Investing in midwifery associations to improve sexual and reproductive health and rights

A policy brief to ground the Feminist International Assistance Policy in evidence

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CAM ACSF
Canadian Association of Midwives
Association canadienne des sages-femmes

McMaster Midwifery Research Centre

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Conflict of interest

The authors declare that they have no professional or commercial interests relevant to the policy brief. The funders played no role in the analysis or presentation of the research evidence profiled in the policy brief.

Merit review

The policy brief was reviewed by a small number of policymakers, stakeholders and health professionals to ensure its scientific rigour and relevance to enhancing the sustainability of women-led civil society organizations.

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EXECUTIVE SUMMARY

Aims

We apply our research findings on midwifery professional association strengthening to argue that investing in midwifery associations is central to increasing the number of qualified educated midwives, and in turn increasing access sexual and reproductive health and rights including modern contraception. Our recommendations to Global Affairs Canada focus on how to enhance the impact of the key action areas of the Feminist International Assistance Policy (FIAP) through midwifery associations. Specifically, our policy brief:

- synthesizes the best available data and research evidence on capacity building of midwifery associations;
- defines the core concepts related to sustainable capacity building of midwifery associations;
- operationalizes these concepts through a 'checklist'; and
- develops policy recommendations based on the findings across programmatic and policy levels.

Main findings

- Midwifery associations are an example of largely women led, nationally recognized, civil society organizations that improve gender equality and overall access to sexual and reproductive health and rights of women and girls.
- A pillar to the profession, midwifery associations support midwives by providing continuing education training, in-service mentorship and supervision in order to improve the experience of pregnancy and childbirth and eliminate maternal and newborn mortality and morbidity.
- Midwifery associations lobby for the integration of midwifery in health systems by overseeing and monitoring standards of midwifery care, supporting accreditation mechanisms for quality midwifery education programs, advocating for appropriate remuneration, among other critical contributions.
- Despite their importance to achieving universal health coverage and meeting the Sustainable Development Goals by 2030, midwifery associations often face barriers to engaging in policymaking arena due to the disempowerment of the profession driven by the intersection of gender, sociopolitical, professional, and economic factors.

Recommendations

- Our research shows that capacity building of midwifery associations combined with continuing education activities that are housed and facilitated by the midwifery association decreases maternal mortality and morbidity - demonstrating the broader system impacts of investing in midwifery associations.
- Core recommendations include: 1) ensuring midwifery associations are embedded in projects that strengthen the midwifery profession and promote access to SRHR; 2) incorporating equity and feminist frameworks for program implementation and evaluation approaches that promote equity and challenge power imbalances; 3) applying a gender lens to the capacity building of midwifery associations including understanding the impacts of ethnicity and race; 4) expanding the FIAP Action Area Key Performance Indicators to include a broader set of indicators; and 5) increasing support for midwifery associations to actively engage in program implementation.

INTRODUCTION

Access to sexual and reproductive health is a basic human right and essential to promoting gender equality.[1] The Government of Canada has committed $1.4 billion annually starting in 2023 to improve sexual and reproductive health and rights (SRHR) globally.[2] This commitment is supported by the Feminist International Assistance Policy (FIAP), which provides a human-rights based approach to development.[3, 4] The FIAP is regarded as a progressive policy that emphasizes gender-focused aid rather than adding gender as an afterthought to international development funding.[4] Gender norms and gender-related inequalities have been shown to be separate but significant determinants of health and wellbeing.[5] Engaging with civil society by supporting local women's organizations to achieve gender equality and protect human rights for all is recognized as key component of the FIAP (Action area 1), and meeting the Sustainable Development Goals (SDGs) by 2030.[3, 6]

Civil society organizations (CSO), in particular local women's CSOs, are key actors who can be leveraged to implement innovative SRHR programming to strategically address gender norms and gender-related inequalities and improve overall health in communities.[6] While women-led CSOs have historically been the strongest advocates for gender equality, they receive only a fraction of total development aid (e.g., 4% of the total bilateral allocable aid of the Organisation for Economic Co-operation and Development's Development Assistance Committee).[6] A major constraint to funding local women-led CSOs is that donor-driven strategies most often focus on service provision and programming rather than capacity building of the organization itself, serving to increase the organization's precariousness and likelihood of survival.[6]

Midwifery associations are an example of largely women-led CSOs that are particularly important to improving access to SRHR.[7] A pillar to the profession, associations support midwives to eliminate maternal and newborn mortality and morbidity.[8] Evidence shows that midwives who are trained and regulated according to global standards have the competencies to provide 87% of essential maternal and newborn care.[9] Midwifery associations support the profession by lobbying for the overall integration of midwifery services in health systems. They lead, oversee and monitor standards of midwifery care and advocate for better remuneration and accreditation mechanisms to support midwifery education programs.[10] Midwifery associations uphold the human rights of women and children, championing for broader SRHR such as female genital mutilation, gendered based violence, or access to care during conflict.[11-13]

Research evidence suggests that while midwifery associations across country contexts strive for stronger involvement in the policymaking process, their contribution is often limited by lack of professional recognition or understanding of the role of midwives in health and political systems.[10, 14, 15] The restricted capacity of midwifery associations to engage in policymaking is due largely to the disempowerment of the profession driven by the intersection of gender, sociopolitical, professional, and economic factors.[14-19] These inequities are reflected in other structural challenges faced by the profession such as lack of governance arrangements or absence of regulatory frameworks, which results in poor integration of the profession into health systems.[15]

Despite their importance, midwifery associations have received limited attention in the academic literature. The International Confederation of Midwives (ICM) recognizes that strong midwifery associations are key component of quality SRHR. The ICM endorses the growth of the midwifery profession in three key areas: 1) education - provision of a qualified and skilled workforce; 2) regulation - setting scope-of-practice and licensing and re-licensing requirements; and 3) professional association - supporting the workforce by unifying the profession under common practice, dissemination of information, and in-service training, among others.[10, 20] The ICM has played a major role in raising the profile of midwifery globally by working to ensure that the voices of midwives are heard in policy arenas,

and through the creation of definitions and global standards to reinforce the capacities and skills of midwives.

