stopped at the source with preventive lessons on hand-washing and hand-washing stations,” says Rita, “Still, most times basic infections such as diarrhoea will spread in hospitals due to a lack of a good water source and recognition of what midwives bring to the table.”

She cites the inherent difficulties in her day-to-day work: lack of basic resources such as running tap water from a safe source, clinical tools such as forceps, gloves and syringes as well as a systemic entrenchment of unfair practices. These practices place midwives in the unenviable position of requiring patients to fund their own supplies and provide basic items to facilitate a midwife’s care. This is the standard of primary health service delivery across Nigeria, where only 31 percent of public health care facilities have access to a basic, functioning hand hygiene station.¹ However, it is one that midwives enforce with great reluctance. Barriers such as these hinder the MamaCare midwives’ work despite having the incentive, knowledge and volition to help mothers and newborns with whatever resources are available.

1 World Bank, 2017.

“We need running taps in rural and even urban areas,” says Eunice, “More enlightenment on hygiene and sanitation needs to be pursued. What we need the most are the basic resources and increased capacity for service distribution, as some of our classes can gather up to 200 pregnant women at a time.”

With such overwhelming demand for midwifery access, the three midwives have to be strategic in how they engage with the community. Data collection is recognised as vitally important, and so they serve a multifaceted role: educators, caregivers and researchers.

“We will firstly register these women and have them undertake key laboratory tests to monitor their health progress,” says Eunice, “As we don’t have the capacity to cover healthcare facilities more frequently, we can only check on the test results and progress once a fortnight.”

Because women in Nigeria have such diverse needs and priorities, WBFA midwives have adopted a holistic approach to MamaCare classes. Subjects range from Malaria, HIV or hepatitis in pregnancy, personal hygiene, environmental hygiene, food safety and beyond. Many of these topics are either new or relatively unexplored – even taboo – to many of the women attending. This requires a nuanced approach: both sensitive to subtle shifts in attitude, but delivery of appropriate information in a manner that is assertive and informative. Eunice’s educational style is focused on building interpersonal relationships with each of the pregnant women in her classes.

“When I am speaking at a class and am covering a topic that is taboo, I will take in the facial expressions and mannerisms of the pregnant women to understand how they are responding to the lesson,” she says, “When I notice that attendees are shy or preoccupied approaching a topic, I will see them fidgeting or whispering to their colleagues. Once the community class is over, I will meet that person and see if they wish to share any queries they may have. Midwives should provide this safe space where the rest of the community cannot.”

Building trust is a key element of midwifery practise worldwide. Therefore, while catering for individual needs, a sense of community must be built through effective regulatory frameworks and strategies as well as an open



Rita Momoh with WBA Founder-President of Wellbeing Foundation Africa Toyin Saraki



Mrs Patricia Komolafe during a MamaCare class



Eunice Akhigbe at a MamaCare class

platform for communication. This is where the veteran midwifery profile of Mrs Komolafe – affectionally known as “Mrs K” – proves to be the glue in the fabric of the MamaCare family. Operating with diligent, transparent oversight in her work, Mrs K is a maternal figure to mothers and midwives alike. Having joined WBFA in 2015, the antenatal to postnatal classes she has led have ranged in settings: from police stations and military bases to general hospitals and working with a variety of partners.

“Getting around to all the places we work in can prove difficult. What we urgently is greater access to these women, in terms of developing the capacity to provide midwifery services across facilities,” Mrs K explains, “We have covered, since 2015, 7 local government areas across Kwara state and are looking to expand the family of communities we cover in months to come.”

The midwives unanimously agree that despite the hindrances in their work, the opportunity to play diverse roles in their practise make even the most challenging situations rewarding and valuable. Their deep solidarity

with the women they support mobilises them as community engagers, where they create a familial sense amongst groups of pregnant women and a culture of community and transparency. Their work underscores the often misunderstood role that midwives play as leaders and team players, educators and motivators, professionals and, perhaps most importantly for communities, family. It is particularly in rural areas such as those across Kwara state where Patricia, Eunice and Rita work, where reproductive and maternal health information is not readily available, that the impact of their work is ever-more worthwhile.

XV

“Midwives should provide this safe space where the rest of the community cannot.”

-EUNICE AKHIGBE
the Mamacare Midwives Family



#MidwiferyLeaders #ICM #WBFA
#RespectfulMaternityCare #WomanCenteredCare
#QualityEquityLeadership #MidwivesLeadingTheWay
#MamaCare #TheSisterhoodOfSolidarity

THE SISTERHOOD OF SOLIDARITY

Thank You

Celebrating the magnificent work of midwives around the world is best done through the power of partnership. As such, we at the International Confederation of Midwives (ICM) would like to thank our Global Goodwill Ambassador, Her Excellency Mrs Toyin Ojora Saraki, as well as the Wellbeing Foundation Africa for their tireless dedication to midwives and the women and newborns we serve.

This book could not have been possible without the midwife leaders profiled in this series – both those featured in this book, and those who will be profiled in our ongoing campaign over the months to come. Thank you for raising the visibility of midwives and inspiring the next generation of midwives. Your stories are wonderful examples of the myriad ways that midwives make a positive difference to the lives of women, babies and families and to the ways that midwives contribute to strengthening the midwifery profession globally.

Thank you to Scarlett Hawkins, the Advocacy Manager of ICM, for pouring her love of narrative advocacy and storytelling into every page of the Midwifery Leaders Showcase. Thank you to Saven Chadha of schillustration for making the visual identity of the Showcase come to life. Thank you to Rachel Firth of Global Office Consulting for her project management expertise.

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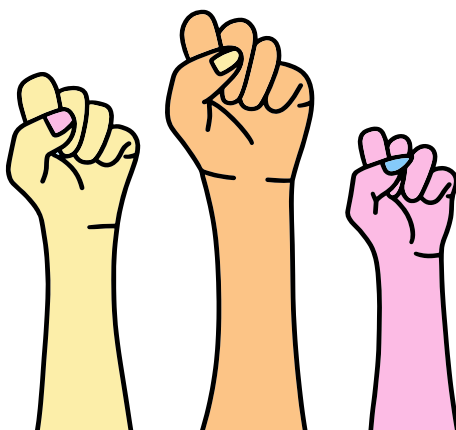
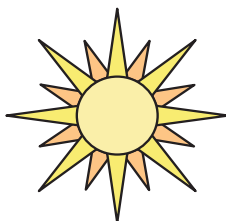
Thank you to White Ribbon Alliance for conceiving the campaign that preceded the Midwifery Leaders Showcase, and providing us with support and resources. An additional thank you to the Global Midwifery Advocacy Strategy Group for identifying and nominating so many stellar

midwife leaders to be featured in the Showcase.

While the stories in this book are about individual midwife leaders, we want to acknowledge and thank all midwives around the world whose daily work exemplifies leadership as they overcome many barriers to support women and ensure they get the quality care they deserve.

The Midwifery Leaders Showcase does not necessarily define what makes midwives exceptional; it merely holds up a mirror.

Sally Pairman
Chief Executive





International
Confederation
of Midwives

#MidwiferyLeaders

