



Lots of responsibility, little appreciation ●

The role of midwives in fragile contexts.
Country examples from Iraq and Côte d'Ivoire



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Achi, Awa, Carine, Diomande, Diyana, Khawla, Mariame, Mariette, Rasha, Sonia, Syntiche, Yasmin

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Publisher:
CARE Deutschland e. V.
Siemensstraße 17
53121 Bonn
Phone: + 49 (0) 228 – 97563 0
Email: info@care.de
www.care.de

Responsible:
Karl-Otto Zentel, National Director

Content Management:
Carla Dietzel (Côte d'Ivoire), Anica Heinlein (Iraq)

Collaboration:
Barbara Kühhas, Omar Saleh, Ndri Yao, Marie-Paule Yao, Leon Stumberger, Alida Kehlenbach, Corinna Henrich, Katharina Kohl

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Abbreviations

ASFI	Association de Sages Femmes Ivoiriennes Association of Ivorian Midwives
BMZ	Bundesministerium für wirtschaftliche Zusammenarbeit und Entwicklung Federal Ministry for Economic Cooperation and Development
CFA franc	Franc de la Communauté Financière d'Afrique Currency of the West African Economic and Monetary Union
CSC	Community Score Card
FLHWs	Frontline Health Workers
GFFO	German Federal Foreign Office Auswärtiges Amt
HICs	High-Income Countries (World Bank classification)
ICM	International Confederation of Midwives
IS	Islamic State
LICs	Low-Income Countries (World Bank classification)
LMICs	Lower-Middle-Income Countries (World Bank classification)
MISP	Minimum Initial Service Package (for Sexual and Reproductive Health)
NGOs	Non-Governmental Organizations
ODA	Official Development Assistance
OECD - DAC	Organisation for Economic Co-operation and Development - Development Assistance Committee
PHCC	Primary Health Care Center
SAA	Social Analysis and Action
SDGs	Sustainable Development Goals
SRHR	Sexual and Reproductive Health and Rights
SRMNAH	Sexual, Reproductive, Maternal, Newborn, and Adolescent Health
UNFPA	United Nations Population Fund
WHO	World Health Organization

Executive Summary

The German word for midwife “Hebamme” comes from the Old High German word *hev(i)anna*, which means “ancestor/grandmother who picks up/holds the newborn.” The work of a midwife is regarded as one of the oldest female professions in the world. Temple paintings from the third millennium BC depicting the triplet birth of the Egyptian sun god Re’s pharaoh children are one of the oldest examples of midwifery art.

Midwives help and support women in absolutely exceptional situations and accompany them not only during but also before and after the birth. When complications arise, they try everything to save mother and child. But their tasks go beyond assisting with births: For many young people around the world, midwives are also the only access to comprehensive sexuality education and contraceptives, allowing them control over their own sexuality and self-determination over their own bodies. Midwives thus make a significant contribution to the realization of sexual and reproductive rights.

Worldwide, there is a shortage of about 900,000 midwives to meet existing needs. At the same time, midwives, the vast majority of whom are women, are confronted with various individual and structural challenges in many contexts, and are thus hardly able to develop their full potential as agents of change.

Midwives become even more important in crisis, conflict, and post-conflict contexts. Due to their close connection to their clients, they are more likely than other healthcare professionals to remain active during a crisis and continue to work even when public healthcare has long since come under pressure or collapsed. As they are often the only medical staff left on site, their workload increases in such situations: In crises and fragile contexts violence against women and children occurs more frequently than planned pregnancies and sexually transmitted increase.



Midwife Diomande at her maternity ward in rural Côte d'Ivoire.

Using the example of midwives in Iraq and Côte d'Ivoire, two countries that exemplify conflict and post-conflict contexts, CARE investigated the extent to which midwives face similar challenges as agents of change despite the very different contexts. Interviews were conducted with 24 experts, including midwives, representatives of a midwives' association, representatives from the health sector, and CARE project staff. The findings were supplemented by desk studies. The key question was to what extent, despite all the differences, structures and needs exist in both contexts that project work can address in order to specifically support change.

The present study follows the approach of exemplary depth rather than comprehensive content; however, the anecdotal findings from the two contexts at hand and the related desk study clearly indicate that the results obtained have potential for scalability.

Parallels Despite All the Differences?

In both Iraq and Côte d'Ivoire, massive underfunding of the health systems by the national governments and a lack of prioritization of the area of sexual and reproductive health and rights (SRHR) by donors have a direct impact on the working environment: Health centers in Côte d'Ivoire lack medicines and basic supplies required for births just as much as the maternity wards studied in Iraq. Midwives, most of whom have chosen their profession out of a deep motivation to save lives, try to bridge this gap as best they can. This goes so far that they even finance patient's medication or transportation out of their own pockets. However, they are also the ones against whom the anger of the population is directed when medicines promised by the state or financed by donors for only a short time are not (or no longer) available.

In both systems, the responsibilities of midwives are restricted by law. At the same time, it is not ensured that there are enough doctors available to care for patients. Midwives therefore bear greater responsibility and have to take on tasks for which their training has not prepared them. Ivorian midwives usually work as the sole midwife in remote health centers. Nevertheless, the country's training system does not allow them to specialize in emergency medicine, for example. Iraqi midwives are only allowed to carry out a few of the emergency care procedures identified by the WHO on their own. In the emergency situations that regularly arise, they therefore operate in a legally uncertain and personally challenging space. In both contexts, midwives have no other choice: To save the lives of mother and child, they must exceed their official competencies.

Analysis of the country contexts clearly shows how important personal commitment is in general when dealing with systemic barriers on a daily basis: Gaps in the system are bridged by putting aside one's own needs (living in remote locations, separation from one's own family), exceeding the legally granted compe-

tences (with the risk of criminalization), and an understanding of the profession that includes a psychosocial element in addition to the physical care of women (psychosocial care with a high level of personal commitment).

In both contexts examined, the midwives interviewed also contribute to inclusive and equitable access to sexual and reproductive health for all.

In particular, they promote the questioning of patriarchal and other discriminatory structures through education (e.g., on family planning methods). At the same time, midwives themselves are also confronted with the challenges of this patriarchal system: differences between men and women in salary rates, decision-making powers, and potential career paths (management positions in health centers, hospitals, or health policy) combined with an overall low appreciation for their self-sacrificing and challenging work are a reality in both Côte d'Ivoire and Iraq.

The interviews conducted in Côte d'Ivoire and Iraq show that training and strengthening midwives in family planning can bring about direct success and sustainable change. Accordingly, the skills that midwives acquire in the area of family planning and education are crucial for realizing their potential in the area of sexual and reproductive health and rights and lead, for example, to fewer early pregnancies.

The present study has shown that in order to achieve SDG 3 (health and well-being) and 5 (gender equality) in the country contexts examined,

- both the training and further education of midwives and the equipment of health centers, delivery rooms, and maternity wards must be financed and promoted more strongly.
- The role of midwives must be given greater consideration, especially in crisis contexts. It is thus crucial that midwives are involved in all decision-making processes relating to sexual and reproductive health (SRHR) and are represented in leadership positions.
- Especially in crisis response and prevention, donors and national governments need to recognize SRHR as a whole, and the

role of midwives in particular as an essential component of health care. This should be reflected by increased investment in the occupational field.

This study shows how midwives use their personal commitment on a daily basis to compensate for under-resourced and sometimes dysfunctional systems. They pay the price for a lack of state care and investment in mostly poorly paid jobs without sufficient legal and physical job security. However, the responsibility for greater access to sexual and repro-

ductive health and rights must not and cannot lie solely with the (mostly female) midwives: Their support and promotion must go hand in hand with the targeted strengthening of healthcare systems and the sustainable and reliable provision of equipment and medication.

To achieve this, the stories of midwives like Diyana and Diomande, who were interviewed for this study, need to be heard and taken seriously.

Midwife Diyana providing postnatal care for a newborn in the hospital in Sinjar.