Similar to the ICM's mission, the Canadian Association of Midwives (CAM) has been engaged in reciprocal capacity building partnerships since 2008 with midwifery professional associations in seven countries (Benin, Democratic Republic of Congo, Ethiopia, Haiti, Somalia and Somaliland, South Sudan, and Tanzania).[21] CAM participates in twinning, which has been recognized as an effective way to improve the quality of midwifery care in health systems and to build the capacity in both of the professional associations involved in the partnership.[7, 22, 23] CAM's global projects are funded through governments (e.g., Canada and Sweden) and private donors (e.g., Sanofi Espoir Foundation), and CAM collaborates with a range of partners including the United Nations Population Fund (UNFPA), Jhpeigo, local ministries of health, midwifery associations, and academic institutions (McMaster University, Université du Québec à Trois-Rivières and University of British Columbia).

While the FIAP has been generally well received by the international development community, there is a lack of clarity about how the policy can be implemented to effectively support sustainable midwifery associations.[24] There is also a paucity of research evidence to guide the implementation and evaluation of SRHR programming that reinforces the capacity of women-led local CSOs. Our policy brief applies our research findings on midwifery professional association strengthening to argue that investing in midwifery associations is central to strengthening the profession, and in turn improving gender equality and SRHR. Our recommendations for Global Affairs Canada focus on how to improve SRHR programming impacts through midwifery associations. Specifically, our policy brief:

- synthesizes the best available data and research evidence on building sustainable midwifery associations;
- defines the core concepts related to sustainable capacity building of midwifery associations;
- operationalizes these concepts through a 'checklist'; and
- develops policy recommendations based on the findings across programmatic and policy levels.

A note on definitions, we adopt the conceptualization of a CSO put forward by the United Nations Research Institute for Social Development, which is a broad and inclusive understanding of the term to capture an organization that is outside of the state and operates as a non-profit.[25] By adopting this broad definition, CSOs are no longer restricted to non-governmental organizations but rather include the full range of associations (e.g., professional associations, trade unions, cultural and religious groups, etc.).[25] As such, CSOs are catalysts to social and economic change in many country contexts.[25] The past two decades has marked an increased recognition by governments and international donors in support of CSO-led country activities.[25]

RESEARCH APPROACH

We conducted a qualitative evidence review and synthesis, more specifically, a critical interpretive synthesis, to create a conceptual framework for midwifery professional association strengthening projects across multiple country contexts where CAM is engaged in global programming with midwifery associations. We used a critical interpretive synthesis as a research approach to inform the development of concepts and theory, which included five types of qualitative data collection:

- qualitative systematic review;
- key informant interviews;
- focus groups;
- observations; and

- documentary review.

We selected the innovative methodological approach as a way to operationalize research evidence to improve project impacts, which to our knowledge has not been used in this way before. The approach allows for evidence-informed program planning and implementation from multiple sources of evidence that generates theory, which serve to strengthen the academic credibility and rigour of the findings.

Sources of evidence

The qualitative systematic review began with a search of electronic bibliographic databases (CINAHL, EMBASE, and MEDLINE) followed by a search of related SRHR and midwifery-specific websites (e.g., ICM, Global Affairs Canada, Society of Obstetricians and Gynecologists of Canada, International Federation of Gynecology and Obstetrics, World Health Organization, and United Nations Population Fund). Hand searches permitted to identify additional relevant literature.

We additionally conducted key informant interviews, focus groups, observations, and documentary review to inform the concepts and theory used in the framework. Prior to data collection, ethics approval was obtained from the Hamilton Integrated Research Ethics Board (HiREB, protocol #7489) at McMaster University in Hamilton, Ontario, Canada and Laurentian University's Research Ethics Board (LUREB protocol #6018380) at Laurentian University in Sudbury, Ontario, Canada. Written informed consent was obtained from each participant and data was collected in English and French. Data collection focused on countries where CAM was or is currently engaged in programming (Benin, Canada, DRC, Ethiopia, Haiti, South Sudan, and Tanzania). A multi-stage purposive sampling approach was used for recruitment. We sought a range of perspectives from inside and outside midwifery associations in order to ensure a variety of voices and perspectives were heard, with a focus on those often underrepresented in research. All interviews were audio-recorded and conducted face-to-face or virtually. Participant observation was documented through notes and audio recordings between researchers (CM and KB).

The selection of the documents for the documentary analysis consisted of any CAM program documents related to projects that included association capacity building activities. These documents ranged from grant proposals, theory of change and logic models, performance management frameworks, and monitoring and evaluation reports.

Data analysis and synthesis

The data collection process was highly iterative and as data were analyzed, themes emerged and informed subsequent sampling and data collection. Data were collected until data sufficiency was reached, when insights drawn from the analysis stages answered the research question. Data analysis of the additional sources of qualitative evidence was coded in the original language that the data were collected in. We applied a constant comparative method for analysis and verified through member checking.[26]

Researcher reflexivity

We practiced researcher reflexivity by applying Mertens principles of critical reflection for addressing constructs of power and validity.[27] Our approach to research is rooted in intersectional feminist, anti-colonial and collaborative perspectives.[27] We recognize the privilege of our positions as white western women academics; however, we make active decisions through our research to destabilize and challenge existing research structures known to create imbalances. We also recognize that collaborative research with midwifery associations must consider gender, race and equity in order for the results to be relevant to advancing the profession of midwifery in those contexts. Therefore, transformative theory and feminist

approaches underpin our research process in order to create an environment where local knowledge is legitimized.

Transformative theory insists that research is based on equitable collaborative relationships and capacity building. It provides a strong practical component for a rights-based research process. Transformative research typically stems from the community itself in order to meet their needs. The theory requires reflexivity, imploring researchers to know themselves in relation to the community and how their unearned privilege impacts relationships, trust building and ultimately the research process.

Ontologically, transformative theory assumes that privilege influences what is real and that these realities are shaped by dominant politics, culture, economy, gender etc. Access to sexual and reproductive health services, while recognized as a human right, is influenced either positively or negatively by its political, geographical, cultural, and gendered landscape. For example, prohibitive legislation, governments' lack of appropriate investment in sexual and reproductive health services, a women's lack of money to pay for healthcare, her distance from home to hospital or quality services provided in hospital all impact the point of contact with midwifery care.

RESULTS

A total of 1,634 records were identified through the searches of electronic bibliographic databases. Once duplicates were removed (n = 279), the remaining records (n = 1,355) were screened by two reviewers (CM and KB) based on title, abstract and the explicit set of exclusion criteria outlined above, leaving 84 potentially relevant records. In addition to the electronic database search, 30 records were purposively sampled for inclusion through grey literature and hand searches. The remaining 99 full text documents were assessed by both reviewers for inclusion. A total of 57 documents were included in the critical interpretive synthesis.

A total of 31 key informant interviews were completed and participants fell into the following five categories, according to their current professional role: 1) administrators; 2) SRHR health professionals; 3) policymakers; 4) project consultants or volunteers; and 5) researchers. We also conducted five focus groups with members of midwifery associations to solicit feedback on findings from the critical interpretive synthesis and initial draft of conceptual framework. A total of 24 CAM program documents were reviewed, in addition to the accompanying observations. The process was a highly iterative approach to the multiple types of qualitative data analysis used to inform the theoretical framework.

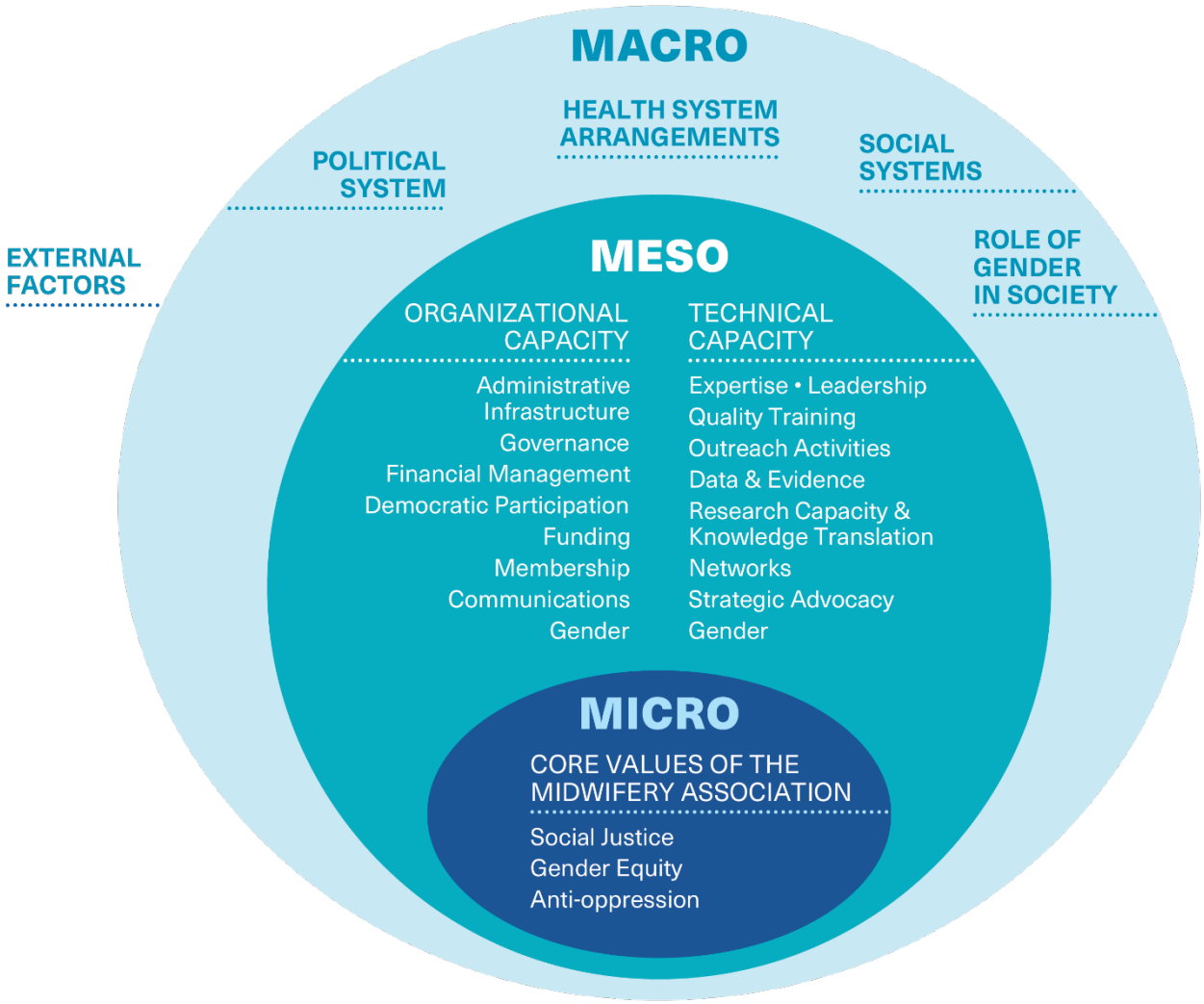
We present our findings below in two main sections. First, we describe the core themes that emerged in our data analysis by presenting the concepts and theory that were generated. These concepts provide the foundation for understanding the main elements required for midwifery association strengthening. Second, we focus on the practical application of these concepts by providing key considerations for Global Affairs Canada.

Core concepts for sustainable midwifery association building

Our midwifery association strengthening findings highlight the importance of addressing both the technical and organizational capacities of associations. The two concepts form a reciprocal relationship in that a base level organizational capacity (i.e., the ability to operate effectively and efficiently, where there is an emphasis on the sustainably of the association) is needed to build opportunities to grow the technical capacity of the association.[28] Technical capacity is conceptualized as the 'core business related to midwifery'. Our framework defines and operationalizes the core factors within technical and organizational capacity needed in order to strengthening midwifery associations.