1

Midwife: A Dream Job?

Diomande regularly delivers babies. Usually in her rural health center, but if necessary due to complications during the birth, also on the back of a three-wheeled motorcycle on the way to the nearest hospital in the city.

Diyana works weekly shifts. One week on site, one week at home. When she is on duty, she is usually at the hospital. She only leaves the delivery room to eat and sleep in the neighboring nurses' home. A doctor is only available on Sundays and Mondays to assist with complications.

Both women are midwives. Diomande works in a health center in rural Côte d'Ivoire, West Africa, where there is no ambulance and the hour drive to the nearest hospital is mostly on dirt roads. In the event of complications during birth, the women must be transported to the hospital on a motorcycle, accompanied by the midwife.

Diyana works in the only hospital in Sinjar, a region in northern Iraq that is heavily affected by conflict. The weekly shifts are necessary because the security situation does not allow Diyana to live close to the hospital. Sinjar became largely known for the genocide of the Yazidis – destroyed towns and villages, mined terrain, and poisoned water sources are still the reality today.

Diomande and Diyana are exemplary for many midwives worldwide: The main responsibility for reducing maternal mortality and access to sexual and reproductive health and rights (SRHR) is often borne by them alone.

Qualified midwives are crucial for reducing maternal mortality, a sub-area of Goal 3 of the *2030 Agenda for Sustainable Development*: As *Frontline Health Workers (FLHWs)*, they work directly with the population. They are usually the only specialists in sexual and reproductive, maternal, newborn, and adolescent health (SRMNAH) for miles around. Their educational work on family planning and physical self-determination contributes significantly to progress towards equality between men and women and overcoming harmful norms.

For all their merit, this role is often thankless: Midwives work in patriarchal systems and as primary health workers in a mostly heavily underfinanced sector. In no respect are they supported in the way that the responsibility and heavy workload they carry would require. Their profession is usually held in low esteem by the public healthcare system or society. They have few opportunities for training and further education, suffer from a lack of legal security, and are inadequately remunerated.

This may also explain why there is a massive shortage of staff in this area: In 2021, there was a global shortfall of around 900,000 midwives who would have been needed to cover the existing demand in the SRMNAH area.¹

In crisis, conflict, and post-conflict contexts, this already precarious situation is further exacerbated: Pregnant women must also receive medical care in acute crisis situations. Sexualized violence and violence against women and children, unplanned pregnancies, and sexually transmitted diseases rise. At the same time, health and care services collapse. Maternal mortality in humanitarian crises and fragile contexts is almost twice as high as the global average,² and more than half of all female deaths during or as a result of child-birth occur in humanitarian contexts.³

At the same time, the right to sexual and reproductive health, self-determination, and sexual identity is often the first to be curtailed in crises. In systems that were already underfunded before the conflict, so-called general health care is seen as a priority; resources for specific services, which usually include sexual and reproductive health, become scarcer. In addition, prolonged crises also affect previously well-functioning healthcare systems, which can partially or completely collapse as the crisis continues.

However, even in crisis situations, midwives are often the ones who stay. As part of their community and in their commitment to life and self-determination, they often risk their personal safety under poor working conditions.



Examination table at the Fari M'babo Health Center in Côte d'Ivoire.

1 UNFPA, WHO and ICM (2021a): [The State of the World's Midwifery 2021](#).

2 WHO (2023a): [Maternal Mortality](#) (accessed 17.10.2023).

3 WHO, UNICEF, UNFPA, World Bank and United Nations Populations Division (2019): [Trends in maternal mortality 2000 to 2017: estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division](#).

The Development of Family Planning as a Human Right

Over 50 years ago, the international community committed itself to the continuous expansion and protection of SRHR for all. The commitment to the right to family planning and the recognition of family planning as part of primary health care followed in the 1960s and 70s. In 1994, the Cairo Programme of Action finally recognized sexual and reproductive health and self-determination as human rights.

Today, SRHR is enshrined as a human right in all landmark documents: In the Convention on the Elimination of All Forms of Discrimination against Women (1979), the Beijing Platform for Action (1995), the Istanbul Convention (2011), the Sustainable Development Goals (2015), or the EU Action Plan for Gender Equality GAP III (2020), to name but a few.

The currently most comprehensive definition of SRHR, on which both the German government's new approaches to feminist development and foreign policy are based and to which CARE is also oriented, is that of the Guttmacher-Lancet Commission: "Sexual and reproductive health is a state of physical, emotional, mental and

social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction or infirmity. Therefore, a positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust and communication in promoting self-esteem and overall well-being. All individuals have a right to make decisions governing their bodies and to access services that support that right."⁴

The right to family planning is not uncontroversial: many areas of the human rights framework around SRHR are being challenged by conservative forces and anti-rights movements. The SRHR definition of the *International Conference on Population and Development* (ICPD, 1994) in Cairo, which is the so-called *agreed language* of the United Nations, is under constant attack.⁵ Comprehensive sexuality education, access to safe and legal abortions, sexual health counseling and services, the sexual and reproductive rights of individuals, and the right to self-determination are all targets of ongoing conservative campaigns.

4 Guttmacher-Lancet Commission on Reproductive and Sexual Health and Rights (2021): [Accelerate Progress: Sexual and Reproductive Health and Rights for All – Executive Summary](#), p. 4.

5 The Program of Action adopted at the International Conference on Population and Development (ICPD) called for all people to have access to comprehensive reproductive health care, including voluntary family planning, safe pregnancy and childbirth services, and the prevention and treatment of sexually transmitted infections. It also recognized that reproductive health and women's empowerment are intertwined and that both are necessary for the advancement of society. UNFPA: [Explainer: What is the ICPD and why does it matter?](#) (accessed 20.09.2023).



Diyana and colleagues with a newborn baby.

1.1 Midwives: Much More Than Just Birth Assistants

In 2019, around 6.5 billion working hours would have been required worldwide to cover the entire demand for basic SRMNAH services. By 2030, this figure will be an estimated 6.8 billion hours. Just over half (55 percent) of the demand is for interventions in maternal and newborn health (prenatal, birth, and postnatal care). Thirty-seven percent is other interventions in sexual and reproductive health, such as counseling, family planning, comprehensive abortion care, and the detection and treatment of sexually transmitted diseases. A further eight percent is interventions in sexual and reproductive health for young people. With the current composition and distribution of health personnel in sexual, reproductive, maternal, newborn, and adolescent health (SRMNAH), only 75 percent of global demand can be covered at most. In low-income countries, this figure drops to just 41 percent.⁶

At the same time, fully trained, licensed, and integrated midwives supported by interdisciplinary teams and an enabling environment could deliver around 90 percent of essential SRMNAH interventions, despite representing less than 10 percent of the global workforce in the field.⁷ Their potential is therefore far from being fully exploited.

Depending on national legislation, midwives already provide many important SRMNAH clinical interventions. Midwives are not only key figures for mothers: They are also essential for improving the care of newborns, promoting breastfeeding, and supporting mothers and families in caring for their babies.

In addition, through their direct contact with the inner workings of families, they can play a central role in general access to health care, combating violence against women, and implementing sexual and reproductive rights. Due to their role in obstetrics, they are also a natural point of contact for the population for sexuality education and contraception, comprehensive abortion care, and the screening

6 UNFPA, WHO and ICM, 2021a.

7 UNFPA, WHO and ICM, 2021a.

and treatment of sexually transmitted diseases.

In societies where women and young people are sometimes deliberately deprived of knowledge about their own bodies, the area of sexuality education should not be underestimated. On the one hand, midwives are the key to knowledge that is relevant for all women; for example, about menstruation or family planning methods. On the other hand, they are often the only option for marginalized women, such as those infected with HIV or disabled women, to access knowledge and health services. Midwives thus contribute to the realization of rights.

In many cases, midwives also play an important and decisive role in educating people about the prevention of harmful practices such as female genital mutilation or other forms of violence against women and children.