Figure 1 presents the main findings from our research by highlighting the core components and programmatic considerations needed for the capacity building of midwifery associations. The figure can be thought of as a guide that outlines the key considerations by level that are required to enhance the sustainability of midwifery associations. The three levels are firmly interconnected. The micro level consists of the embedded values that guide the association. These core values interact with the meso-level to influence the organizational and technical capacity of the organization. Finally, the outer system (macro level) recognizes the institutional contexts and external factors that either enable or constrain the influence of the association's actions. Below we summarize our research findings based on each of the levels.

Figure 1. Components for sustainable midwifery association building



Outer system factors (macro)

We begin the evidence synthesis by working from the outer context towards the centre. Enhancing the sustainability of midwifery associations is influenced by a number of macro-level (outer system factors), such that any decision regarding the organization needs to take into account the political system,[29] health system[30] and/or social systems[31] where decisions about the organization will be made. Any programming or new development of the association needs to be understood and mitigated within these outer system factors, where the potential outputs of programming could be located.[32] Strengthening midwifery associations is both a political and technical process that is shaped by the individual country context, reflecting the countries' different political, economic and social characteristics.[14] These characteristics thereby influence how midwifery is integrated overall within health and education systems.

Understanding outer system factors can also help to orient midwifery association activities themselves. For example, although international policy supports midwifery as an autonomous profession, it is often not autonomously regulated. This lack of professional autonomy can create confusion for decisionmakers who may conflate the purpose of midwifery outside of the nursing profession. Similarly, our research found that in some cases, decisionmakers (e.g., government officials and funders) were unaware of ICM's

definition of midwifery[1] and Global Standards, resulting in a lack of differentiation between nursing and traditional birth attendants from midwives in the delivery of SRHR midwifery programs. A further implication of the lack of understanding of midwifery as a health profession cited by interviewees was that midwives were often not remunerated appropriately as skilled midwifery professionals (or a regulated health profession).

The role of gender within society is an inseparable component of the outer context and cross cuts all concepts. Societal values and the social construction of gender impact the value placed on women in society, and in turn the value placed on predominately women led midwifery associations within society. Gender norms and public opinion may influence the relationships that associations have with decisionmakers, often resulting in a lack of recognition and credibility of the organization.[14, 33] For example, our results showed that decisionmakers within health sectors tended to be male and physicians. By extension, this social construction of gender and midwifery as a gendered profession influenced midwifery associations' relationships with authority and leadership due to an overall lack of societal respect for women.[34] Finally, strains on health systems caused by long term events such as conflict (i.e.: political coos) or market inflations for example, impact gender (and intersects) disproportionately and thus threatening the midwifery associations' sustainability.

Lastly, forces and events outside of the political, health and social systems can influence capacity building efforts of midwifery associations or reorient their strategic planning. Specifically, external shocks to the system, such as pandemics, climate change, global economic crises, and natural disasters eroding women and girls' stability and safety (increased rates of gendered based violence for example). Shifts in resource allocation away sexual and reproductive health services delivery further impact the viability and power of midwifery associations.

Midwifery associations are key change agents that hold valuable expertise and in-depth understanding of the local barriers and facilitators to change, however, understanding how their participation is constrained or enhanced by the institutions and structures across political, health and social systems must be properly evaluated and understood as direct drivers of their sustainability.[3, 35]

Organizational factors (meso)

At the meso level, the capacity of the midwifery association is broken down to two main concepts, organizational and technical capacity that are further divided into key sub-components. We view organizational capacity and technical capacity as linked concepts in a reciprocal relationship. Organizational capacity is the ability of the midwifery association to have sustained capacity to operate as an organization effectively and efficiently and is achieved through the elements outlined in Table 1.[28]

Technical capacity is conceptualized as the 'core business' of the association. It refers to the midwifery association's ability to have the technical capacity to support and maintain effective programming and activities.[28] Technical capacity includes the development of evidence-based guidelines for midwifery care, continuing education for core midwifery competencies, public education, advocacy for midwifery inclusive policies legislation. A base level organizational capacity is needed to build opportunities to grow

[1] The ICM's definition of the midwife: "a midwife is a person who has successfully completed a midwifery education programme that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education and is recognized in the country where it is located; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery".[20] Midwives provide quality care when they are trained and licensed according to international standards.

technical capacity thus increasing the likelihood of sustainability of the organization. The main elements of technical capacity are outlined in Table 2.

Example of the interrelationship between organizational and technical capacity

When midwifery associations housed programs for increasing the capacity of in-service midwifery, such as emergency skills training, the internal capacity and expertise of the association was increased. To effectively operate emergency skills, midwifery associations were trained in programmatic and administrative skills and team building. These skills were generalizable and transferable to efficiently running the midwifery association. Furthermore, when midwifery associations trained their executive members to be emergency obstetric and newborn care (EmONC) facilitators, evaluators, mentors and supervisors, these midwives then went on to continue providing EmONC training even after project completion. These embedded skills in the executive membership of the association helped to build external recognition for the association's capacity to train midwives to international standards.

In-service midwifery training also raised the profile of the midwifery association with hospitals and health networks. This visibility and credibility increased the association's capacity to be effective in other activities such as overseeing accreditation of schools and education programs and lobbying for midwifery inclusive policies. Furthermore, midwives themselves were more likely to understand the role of their association and become members. Associations were then able to better advocate for their members at the institutional-level (e.g., hospital) and governmental level for appropriate remuneration mechanisms. Finally, increases in membership and EmONC training became vital sources of income for the association, that in turn supported the operationalization of the organization and sustained organizational capacity.

We make special note of the role of gender within organizational factors. Gender underpins both organizational capacity and technical capacity in different ways. In terms of organizational capacity, there is gender inequality when it comes to accessing post-secondary educational opportunities particularly in financial and administrative domains. Special consideration must be taken when strengthening midwifery associations to ensure that these non-traditional roles, particularly leadership roles, are given to women or that women are appropriately mentored and supported to fill them. We found that EmONC training housed within associations allowed for support and mentorship of women and as well as young leaders. However, we also found that some midwifery association members lacked advanced literacy skills and spoke more common local languages as opposed to National ones. These communication barriers may have hindered the ability to contribute to the organization's governance and collaboration with international partners who do not speak local languages. Taking into consideration the capacity needs based on gender and its intersections therefore becomes extremely important.

Equitable governance structures with respect to gender and its intersects (race, ethnicity, class, age, etc.) are central, as diversity of representation of the board will encourage equitable representation in membership. Internal equitable representation within governance structures of the midwifery association provides important leadership opportunities that might not otherwise be accessible to them externally. Finally, missions, policies, procedures and strategic planning must take into consideration gender and its intersects including their operationalization and implementation. A limitation we identified with respect to gender and organizational capacity, is that often board members were volunteers and not appropriately compensated for their work. For example, members took time away from wage earning positions to contribute to the association, compromising the economic stability of their households. Observational data suggests that volunteerism often preferred men or older women and contributed to their likelihood to hold leadership positions at the association. These effects are likely a result of gender-barriers that disadvantage women of child-bearing age, when there is often an inequitable distribution of labour in the home.

Within technical capacity, gender considerations consist of the midwifery association's capacity to conduct their own gender analysis and have the resources to appropriately respond to recommendations. This includes being able to apply a gender lens to their external environment and within the organizational structure and provide support and training for their members. Our data showed that often gender analyses were an afterthought in projects, which were completed by often costly external international consultants, thereby limiting the timeliness, relevance and local applicability of findings.

Table 1. Main elements of organizational capacity for midwifery associations[2]

ELEMENT	DESCRIPTION OF ELEMENT
Administrative infrastructure	• Establishing infrastructure is an important step in midwifery association strengthening and includes the necessary space and tools in order to be able to carry out the organizational mission • A base level of administrative infrastructure is needed in order to support technical capacity
Governance	• Governance system to direct and control the association • The capacity of the midwifery association will determine the complexity of the governance structure
Financial management	• A concrete plan and system for financial oversight of the association • Yearly budgets to align with the association's priorities and strategic plan
Democratic participation	• There are two main factors that influence democratic participation: ○ the broader sociopolitical conceptualizations of democracy and historical impacts within a given context; and ○ the shared values and beliefs of the midwifery association and creating contextually relevant equitable democratic procedures
Funding	• The organizational capacity of the midwifery association is conditional on its capacity to generate its own funds • Funding sources must be diverse (i.e., cannot be completely reliant on project funds)
Membership	• Membership recruitment activities to increase the visibility and traceability of the association • Ability to maintain membership database and records on how membership needs are being met • Ability to recruit diverse membership (e.g., attracting youth members and fostering student chapters)
Communications	• Communications strategy is needed in order to build advocacy (technical capacity) • Four levels of communications: ○ internal communications, which includes from board members communicating to each other (e.g., meeting minutes), as well as communications from board to staff;

[2] Adapted from: Mattison CA, Bourret KM, Hébert E, Leshabari S, Kabeya A, Achiga P, Robinson J, Darling EK. Health systems factors impacting the integration of midwifery: An evidence-informed framework on strengthening midwifery associations. BMJ Global Health. 2021; In Press.

	○ with members regarding what is happening at the board level (e.g., social media, website, WhatsApp groups, and newsletter) ○ to networks (e.g., government and international community); and ○ to the public through a range of media
Gender	• Equitable governance structure ensures inclusivity and diversity of representation, particularly in terms of the gender and ethnicity of the board • Equitable governance structure will enhance equitable representation in membership

Table 2. Main elements of technical capacity for midwifery associations[3]

ELEMENT	DESCRIPTION OF ELEMENT
Expertise	• A strong body of professional knowledge within midwifery (fostered by quality continuing education), and credibility and external recognition of the expertise held within the midwifery association
Leadership	• Leadership in midwifery associations consists of: 1. association membership's ability to influence and contribute to leadership within the broader system (political, health and/or social) through outreach activities; 2. an organizational leader to advocate and push forward the aims of the association externally in public and political spheres; and 3. the internal capacity of the association's leadership to manage the organization appropriately (e.g., democratic processes, accountability, transparency, and succession planning)
Quality training	• Midwifery association work with midwifery education programs to ensure quality pre- and in-service education opportunities for members
Outreach activities	• Association-led SRHR community outreach activities • Assists in improving gender equality, overall health and legitimizing the organization's role in the delivery of health services
Data and evidence	• Supporting the associations ability to own, collect and/or share data to inform local midwifery practice and standards (includes monitoring and evaluation and gender analyses)
Research capacity and knowledge translation	• Building research capacity strengthens and empowers midwifery associations by developing methodological, analytic and writing skills • Publications and knowledge translation activities raise the national and international profile of the midwifery association • Developing grant writing skills supports securing of future funding

[3] Adapted from: Mattison CA, Bourret KM, Hébert E, Leshabari S, Kabeya A, Achiga P, Robinson J, Darling EK. Health systems factors impacting the integration of midwifery: An evidence-informed framework on strengthening midwifery associations. BMJ Global Health. 2021; In Press.

Networks	• Strong alliances and networks at all levels (local, provincial, national, and international) through strategic activities • Twinning, particularly South to South partnerships are a powerful alliance tool
Strategic advocacy *(an outcome of networks)*	• Strong leadership from associations engaged in policy dialogue and decision-making advances agendas related to achieving universal health coverage and meeting the SDGs by 2030 • Advocacy involves individual dedication to effectively influence the association's own membership, policy and governmental services
Gender	• Developing the skills within the association to undertake their own gender analysis • Having the appropriate resources to implement these recommendations

Core values of midwifery associations (micro)

The core values and beliefs of the midwifery association underpin the organizational activities and outputs at the micro level. These align closely with the strategic planning of the organization, including the mission and vision, which fosters the organization's role in the community and the key programming/services offered. Within midwifery associations, we identified social justice, equity, and anti-oppression as common core values. Importantly, midwifery associations have their own definitions and perceptions of the value and benefit that they bring to the community, and these values are context specific.