1.2 Midwives as Part of Crisis Care

In reality, midwives are often only able to provide a fraction of the full range of care services described due to a lack of training, equipment, and licensing. In humanitarian and development contexts, scarce resources further limit their work. But midwives are specialists and, with good training and an appropriate legal framework, can provide most of the SRMNAH services that become a priority in a crisis.

Another reason in favor of midwives as key caregivers is that they are more likely than other healthcare staff to remain active during a crisis. One reason for this is their close connection to the communities in which they work. Also, they often do not have the financial means to flee the crisis area due to their often poorer social status and pay compared to other healthcare staff. They play an important role in supporting and caring for refugee and inter-

nally displaced women and girls, as they are often members of this group themselves.

In 2014, the International Confederation of Midwives (ICM) published a statement on the role of midwives in disaster preparedness. They state that it is crucial to include midwives in national emergency preparedness to ensure that midwifery is integrated into disaster response. Accordingly, however, it is also important that the curricula for general and professional midwifery education cover the provision of effective SRMNAH care in a crisis.⁸

1.3 Two Types of Discrimination: As a Woman in a ‘Women’s Profession’

Sex distribution in healthcare professions is determined by existing norms. These tend to define nursing as women’s work, while technical specialist areas such as medicine are seen more as male areas. Following to this narrative, the majority of doctors, dentists, and pharmacists worldwide are men, while almost all midwives (93 percent) and the majority of nursing staff are women. In Iraq, 100 percent, and in Côte d’Ivoire 97 percent of midwives are women.⁹

Professional groups in the healthcare sector that are predominantly made up of women are assigned less social prestige, less decision-making authority, and less pay than those that are predominantly made up of men.¹⁰ Rasha, who works as a midwife in Iraq, reports that her profession is often seen as “superfluous” by those around her, as she is paid to do what “all women know.” This view is often only changed by direct or indirect experience of a first birth and the midwife’s role in it.

8 ICM (2014): [Role of the Midwife in Disaster/Emergency Preparedness](#).

9 UNFPA, WHO and ICM, 2021a; WHO (2022a): [The gender pay gap in the health and care sector a global analysis in the time of COVID-19](#).

10 WHO, 2022a.

This shows on a small scale what UNFPA's *The State of the World's Midwifery* report (2021)¹¹ also found at another level: In only half of the reporting countries midwives hold leadership positions in the national health ministry. The overall limited opportunities for midwives to hold leadership positions in health centers, hospitals, or a country's health policy lead to the absence of an important voice at the table when strategic decisions are made in the area of sexual and reproductive health and rights. It also reinforces stereotypes about the role of women and prevents midwives as a professional group from realizing their full potential and acting as agents of change.

As a result, the importance and complexity of midwifery and its role in family planning are often underestimated. A lack of investment in training, inadequate workplace equipment and safety, high workloads, and a significant pay gap between men and women are further practical consequences of this reality.

1.4 Funding Status and Lack of Prioritization: Sexual and Reproductive Health and Rights

The often low esteem in which the midwifery profession is held in comparison to other medical professions is reflected in the funding status of SRHR as a whole. The sector is one of the most underfunded by governments and donors worldwide.

According to the Guttmacher-Lancet Commission, low-income countries (LICs) could cover the entire population's need for contraceptives as well as care costs for mothers and newborns with just US\$13 per capita per year. This also includes some of the work of midwives. However, on average, only US\$1.10 per capita is actually spent on this area.¹²



Diomande in front of her maternity ward, which was equipped with funds from CARE.

In 2020, low income countries (LICs) spent an average of just 6.22 percent of their total expenditure on health. Over the last 10 years, the average share has stagnated instead of rising as urgently needed.¹³ It was not until the COVID-19 pandemic that healthcare expenditure increased in all countries in 2020.¹⁴ However, it can be assumed that in most cases this did not lead to an increase in expenditure on SRHR and family planning.

11 UNFPA, WHO and ICM, 2021a.

12 In low- to middle-income countries (LMICs), the cost would be only \$7.8 per head. But even in these countries only \$5.2 was spent per head in 2016. The costs of HIV prevention and treatment were not included in this calculation. The Partnership for Maternal, Newborn & Child Health (2020): *Funding for sexual and reproductive health and rights in low- and middle-income countries: threats, outlook and opportunities*.

13 WHO (2021): *Global expenditure on Health: Public spending on the rise?*

14 WHO (2022b): *Global expenditure on health. Rising to the pandemic's challenges*.

Countries with a higher average income also spend more on health on average: 8.28 percent is spent in low- to middle-income countries (LMICs) and 13.58 percent on average in high-income countries (HICs).¹⁵ According to calculations, LMICs would have to increase their healthcare expenditure by 37 percent to achieve universal healthcare. Instead, 55 percent of healthcare spending in LMICs to date is out-of-pocket expenditures, which is money that individuals pay out of their own pockets for their healthcare.

This often means that the poorest population groups cannot afford health care and family planning via contraceptives. The underfunding of the health sector in LMICs is also hardly compensated for by international donors: To achieve universal health coverage, funding for official development assistance (ODA) for health in LMICs would have to be 90 percent higher than at present.¹⁶

ODA funds for SRHR amounted to just over US\$12 billion worldwide in 2021. Although this was an all-time high in absolute terms, donors invested a lower proportion in SRHR compared to the previous year: While they had allocated 6.48 percent of their total public development funds to SRHR in 2020, this figure was only 6.21 percent in 2021.¹⁷

Only seven OECD-DAC countries¹⁸ spend more than five percent of their ODA funds on SRHR: Canada, the Netherlands, Sweden, Iceland, Norway, and Luxembourg. The largest donor worldwide, both in absolute terms and as a percentage of SRHR, is still the US government, which poses challenges for the sector: Every change of government and potential change of direction has an enormous impact on the financing of the entire sector.¹⁹

15 WHO (2023b): Domestic general government health expenditure (GGHE-D) as percentage of general government expenditure (GGE) (%). Data by country (accessed 18.10.2023).

16 Strupat, C.; Balasubramanian, P.; Srigiri, S. and Hornidge, A.-K. (2023): Health Financing in Times of Multiple Crises: Analysis and Recommendation.

17 SRHR here refers to the categories of the Donors Delivering for SRHR Report, in which SRHR funding is related to how donors support the full SRHR agenda. Deutsche Stiftung Weltbevölkerung (DSW) (2023): Donors Delivering for SRHR, Report 2023.

18 Countries belonging to the Development Assistance Committee of the Organisation for Economic Cooperation and Development.

19 DSW, 2023.



Medical equipment in the hospital in Sinjar, Iraq.

Germany's Donor Performance in SRHR

In absolute terms, Germany was the second largest OECD-DAC donor for the overarching thematic area of global health in 2021. However, Germany only ranks 16th in the relative prioritization of this area.²⁰ Even after an increase in the years 2019 to 2021, the German government only allocated 2.62 percent of its ODA funds to SRHR measures. A significant proportion of German funding consists of core contributions to multilateral organizations.²¹

The work of midwives could theoretically be financially supported through ODA funds in the areas of reproductive health services, health infrastructure, family planning, and health workforce development. With the exception of the contribution for reproductive health, German funding for all these areas was reduced in 2021.²² Nevertheless, Germany was still the world's second largest donor in absolute terms in SRHR in 2021. However, in terms of prioritizing its funding, advocacy for the

sector, and commitment to the urgency of closing the funding gap, it ranks only mid-table among OECD countries.

It remains to be seen whether the commitment to a feminist foreign and development policy will change this: Both ministries, the Federal Ministry for Economic Cooperation and Development (BMZ) and the German Federal Foreign Office (GFFO) have identified SRHR as a priority issue in feminist foreign and development policy. In the policy papers, they commit themselves to the defense and realization of sexual and reproductive health and rights both in projects financed by Germany and in international negotiations. However, no concrete financial commitments have yet been made or target indicators defined.