The internal culture of the midwifery association can be positively or negatively influenced by contextual factors and as a result impact how core organizational values are implemented internally. One challenge with midwifery associations was the lack of transparency of the board to its members and a tendency to disregard procedures for democratic succession planning. Members expressed the need to have open discussions to encourage equitable distribution of leadership roles, which they perceived as important to sustaining participation in the association over time.

Empowerment emerged as an outcome of midwifery association strengthening and was identified in the literature as "a powerful catalyst for positive change".[22] It is founded on the sense of value and credibility that association members felt as a direct product of success internal and external to the organization. For example, feeling empowered was described by participants as having impact, being autonomous, participation in institutions (e.g., decision-making and policy), economic opportunity, access to education, and professional self-worth.[36] Empowerment acts as a positive feedback loop. As the organizational capacity of the association is built, individuals become empowered, thus reinforcing and further strengthening organizational capacity, and so on.

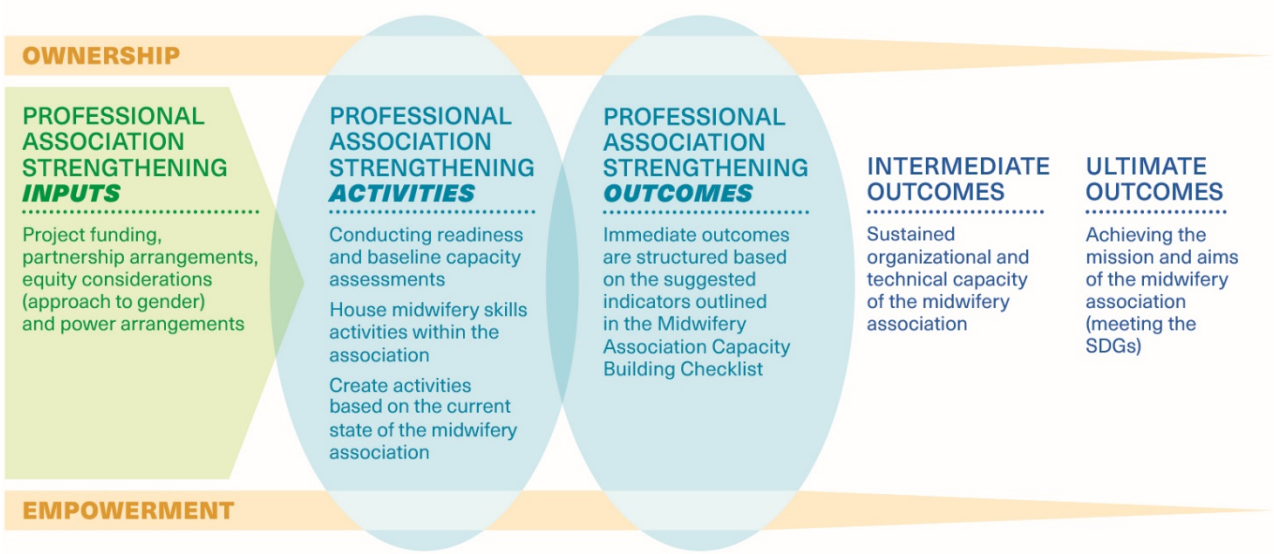
> *"When you have disempowered midwives, you don't have good quality care. You really just don't and you don't have any opportunity to provide input in to national programs or local programs because there is not a respect for the midwives who would like to have their voices heard at those tables." [Key informant]*

Applying the concepts to build the sustainability of midwifery associations

Strong partnership conditions must take into consideration current capacity of the midwifery association as well as how capacity building and sustainability will be incorporated into the project, without pushing too fast or too hard for growth. Understanding the capacity of the association both organizationally and technically will further ensure project activities align with aims and vision/mission, as well as their strategic plan, further reinforcing the probability of long-term sustainability past project funding. It will also ensure that the planned activities for capacity building are context specific and within the limitations of the current capacity of the midwifery association. Assessments of capacity require a gender lens and other intersects (e.g., ethnicity, indigeneity, and disability).

Using the results of our research, we developed underlying logic model considerations for midwifery association capacity building (see Figure 2)

Figure 2. Logic model considerations for midwifery association capacity building



Conditions: Process and partnership

Equitable partnerships and collaborations are required to mitigate power imbalances between visiting or contributing funders and host midwifery associations. Equitable collaboration is a process of knowledge construction and sharing that requires equal partnership in order to properly function.[37] Equity can be achieved by applying the principle of reciprocity within the partnership. CAM held strong principles in their partnerships with midwifery associations grounded in reciprocity and mutual respect, which was key to building trust in the relationship. This was reflected in the participants' perspectives of their relationship with CAM and its positive impact on project outcomes:

> *"With that, I can say this relationship was very, very strong. It was a mutual relationship. That I can say. We worked as an equal…in spite of that they are*

coming from a developed country, and this is a developing country, but our relationship was like we are sisters, equal - equally." [Key informant]

A similar equity framework can be applied to guide the relationship during the process,[35] including pre-project discussions and memorandum of understanding whereby goals, shared vision and mutual agreement of contributions and roles are agreed upon.[38] A rights-based approach is also key, whereby all stakeholders (e.g., government officials, project officers, consultants, volunteers, staff, etc.) are committed to anti-colonial approaches. In practice, this means that the partnership is not unidirectional (visiting funder to host development), but rather projects and activities are underpinned by anti-colonial and feminist frameworks.

Strong equity and anti-colonial frameworks help to foster collaboration and consensus thereby empowering leadership within the midwifery association. Gender equality is a value that all parties must explicitly share when working to improve gender equality and SRHR. When these elements are concretely integrated into the project inception and operationalization of activities, project hosts describe the outcome of strong empowerment. Our data demonstrated that when empowerment was present within transnational projects, there were sustainable outcomes within the midwifery association with regards to both technical and organizational capacity.[22, 39-41] Participants described trust and reciprocity between themselves and their Canadian partners, leading to a sense of empowerment during and following projects to advocate for SRHR and the involvement of midwives in policy and decision-making. They also were more likely to be involved with the midwifery association with broader commitments to continue with the aims of the organization post project completion.

In conclusion, an equitable process during the construction and development of the collaboration, supported by clear evaluation strategies during the project, strengthens the conditions that influence project inputs, activities and outcomes.

Activities and Outcomes

By creating reciprocal and equitable conditions within the partnership, a clear map of capacity needs of the midwifery association as well as how the aims of the midwifery association and the project align are developed. Activities and outcomes for capacity must both be considered. The level of attention provided to them and specific focus will emerge from the baseline assessment and the initial discussions between the visiting funder and host midwifery association. The following checklists outline the key elements of organizational and technical capacity that can be utilized to assess baseline capacity and to build activities, input indicators and outcomes. The checklist provides a guide for how to approach project activities as well as how to measure immediate outcomes.

Intermediate and long-term outcomes are based on both organizational and technical capacity of the midwifery association. Their ability to sustain capacity in both ultimately demonstrates the ability to achieve the organizational aims, which are likely parallel to project objectives and aims regarding meeting the SDGs by 2030. Sustained capacity across projects or following projects strongly suggests a shift in gender equality both internal and external to the organization and as such is an important outcome of the project.

Monitoring and evaluation

Rather than defining sustainability, it is more effective to measure the midwifery association's capacity to be sustainable. This capacity is one approach to determining the overall longevity of the midwifery

association. The monitoring and evaluation of the elements presented in the checklists below link to the likelihood of the sustainability of the organization. When internal capacity both organizationally and technically are increased, so are the chances of sustained efficiency and efficacy.

In terms of monitoring and evaluation metrics and approaches, the types of indicators must incorporate both the quantifying and qualifying aspects of capacity and reflect the values of the midwifery association[4]. Process evaluations are a useful method of capturing lived experiences of trust and empowerment, two factors strongly associated with capacity. Furthermore, if gender has been integrated into the capacity building of the midwifery association, increased capacity is also a strong indicator of gender equality and gender transformative paradigms.

[4] It is important to note that the checklists provided were meant as guides to program officers to develop indicators and to delineate potential measures for organizational and technical capacity. The development of concrete indicators will be undertaken in upcoming research.

Midwifery Association Capacity Building Checklist

ORGANIZATIONAL CAPACITY

- The sustained capacity to operate as a midwifery association effectively and efficiently
- Baseline capacity assessment to determine organizational values and beliefs, the complexity of organizational structure and organizational needs

INFRASTRUCTURE

- Core infrastructure needed to conduct the work of the midwifery association, which includes physical space (safe and secure office space) and resources (reliable internet access, materials, supplies, and equipment)

ADMINISTRATION

- Policies and procedures and human resources that include gender and equity policies to ensure equitable representation

GOVERNANCE

- An outlined governance structure according to local standards (e.g., board of directors, officers, committees, staff) with clear roles and responsibilities, constitution, policies, by-laws and strategic plan (mission and vision)
- Registration, licensure, practice standards, fee schedules
- Includes developing branches, provincial arms or state chapters of the midwifery association

FINANCIAL MANAGEMENT

- Financial policies, procedures and regular schedule of financial reporting that are open for review by board of directors

DEMOCRATIC PARTICIPATION

- Governance structure includes contextually specific democratic procedures for transparent reporting to board and membership, and succession planning

FUNDING

- Supporting business development skills
- Funding sources must be diverse (i.e., cannot rely solely on project funds)
- Funding sources can include a mix of operational funds provided by baseline membership fees, individual donations, income generating activities, and securing new sources of funding

MEMBERSHIP

- Clear demonstration of benefits to becoming a member, attracting new members, supporting student chapters, and improving the responsibility and accountability to its members
- Up-to-date membership database
- Engage members as champions or ambassadors of the midwifery association

COMMUNICATIONS

- Established connections with media to raise public and governmental awareness
- Strong written communications plan
- Visual impact through compelling images or videos
- Communications align with government priority areas, are non-partisan, timely and provided in accessible language (includes availability in official languages)

Citation: Mattison CA, Bourret KM, Hébert E, Leshabari S, Kabeya A, Achiga P, Darling EK. Midwifery association capacity building checklist. Hamilton: McMaster Midwifery Research Centre, 2020.©

Midwifery Association Capacity Building Checklist
TECHNICAL CAPACITY

- The ability to support and maintain effective programming and activities of the midwifery association

EXPERTISE

- Evidence-informed professional midwifery knowledge
- Professional code of conduct
- Internal and external credibility and visibility

LEADERSHIP

- Role of the midwifery association in public education, policy and implementation of SRHR issues
- Role of members at large now involved in decision-making and leadership roles external to the midwifery association
- Role of members internally to effectively lead the organization

QUALITY TRAINING

- Evidence-informed pre- and in-service midwifery training for members
- Gender inclusive and equity training for members as appropriate

OUTREACH ACTIVITIES

- Midwifery association-led outreach activities to improve community health and raise awareness of SRHR issues

DATA & EVIDENCE

- Data sovereignty (reinforced by governance structures)
- Ability to own and collect and/or share data to inform local midwifery practice and standards
- Skilled in monitoring and evaluation of the association's programs to inform activities
- Capacity to conduct own gender analyses and make appropriate adaptations to their own organization and continuing monitoring

RESEARCH CAPACITY & KNOWLEDGE TRANSLATION

- Enhancing knowledge translation by engaging knowledge users and building internal capacity in grant writing skills to secure future funding, advocacy and networks
- Midwifery associations leading and publishing, sharing and participating in research to increase credibility and visibility for local and/or foreign gaze

NETWORKS

- Strategic activities include: hosting activities and inviting range of stakeholders, regular meetings with policy makers, active digital media presence

STRATEGIC ADVOCACY (AN OUTCOME OF NETWORKS)

- Strategic advocacy is an outcome of strong networks and includes:
  - clear and succinct messaging to decision makers;
  - training association members as spokespeople;
  - learning how to strategically leverage the position of the midwifery association; and
  - individual level advocacy (e.g., strategic advocacy that targets other parts of the sector/system in order to advocate)

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CONCLUSION

Midwifery associations act as the web that holds the profession together. The ICM's three areas of focus increase the number of accredited midwives through education, regulation and professional association.[10, 20] Our findings highlight that in order to build these three focal areas of midwifery, we have to lead with association strengthening. Building strong associations is the foundation that is necessary to create formal quality midwifery education systems and support midwifery regulation and accreditation mechanisms. Investing in the capacity building of midwifery associations is crucial to improving gender equality and reducing maternal and newborn mortality and morbidity.