In the guidelines on feminist foreign policy, the GFFO states that commitment in the area of SRHR should be strengthened: "We will focus our project work more heavily on sexual and reproductive health and rights."²³

20 Donor Tracker (2023): [Germany / Global Health](#) (accessed 18.10.2023).

21 DSW, 2023.

22 Donor Tracker, 2023.

23 German Federal Foreign Office (GFFO) (2023): [Shaping Feminist Foreign policy. Federal Foreign Office Guidelines](#), p. 41.

The GFFO also recognizes that a holistic approach, as called for in the triple nexus 'humanitarian aid – development cooperation – peacebuilding,' is essential. It also aims to use its funding to help facilitate the transition from humanitarian aid to regular health-care for all people and avoid the gaps in care that often arise at such interfaces.²⁴

In view of the increasing number, extent, and duration of crises, the BMZ and GFFO want to work on feminist reorientation concerning the topic of SRHR in "coherence"²⁵ and are committed to "close cooperation"²⁶ here.

1.5 CARE Theory of Change: Midwives as Agents of Change

To achieve sustainable change, CARE always works at three levels: at the individual level, at the level of relationships in society, and at the level of system structures.²⁷ In the work towards a universal right to health, this means, among other things, strengthening the relevant health personnel (individual level). It also includes the institutional strengthening of local healthcare systems and their independence (systems). Equally important in the work in the health sector is the sustainable transformation and eventual overcoming of discriminatory norms and practices that limit access to health services for all (society).²⁸

CARE promotes the development of resilient, equitable, and accountable health systems that can respond to shocks and crises and ensure sustainable access to quality health services for all. Due to the intersectional understanding of discrimination, there is a particular focus on women, girls, and the most marginalized groups in crisis and fragile contexts. In order to achieve sustainable change, CARE focuses

on the structural causes of inequality. After all, restrictive norms and inequalities between men and women are reproduced and reinforced in healthcare systems.²⁹

Due to their importance for society and the healthcare system, special attention is paid to Frontline Health Workers (FLHWs), all those who connect health systems / institutional care with communities. Especially in remote and rural areas, FLHWs provide the first—and often only—access to important healthcare services for millions of people.

Most FLHWs are women. They are themselves members of the communities in which they work. This not only helps them bridge socio-cultural barriers through an intuitive understanding of their own communities, but also helps them reach out to vulnerable and underrepresented individuals. In addition to providing medical services, they are also responsible for providing health education and information, coordinating care between different components of the healthcare system, providing healthcare resources and products, and improving patient self-efficacy.

Midwives are a central professional group within the FLHWs. Working with midwives is crucial for the promotion of sexual and reproductive health, the realization of related rights for women, girls, and marginalized groups, and maternal and newborn health. CARE's programs therefore specifically support midwives as competent, well-equipped, and empowered agents of change. Working for more say and independence for midwives not only strengthens their role in the healthcare system, but also their position as women, thus contributing to the transformation of patriarchal social systems.

Around a quarter of the 129 million people worldwide who are dependent on humanitarian aid are women and girls of childbearing

24 German Federal Foreign Office (GFFO) (2020): [Federal Foreign Office Strategy for Humanitarian Assistance in the Health Sector \(2020–2025\)](#).

25 Federal Ministry for Economic Cooperation and Development (BMZ) (2023): [Feminist Development Policy. For Just and Strong Societies Worldwide](#), p. 21.

26 GFFO 2023, p. 40.

27 CARE (2023a): [Gender Equality Framework. CARE's Theory of Change for Achieving Gender Equality](#).

28 CARE (2021): [Health Impact Area Strategy – Vision 2030](#).

29 CARE, 2021.



Build assets and agency of women, girls, and other groups facing injustice.



Change the power relations to enable collective voice and wellbeing



Transform health systems and structures to enable universal access to health

CARE Frontline Health Workers (FLHWs) Strategy: Theory of Change

Key Approaches:

Improve FLHWs Agency and Wellbeing



Transform community norms, trust, and health behaviors



Strengthen primary healthcare systems



Activities:

- Train
- Equip
- Manage
- Incentivize performance targets, inclusive decision making, leadership opportunities



- Community dialogue & reflection
- Rapid Gender Analyses
- Participatory social accountability mechanisms
- Data collection



- Improvement and linking of services
- Localisation of administration
- Provision of resources



Outcomes:

FLHWs are trained, equipped, and incentivized to bridge the gaps in access to health information and equitable service delivery.

Communities are actively engaged in the facilitation of primary healthcare service delivery networks and in shifting norms towards healthy behaviors.

Primary health care systems are inclusive of FLHWs as care deliverers and responsive to the needs of vulnerable populations.

Impact:

The potential for FLHWs as agents of change in their communities is maximized.

age. CARE thus identifies the strengthening of sexual and reproductive health and rights in emergency situations as crucial for needs-oriented assistance in crises.

As an organization with a dual mandate in humanitarian aid and development cooperation, CARE is well positioned both to respond flexibly to emergencies and to strengthen the resilience of public health systems. It is crucial for the care of women and girls to plan comprehensive SRH services from the beginning of a crisis, which go beyond the life-saving

measures described in the *Minimum Initial Service Package (MISP)*³⁰. This enables a smooth transition to the work of strengthening healthcare systems.³¹ The work with midwives, their further training, and the strengthening of their position in the health system must therefore be incorporated into humanitarian programs and linked to resilience-building programs in fragile contexts in accordance with the nexus, as illustrated in this report using the country examples of Iraq and Côte d'Ivoire.



30 The *Minimum Initial Service Package (MISP) for Sexual and Reproductive Health* includes a series of crucial, lifesaving activities required to respond to the SRH needs of affected populations at the onset of a humanitarian crisis. The Sphere Project (2018): *Humanitarian Charter and Minimum Standards in Disaster Response*.

31 This is based on the *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, IAWG, 2018.

2

Midwives in Action for a Self-Determined Life – Examples from Iraq and Côte d’Ivoire

Midwives worldwide are confronted with a multitude of individual and systemic barriers. Harmful norms restrict and challenge both patients and midwives. Conflicts and crises make their work more difficult in many regions and jeopardize their security.

This raises the question of how midwives can be supported in a sustainable and concrete way: What do midwives need in contexts where they are inadequately trained, work in under-equipped workplaces, and perform their duties with an extremely high level of personal commitment?

To answer these questions, CARE examined two country contexts, Iraq and Côte d’Ivoire, which exemplify conflict and post-conflict contexts. Desk studies on the situation of SRHR and interviews with midwives and other local experts were used to identify the challenges faced by midwives in these contexts, their needs and demands, and the practical framework for project work on the ground.³²

These results provide an insight into the realities of midwives’ lives and provide important starting points for achieving impact in a complex area.

32 In Iraq, four CARE Iraq midwives and project staff were interviewed. In Côte d’Ivoire, interviews were held with seven midwives, representatives of the national midwives association, CARE project staff and community representatives active in the health care sector and local programs. Diyana from Iraq and Diomande from Côte d’Ivoire play quite a prominent role here, as they are also featured in the photography exhibition “In Action for Life – Midwives Worldwide” organized by CARE.

2.1 Iraq: Active during Crisis

In 2014, Diyana³³, a Yazidi woman, had to flee to the mountains with her family and thousands of other people from Sinjar in northern Iraq. There she witnesses a dramatic birth in which the child dies and the mother barely survives: Perhaps the child could have been saved, but no one knew what to do. For Diyana, this is the moment when she decides to become a midwife.

Today, Sinjar is no longer actively contested, but the area is still very insecure. In 2023, Diyana, who has been working in the only local hospital for five years, is still unable to live locally due to the security situation. That is why the 26-year-old lives in Mamrashan Camp north-east of Mosul, from where it takes her a good three hours to get to Sinjar Hospital. Her shifts therefore last a whole week. Over the past five years, she initially worked in the general maternity department and has now been working in the delivery room for two years. The hospital in Sinjar urgently needs medical equipment and doctors. "If you want to give birth, you should do it on Sundays or Mondays; then a doctor will be there in an emergency," explains Diyana.