The FIAP is much more than the creation of a feminist-oriented Canadian foreign policy, it necessitates explicit feminist processes in order to appropriately implement international development funding. Our findings ground midwifery association capacity building processes and programming in the best-available research evidence. The policy brief is timely given the gendered impacts of the COVID-19 crisis.[42] Recent modelling shows that health system disruptions due to the pandemic will lead to substantial increases in maternal and child deaths.[43] Similarly, the Guttmacher Institute estimates that pandemic-related disruptions will result in an unmet need for modern contraceptives for 49 million women and an additional 15 million unintended pregnancies over the course of a year.[43] Midwifery associations are both women-led and predominantly women-membered organizations that when properly invested in, lead country responses to these gendered impacts to SRHR and more broadly ensuring that pandemic responses account for gender-related inequalities.

RECOMMENDATIONS

In order to achieve the SDGs, the FIAP includes a targeted and crosscutting approach to support gender equality and SRHR.[3] Specifically, the FIAP supports women led CSO's to advocate for stronger legislation, policies and services. Our research shows that capacity building of midwifery associations (an example of a national CSO) combined with continuing education activities that are housed and facilitated by the midwifery association strongly suggested maternal mortality and morbidity. For example, when midwifery associations provided EmONC training for their members, midwives reported integration of skills and described saving lives as a result. Furthermore, even post project funding, midwives/association members continued to receive support, supervision and mentorship from their midwifery association to safely work and apply their skills suggesting sustainability to this approach and demonstrating the broader system impacts of investing in midwifery associations. We map to the following FIAP action areas and SDGs:

Action areas 1: (gender equality and the empowerment of women and girls) and 2 (human dignity)

Good health and well-being (SDG3)

- Midwifery associations that house continuing education activities such as emergency skills training that includes safe abortion care where legal, post abortion care and contraception and respectful maternity care, are champions for human rights, dignity and autonomy of women and girls.
- In addition to increasing the number of trained midwives and overall SRHR workforce, midwifery associations were able to support these trainees over the long-term through integrating and applying skills and enhancing the quality of care at individual hospitals. For example, with the support of their midwifery associations, trained midwives went on to train other health professionals in their hospitals, provide mentorship to other midwives who were not trained, provide education and information to hospital management to incorporate updated equipment.
- Sustainable and long-term increase in SRHR was demonstrated by examples of midwifery associations marketing their emergency skills training to other organizations and hospitals for private trainings. By collaborating with midwifery education programs to train student midwives, associations provided to the economic growth and stability of their organization.

Quality Education (SDG4)

- Midwifery associations were involved in activities at both the secondary and university levels educating girls and women on SRHR, while also using the opportunity to recruit potential students into the profession.
- Midwifery associations were also able to advocate for regulated and accredited midwifery education programs to support the quality of midwives graduated before and after graduation. These long-term networks continued post project completion.

Gender responsive humanitarian action (SDGs 3 and 5)

- Midwifery associations were sought out at the ministerial and international NGO level, which served as important hubs for humanitarian action. Associations demonstrated leadership and advocacy for continued access to SRHR and ending gender-based violence during the COVID-19 pandemic demonstrating longer term impacts of strengthening capacity of civil society.

Recommendation 1

Ensure that midwifery associations are central and properly embedded in projects that strengthen the midwifery profession and promote access to SRHR. This includes capacity building of midwifery associations and housing activities facilitated by midwifery associations.

Our research showed that capacity building of midwifery associations combined with continuing education activities that are housed and facilitated by the midwifery association directly impact maternal mortality and morbidity post project.

Recommendation 2

Incorporate equity and feminist frameworks for program implementation and evaluation approaches that promote equity and challenge power imbalances.

Our research showed that a feminist, collaborative and decolonizing approach to midwifery association strengthening resulted in reciprocal relationships, which built the trust and motivation of midwifery associations and resulted in empowerment and ownership of activities.

Recommendation 3

A gender lens is critical to capacity building of midwifery associations including understanding the impacts of ethnicity and race. Establishing a base capacity of midwifery associations and outlining the limitations of those associations based on gender and other intersects all support an equitable and feminist approach.

Our research demonstrates that gender inequity impacts midwifery associations and midwives in unique contextually specific ways. For example, women midwives were often family caretakers and sole bread winners yet volunteering their time for projects and activities. However, when midwifery associations are properly invested in, they provide leadership opportunities for women to advance themselves professionally.

Recommendation 4

Expand the FIAP Action Area Key Performance Indicators (e.g., Education, Human Dignity) to include a broader set of indicators to more fully capture the impacts of skills training. Expansions include indicators that capture the who, what, and where of the training (e.g., who gave the training, what type of health professional attended, content/quality of the programming, and where the training took place).

Our research found that skills training indicators were often limited to focus on attendance/ the number of trainees. Mix of health professionals, evidence-based curriculum type and site of training delivery among others are important considerations for indicators and can improve facility or hospital involvement and implementation of skills.

Recommendation 5

Increase support for midwifery associations to actively engage in program implementation. National midwifery associations require appropriate financial support along with technical expertise to gain practical experience in project design and implementation. Peer-to-peer models of organizational capacity building, where organizations are able to progress at their own rate, are a tool for sustainable organizational development. Additional important considerations include support for midwifery association's organizational and staff costs, and adequate room to adapt programming to the pace of learning and allowing for margins of error.

Our research identified barriers in current funding models that often stipulate midwifery associations as 'beneficiaries' or 'implementation partners', which may undermine the complex nature of organizational capacity building.

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