Diyana is both a midwife and an educator. She conducts family planning courses and explains contraceptive methods. She wants to empower



Midwife Diyana.

women. Despite adverse circumstances, she does everything she can to give the women in Sinjar a sense of security at the moment of giving birth, when they are most vulnerable.

Click here for more information about Diyana and her work



Iraq has not been at peace for decades: Due to successive crises, the country has a complex and persistent decades-long history of conflict, internal displacement, and violence. This has left its mark on both people and systems. Many health facilities are still destroyed and a large part of the Iraqi population suffers from untreated psychological trauma.

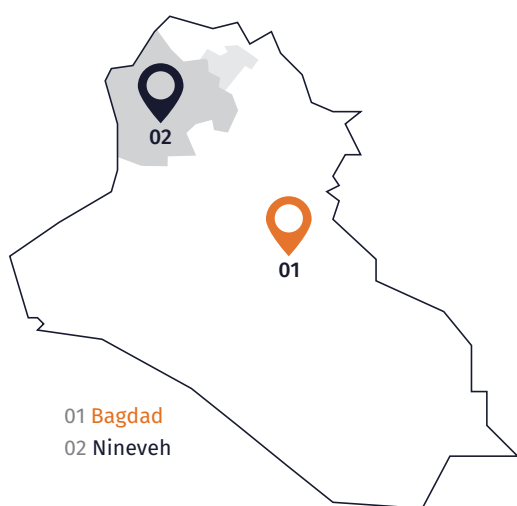
More than five years after the official end of hostilities, progress in reconstruction remains limited and humanitarian needs persist. The country continues to face multiple security and socio-economic crises, exacerbated by the fall in global oil prices in 2020 and the COVID-19

pandemic, which has affected all sectors, as well as by the impact of the climate crisis. Armed groups are still acting against the civilian population and civilian infrastructure.

Although, according to the Humanitarian Response Plan (HRP) 2022, which was only 67 percent funded, one million people were still in acute need in Iraq, an official end to humanitarian coordination was declared for 2023. In 2023, a humanitarian response plan was no longer drawn.

³³ In Iraq, Diyana (26) and Khawla (28), midwives in Sinjar, and Rasha (27) and Yasmin (29), midwives in Shekhan Hospital, were interviewed for this study. All are unmarried and have no children. Three of them are afraid of giving birth for the first time.

However, the consequences of years of armed conflict are still clearly noticeable today: More than one million people are still living as internally displaced persons, mainly in the north of the country.³⁴ Many of them are Yazidis who fled the fighting in the Sinjar region. After the violent events, which the German parliament recognized as genocide in January 2023, most of the survivors sought refuge in the areas of the autonomous region of Kurdistan in Iraq.



The living situation is difficult both for people who have already returned to their communities of origin and for those who continue to live as internally displaced persons. In many areas, the infrastructure has been destroyed and reconstruction is slow. In areas such as Sinjar, where armed conflict continues, humanitarian aid and reconstruction are also at risk. Newly equipped health centers are repeatedly occupied and looted and medical equipment is stolen. The security situation is volatile and people lack opportunities to earn a living. Half a million returnees were still dependent on humanitarian aid in 2022.

In large parts of Iraq, the healthcare system is now functioning reasonably well again. In north-western Nineveh, too, enormous progress has been made in recent years with regard to child and infant mortality. In some districts, such as Sinjar, however, provision of care remains difficult.³⁵ Iraq spends comparatively little on health, at around six percent of its total expenditure.³⁶

In humanitarian crises such as this one, women suffer particularly from a lack of reproductive health services: Poor delivery practices, lack of equipped and functioning maternity wards, and a very high rate of anemia among pregnant women were identified as primary problems in the crisis in Iraq. In this fragile context, midwives are particularly important as primary healthcare staff, but also as key players in the area of sexual and reproductive rights.

2.1.1 Midwives in Iraq: Facts and Figures

Iraq is one of the countries in the Arab region with the highest shortage of midwives. In 2017, Iraq had only 0.96 midwives per 10,000 people (absolute: 3,793 midwives).³⁷ According to an analysis by UNFPA, there was a shortfall of around 18,800 midwives in the country in 2020 to meet demand efficiently. Forecasts predict that this shortage will worsen by 2030 if no proactive measures are taken to increase the training of midwives.³⁸

The potential for meeting the demand for essential SRMNAH services by the existing workforce (midwives, nurses, doctors) in Iraq is 94 percent. However, this Potential Met Need (PMN)³⁹ “estimates the maximum percentage of the need for essential SRMNAH interventions that could potentially be met by the current workforce, if it was well educated, equitably distributed and working within an ena-

34 International Organisation for Migration (2023): [Displacement Tracking Matrix. Iraq](#) (access 18.10.2023).

35 WHO (2022c): [Global Health Observatory Data Repository. Iraq](#); WHO Regional Office for the Eastern Mediterranean (2018): [Iraq: Health Systems Profile](#).

36 WHO, 2023b.

37 UNFPA, WHO and ICM, (2021b): [The State of the World's Midwifery, Country Profile Iraq](#).

38 UNFPA (2022): [The state of the Midwifery Workforce in the Arab Region](#).

39 Potential to cover needs = available working time / required working time for universal coverage of essential SRMNAH interventions UNFPA, WHO and ICM, 2021a.



Diyana and colleagues in the hospital.

bling environment⁴⁰ (and thus able to deliver high-quality care)⁴¹ These conditions are not met in Iraq. In particular, the potential of midwives is not being fully exploited.

The distribution of personnel is a particular problem in Iraq: Specialized doctors who offer SRMNAH services are concentrated in the country's major cities.⁴² Midwife Diyana explains that even in 2023, doctors will only be present at the hospital in Sinjar on Sundays and Mondays. And even when they are present, they are heavily overloaded. For this reason, they often refer women to the next larger hos-

pitals in Tel Afar or Mosul early on in labor if complications arise. For the women, this is associated with great hardship and anxiety due to past experiences of violence and the language barrier.

“Many of the women only speak Kurdish, not Arabic, especially if they have no education or are not studying. So it is difficult for them to communicate when they are in hospital in Mosul. They then ask me for help, but I can't do anything for them when the doctor refers them. It is what it is.”

Diyana, 26, midwife

40 An enabling environment means that SRMNAH workers can practise to their full scope, are accountable for independent decisions within the regulated standard operating procedure, work within a functional health infrastructure with adequate human resources, equipment and supplies, have access to timely and respectful consultation, collaboration and referral, be safe from physical and emotional harm and have equitable compensation, including salary and working conditions. UNFPA, WHO and ICM, 2021a.

41 UNFPA, WHO and ICM, 2021a.

42 WHO Regional Office for the Eastern Mediterranean, 2018.

2.1.2 Iraqi Midwives in the Healthcare System: Tasks and Restrictions

The maternal mortality rate⁴³ in Iraq fell from 116.9 per 100,000 live births in 2000 to 76.1 in 2020.⁴⁴ One explanation for this is probably the very high proportion of births attended by trained staff, at 96 percent.⁴⁵ Iraq is therefore well on the way to achieving SDG 3, which aims to reduce the maternal mortality rate to less than 70 deaths per 100,000 live births by 2030.

Many SRMNAH interventions in Iraq are officially only allowed to be carried out by doctors, although they could be carried out more efficiently and cost-effectively by midwives.⁴⁶ Iraqi midwives are only authorized to provide a few services under the applicable laws. For example, they are only allowed to carry out two of the seven treatment procedures identified by the WHO for emergency obstetric and neonatal care. In comparison, Moroccan midwives are authorized to perform all of these seven basic treatments.⁴⁷ Especially in remote health centers and locations with a shortage of doctors, such as Sinjar, it would be a great advantage if well-trained and equipped midwives were allowed to act more comprehensively.

In theory, midwives are only allowed to attend births under the guidance and in the presence of specialized gynecologists. In practice, however, things often look different. Often the

women giving birth only arrive in the delivery room when the birth is already in full swing, which also puts the midwives in a legal dilemma. Midwives must then provide immediate assistance, even if this goes beyond their legal powers.

Midwives in Iraq are also only allowed to act independently to a limited extent in other areas. Pre- and postnatal examinations are carried out by doctors in hospitals, midwives are only allowed to assist. However, some midwives report that they also carry out such examinations on their own responsibility.⁴⁸

“Prenatal examinations are carried out in Shekhan four and eight weeks before birth, but only by the doctors. The situation is different in the Primary Health Care Centers (PHCCs), where both doctors and midwives are stationed and both can carry out the preliminary examinations. Home visits by midwives after the birth are unusual; there are far too many births and we couldn’t possibly visit that many women.”

Yasmin, 29, midwife

However, all decisions are made by doctors. The midwife’s expertise and assessment are hardly taken into account. This also includes the choice of birth method, which potentially explains the high rate of cesarean sections at 33.2 percent.⁴⁹

43 The maternal mortality ratio is the estimated number of women aged 15 to 49 years, per 100,000 live births, who die from pregnancy-related causes or within 42 days of an abortion.

44 This puts Iraq in 76th place out of 182 countries. UNFPA (2023a): [UNFPA State of World Population 2023: 8 Billion Lives, Infinite Possibilities. The Case for Rights and Choices.](#)

45 Assisted births means the percentage of births carried out by trained medical personnel (doctors, nurses or midwives).

46 UNFPA, 2022.

47 For Iraqi midwives, only newborn resuscitation with bag and mask and assisted birth using a suction cup (vacuum extraction) are permitted. Emergency obstetric care as defined by WHO also includes administration of intravenous/intramuscular antibiotics, administration of intravenous/intramuscular uterotonic medications (e.g. oxytocin), administration of intravenous/intramuscular anticonvulsants and uterotonics, manual removal of the placenta and manual vacuum aspiration of retained products of conception. UNFPA, 2022.

48 In Iraq, 67.9 percent of women attend prenatal check-ups at least four times. A follow-up examination within two days of giving birth takes place in 82.6 percent of women. UNICEF (2018): UNICEF Data. Iraq (accessed 18.10.2023).

49 UNFPA, WHO and Inter-Agency Working Group on SRH and HIV linkages (2021): [Sexual and Reproductive Health and Rights Infographic Snapshot. Iraq 2021.](#)



Diyana examining a patient.

“When the patients come to the hospital to give birth, the doctor first signs a piece of paper, and then the midwives actually do almost everything in the further course of the birth. If complications are foreseeable, doctors tend to refer patients to the next largest hospital. It is the doctors’ sole decision; we midwives have no say in this and our opinion is not heard either—sometimes midwives know that doctors just don’t want to take on any risks or work and therefore often continue to refer the women.”

Yasmin, 29, midwife

A major challenge in the everyday life of midwives is the poverty of the population. The cost of routine check-ups in public health centers is only ID3,000 (equivalent to around US\$2.30). In emergencies, the costs are reduced to ID500 (around US\$0.40). However, the trip to the hospital must also be financed, and ultrasound diagnostics are an additional service that often exceeds women’s financial means. Women save on these examinations, as

obstetric care at the hospital costs around US\$11 for the paperwork. In addition, medication often has to be obtained from pharmacies as it is not available in the hospital. This means that women usually give birth without an ultrasound or other laboratory tests.

“The financial situation of the people in Sinjar is really bad. They have no source of income. There are no job opportunities. So if women are referred and the ambulance is not available, they have to rent a car or take a cab. Sometimes they don’t have the money; then we give them the money.”

Khawla, 28, midwife

Midwives in Iraq also take on important tasks in the psychological care of women. This “unique care philosophy of care that midwives provide”⁵⁰ facilitates access to healthcare, especially for the most vulnerable and marginalized groups, such as traumatized women who have experienced forced displacement.

50 UNFPA, WHO and ICM, 2021a.



Diyana in front of the entrance to the surgical department of Sinjar Hospital.

“Sometimes the woman comes and has the child, and then she needs some kind of psychological support. Someone to talk to her to reassure or comfort her or give some kind of support. It is very difficult for some people. Even if they are transferred, they are afraid to leave the area in which they live. On the way from Sinjar to Mosul, you have to drive through Tel Afar and all the areas where the main villages and districts of IS were located. So for them, traveling somewhere in the middle of the night is very scary. That is not easy.”

Diyana, 26, midwife

2.1.3 The Iraqi Midwives Association: Tiger Without Teeth

Midwifery is recognized as an independent profession in Iraq and there is a legal definition of what a professional midwife is. A license is required to practice the profession, as well as the entry of licensed midwives in a register. This registry is under the authority of the Iraqi Nursing Syndicate, a general professional organization for nursing staff.⁵¹

The Professional Association of Midwives, first founded in 1959, and then refounded in 1971 and again in 2012, is also subordinate to the Nursing Syndicate. It is responsible for further development of the profession, individual and professional guidance and representation of its members, and for advising the government on basic papers in the field of maternal and newborn health. Negotiations on working and wage conditions in the public health sector with the government do not fall within the remit of the professional association.⁵²

The average yearly salary of Iraqi midwives is around US\$6,500. Some midwives feel that this is too low a reward for their work. What's more, midwives are also not adequately insured: Occupational safety is not guaranteed, nor is financial protection in the event of accidents at work. Although the midwives interviewed were very aware of these grievances, none of them were aware of a midwives' union or interest group in Iraq that would campaign for the working conditions of midwives and the appreciation of their work.

51 UNFPA (2014): *The State of the World's Midwifery 2014*. Iraq.

52 UNFPA, 2014.



Counseling by the midwife Diyana in Sinjar.

“Our salary and our protection are not good. For example, there is an insurance benefit that you receive if you contract a viral infection at work. Midwives receive ID80,000 (approx. US\$61) in the case of an insured event, but doctors receive ID150,000 (approx. US\$115). I think that’s unfair because normally the midwives do all the ‘dirty work’ and therefore have a much higher risk. During Covid, doctors often didn’t examine patients at all, but left all the work to the midwives.”

Yasmin, 29, midwife

In Iraq, midwives do not hold leadership positions in the national Ministry of Health, sub-national Ministry of Health departments, or the professional regulatory authority. There is no regulatory unit in the healthcare system that is solely responsible for midwives.⁵³ This limits direct representation of their interests. As there are also no midwives in leadership and management positions in the health sector in Iraq, midwife-led improvements in SRM-NAH service delivery are not possible. This means that considerable potential to sustainably improve the situation of sexual, reproduc-

tive, maternal, newborn, and adolescent health remains untapped.

2.1.4 Training and State Recognition

In order to begin midwifery training in Iraq, one must complete the 10th grade of school, and a minimum grade point average is required. Training at the Iraqi state *Midwife High School* takes three years.⁵⁴ The training and work of midwives is not particularly valued by large sections of the population in Iraq. Women who decide to train as midwives are met with disdain and a lack of understanding about the role and importance of midwives.

“People look down on our job and what we do. There is a trivializing, derogatory term that they use in Kurdish. People are not very well informed about our work and the importance of our work. What we do is much more important than the doctor, because the doctor comes and sees the patient briefly and leaves, and then the midwife is the one who takes full responsibility for the birth.”

Khawla, 28, midwife

53 UNFPA, 2022.

54 Interview with Omar Saleh, Health care expert, CARE Iraq. See also UNFPA, 2014.

There is no standardized curriculum and there is no minimum number of supervised births required during training. Only 50 percent of trainers are midwives themselves.⁵⁵ There is no qualitative review of this training, nor is continuous further training offered to midwives. A bachelor's program that goes beyond basic training and also includes a high degree of practical experience is only offered in one region in Iraq.

In view of the high birth rate of 3.4 children per woman on average⁵⁶ and the challenging environment in the maternity wards with little equipment and too few staff, newly qualified midwives in Iraq are generally exposed to high levels of stress.⁵⁷ In only a few regions of Iraq midwives have the possibility to enter a transitional period program, which helps them put their theoretical knowledge into practice in the first months on the job. Many new midwives feel overwhelmed by the enormous responsibility and the challenge of putting the theoretical knowledge they have acquired into practice without further structured guidance. This leads to a high dropout rate and abandonment of the profession already at this stage.

To enter the profession, midwifery graduates need both a practical curriculum during their training and a supportive environment from colleagues and managers that enables them to gain sufficient practical self-confidence. Only then can they stay in the job and perform efficiently.⁵⁸

2.1.5 Additional Training and Tasks: Family Planning and Awareness-Raising

An important task of midwives worldwide is providing information about family planning and carrying out educational work.⁵⁹ However, the legal framework in Iraq severely restricts the range of services that midwives are allowed to offer. Djibouti and Yemen are the only countries in the region that allow their midwives to offer all five contraceptive methods (pill, injection, intrauterine device, emergency contraception, and implant). Midwives in Iraq, as in Jordan and Libya, are only allowed to distribute condoms, a form of contraception that is not widely used in the Arab world.⁶⁰

In order to be allowed to offer family planning education in health facilities, Iraqi midwives can voluntarily participate in additional training provided by the local health authorities. There is a clear need for counseling. Almost 90 percent of women who have recently given birth express the wish not to get pregnant for two or more years. Nevertheless, the use of contraceptives is still only between 28 and 36 percent.⁶¹ The number of women actively using contraception has been increasing for several years. However, unequal norms, stereotypes and a lack of self-determination are still major obstacles. The use of contraceptives is, in fact, only possible with the man's consent.

55 UNFPA, 2022.

56 DSW, 2023.

57 Naqshbandi, P. S.; Karim, M. A. and Qadir, D. O. (2019): A qualitative Study of the Recent Midwifery Graduates' lived Experiences During Transition Period. International Journal of Medical Investigation.

58 UNFPA, WHO and ICM, 2021a.

59 WHO (2018): Task sharing to improve access to Family Planning/Contraception.

60 UNFPA, 2022.

61 Further significant differences can be seen in the fact that younger women are the least likely to use modern or other family planning methods. The high rate of "unintended pregnancies" is also striking – around 24 percent of pregnancies (during the survey period) were either unintended or unplanned, with a higher percentage in women over 30. UNFPA and Republic of Iraq, Ministry of Health (2020): National Birth Spacing & Family Planning Strategy (2021 - 2025).



Waiting patients in front of the ward where Diyana works.

“Just recently, a 37-year-old woman came to us who already had 13 children. Her husband nevertheless forbade her to use contraceptives.”
Yasmin, 29, midwife.

Another factor also has a significant influence: Although other contraceptive methods are generally permitted, women in the public healthcare system are de facto only given the contraceptive pill after it has been prescribed by a doctor. Other contraceptives are generally only available through the private sector and are expensive, costing between US\$100 and US\$350. Nevertheless, the private sector holds over 80 percent of the market share in modern family planning, with the public sector accounting for only 15 percent.⁶² The figures clearly show that financially weaker women and families only have limited access to modern contraceptives.

2.1.6 Work Overload and Lack of Support

Midwives in Iraq are employed by the public health system. By law, they work 40 hours a week. The length of individual shifts depends on the respective hospital or birthing center.

“Iraqi midwives work in shifts that usually last 24 hours and are very exhausting because you don’t really get to sleep. There are usually several midwives present who divide the work somewhat. There are four beds in our delivery room where women give birth at the same time. During the weekly shifts, the midwives are accommodated in the hospital’s guest house, which is in a terrible state. Even the food we get is barely edible.”

Yasmin, 29, midwife

Like all Iraqi employees, midwives are entitled to maternity leave (21 days before the birth and up to 51 days afterwards) and parental leave (up to one year). However, like many women in Iraq, they are confronted with patriarchal role concepts and a lack of systemic support for working mothers when they return to work.

62 UNFPA and Republic of Iraq, Ministry of Health, 2020.



Diyana with colleagues in the hospital guest house where they live during their weekly shifts.

“When midwives themselves have children, they can take a year’s parental leave on half pay. Whether they then go back to work is again a question that they need to discuss with their husband, but I would certainly want to continue working. Some midwives also take children with them on shifts if they do not have childcare.”

Yasmin, 29, midwife

A total of 36 midwives are employed in Sinjar’s only hospital, where Diyana works as a midwife. There are always six midwives on duty during a shift. They work in a large room with many women in labor. There is a room with two beds for the last phase of the birth. If these beds are occupied, other births have to take place in the large labor room. Since international non-governmental organizations (NGOs) have ceased their activities due to a

lack of funding in the area, more women are coming to the hospital. Local health centers, which had previously absorbed some of the work, have closed their maternity wards.

This leads to a constant work overload for midwives. The lack of basic care can often only be addressed by referring pregnant women to other hospitals. Midwives often feel that their work is not valued and recognized enough.

“We would like to feel that we matter in the community, and that they understand our job and see how important what we do is. People in the communities do not understand the importance of midwifery well enough. And, of course, we need more training to continuously improve and develop our skills.”

Khalwa, 28 and Diyana, 26, midwives

2.1.7 CARE Project: Health and Reconstruction Involving Midwives

In the environment described above, CARE implemented a project⁶³ in the governorate of Nineveh in northern Iraq, which was particularly hard hit by the armed conflict. In addition to other components of SRHR, the project also included training midwives in family planning and training them to strengthen the local health structure.

Forty-one midwives from the north of Nineveh took part in an eight-month course to expand their practical expertise and be better equipped for the field of comprehensive sexuality education. The project design also recognized their position as Frontline Health Workers (FLHWs), often the only health professionals in their home communities. The selected women received courses specially tailored to their situation. The curriculum was developed jointly by CARE and the hospital in Dohuk. The participants also interned at the hospital in Dohuk. For the duration of the training, they lived together in an apartment rented for them, which enabled them to exchange amongst each other and laid the foundations for a professional network. The project also included two specialist symposia for medical staff from the SRMNAH sector. Doctors and midwives were able to openly share their experiences and learn from each other.

The project concept was based on the assumption that the trained midwives would contribute to improving knowledge about reproductive health among expectant mothers, both returnees and the local population, through increased awareness-raising work. At the same time, the project expected a transformative effect, which could lead to the dismantling of harmful or discriminatory stereotypes and practices, among other things, as a result of the educational and awareness-raising work.



Equipment for midwives in a hospital in Iraq.

As women are often restricted in their mobility due to traditional role models and expectations in Iraq, and traditionally hardly participate in activities outside the family, the midwives offered targeted home visits and focus group discussions. These were very well received, but are hardly possible in the non-project-financed daily routine of midwives due to scarce resources.

The materials used by the midwives also addressed equality between men and women at community level to better educate women and girls about their rights. Issues of violence against women and children in the context of SRHR (such as early marriage) were a major topic.

⁶³ From May 1, 2016 to the end of 2018, CARE Deutschland ran the project “Healthy Reconstruction: Improving Maternal and Child Health in Return Areas in Northern Iraq” in the Zummar and Rabia subdistricts and the surrounding villages in the governorate of Nineveh. It was financed with EUR 2.9 million in funding from the German Federal Ministry for Economic Cooperation and Development. The development-focused relief and rehabilitation project was implemented in partnership with local NGO Harikar and Nineveh’s Directorate of Health (DOH), coordinating project activities with other health-related development actors, including UNFPA, WHO and international NGOs.

The development of knowledge and skills was accompanied by a resilience-building component in the form of the reconstruction and establishment of four health centers with mother and child wards to improve access to professional support and equipment during pregnancy and childbirth.

While private hospitals or clinics were mainly used for prenatal care and births before the project began, 72 percent of the population preferred Primary Health Care Centers (PHCCs) at the end of the project. The reasons cited for this were improved infrastructure, improved accessibility and availability of medication, and the improved care provided by midwives and doctors. The last aspect in particular is directly attributable to the further training of midwives.

The midwives' educational work was rated very positively by project participants. Raising awareness about roles of men and women and their transformation as well as the area of violence against women and children were highlighted as added value. These results show that the project has made a lasting contribution to change, and that the project participants put what they have learned into practice and also act as disseminators of the knowledge they have acquired.

In addition to the project evaluation, there is much more direct evidence of successful and sustainable project design and implementation: Diyana took part in one of the eight-month courses organized by CARE before working as a midwife in the hospital in Sinjar. Years after the end of the project, she continues to advise and raise awareness among adults and young people about family planning. She emphasizes that she always involves the husbands and explains to them why spacing of pregnancies is important for their wife's body. According to her, she has achieved great success with this, including changing men's attitudes. Her colleague Khawla, who works in the same hospital as Diyana, also emphasizes the importance of better educational work and Diyana's role as a multiplier of knowledge, also for her colleagues. In the last three to four years, she has increasingly noticed that early marriage has decreased massively, which she attributes directly to the educational work of actors like Diyana.

“Diyana has different knowledge than we were taught. We learn from her every day.”

Khawla, 28, midwife

Results of Midwives' Educational Work in the Area of Family Planning

93 %

of project participants have a better awareness and greater knowledge of contraceptives and family planning.

76 %

of respondents found the awareness-raising sessions to be the best part of the project's interventions.

72 %

favoured public maternity wards over private clinics.

2.2 Côte d'Ivoire: Active in a Post-Conflict Context

Diomande⁶⁴ wants to save lives. “My sister-in-law died a few days after the birth of her twins. I knew then that I wanted to help other women. Every woman should have the chance of a safe birth.” Diomande has been a midwife since 2018 and works at Fari M’babo’s rural health center in Côte d’Ivoire. The 34-year-old midwife from Touba in northern Côte d’Ivoire lives with her two nieces right next door to where she works. She is always available and works around the clock, seven days a week. “If it gets too much for me, I take my annual leave. Then I’ll go to my parents up north. Otherwise, I’m on duty – at any hour, on any day, whatever the weather.” As a midwife, she is not only responsible for births and pre- and postnatal care, but also provides information about contraception. In the past, young people were ashamed to come to her. Today, even the parents accompany them. The number of unplanned pregnancies has fallen sharply.

“More than anything, we need an ambulance.” Emergency patients are currently being transported on the back of a motorized tricycle. In the worst-case scenario, they also give birth on the road. The high risk of falling from the loading area while accompanying the women is not an issue for Diomande – she wants to save



Midwife Diomande.

lives. “I am so proud and happy to see the parents’ joy after a successful delivery. Women keep coming back to me years after the birth to thank me for my support and advice. That is what makes me content.”

Click here for more information about Diomande and her work



For a long time, Côte d’Ivoire, with its 28.2 million inhabitants, was considered a stable and comparatively prosperous country in the middle of a region characterized by poverty and political instability. Between 2002 and 2011, the country experienced two civil wars with thousands of deaths and over a million internally displaced people. The violent conflict was resolved in April 2011 and democratic elections were held. However, the healthcare system is still suffering from the long-term effects.

Since 2022, increasing insecurity in the neighboring countries of the Sahel region has led to an increased influx of refugees, especially from Burkina Faso.⁶⁵ This has put additional pressure on the already inadequate basic social services in the two regions in the north of the country, which have taken in the most refugees.

64 In Côte d’Ivoire, midwives Diomande (34), Mariame (38), Ndri, Mariette, and Achi, who all work in rural health centers, were interviewed for this study. CARE also spoke to Carine and Sonia, who work in urban health centers. All are employed in the Gbêkê region in central Côte d’Ivoire and are members of the Ivorian Midwives Association. Sonia is also chair of the regional committee of the Ivorian Midwives Association. A further interview took place in Abidjan with the national president of the Ivorian Midwives Association, Awa Diallo.

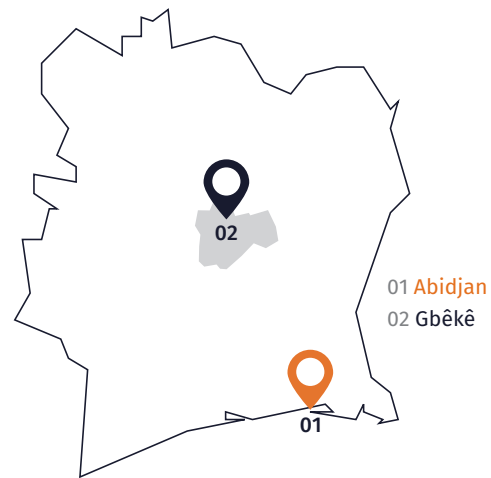
65 UNHCR (2023): [Côte d’Ivoire](#) (accessed 19.10.2023).

Côte d'Ivoire is one of the world's largest cocoa producers and is one of the most important exporters of coffee, cashew nuts, palm oil, and rubber on the African continent. The country also has a well-developed service sector by regional standards. Despite this, Côte d'Ivoire only ranks 159th out of 191 countries on the United Nations Human Development Index (HDI), with an average life expectancy of 58.6 years and an average school attendance of five years.⁶⁶ Although the economy has grown strongly in recent years, this has not been reflected in healthcare expenditure.⁶⁷

The health sector in Côte d'Ivoire has always been severely underfunded and structurally weak. During the 2010–2011 conflicts, a large number of health facilities were closed and some were looted. After the end of the conflict, the government prioritized the rehabilitation and construction of health centers and hospitals and introduced a system of free services. However, the proportion of the country's total expenditure spent on health has only been around five percent for years,⁶⁸ a far cry from the target set by African countries in the Abuja Declaration, which was to spend 15 percent of the national budget on health.⁶⁹

Only 10 percent of the country's population currently has access to adequate healthcare.⁷⁰ The maternal mortality rate is extremely high at 480 women per 100,000 live births.⁷¹ Funding from international donors for health peaked in 2014/2015 as part of the reconstruction efforts, but has since returned to pre-conflict levels and continues to focus on

HIV and malaria (70 percent). As the economic and political situation stabilizes, the country now faces the challenge of moving from an emergency situation to building a sustainable healthcare system.⁷²



2.2.1 Tasks of Ivorian Midwives: Balancing Act Between Legal Restrictions and Individual Responsibility

Diomande is one of around 7,000 professional midwives in Côte d'Ivoire.⁷³ She is the only midwife in the catchment area of her health center and looks after around 200 pregnancies a year.⁷⁴

“In the maternity ward, the midwife is obliged to do everything related to care. When I say care, I mean prenatal consultation, family planning, delivery, newborn care, and postnatal consultations.”

Diomande, 34, midwife

66 The Human Development Index (HDI) is a summary measure of average achievement in key dimensions of human development: a long and healthy life, being knowledgeable and having a decent standard of living. UNDP (2023): [Human Development Index \(HDI\)](#).

67 World Bank (2020): [Health Systems Assessment for Côte d'Ivoire. Accelerating Reforms Toward Universal Health Coverage](#).

68 World Bank, 2020.

69 Heads of State and Government of the Organisation of African Unity (2001): [Abuja Declaration on HIV/AIDS, Tuberculosis and other related infectious diseases](#).

70 WHO, 2023b.

71 The global average is 223 per 100,000 live births. Côte d'Ivoire's figure of 480 even exceeds the average for the least developed regions in the world, which is 377 women per 100,000 live births. DSW, 2023.

72 World Bank, 2020.

73 The president of the Ivorian Midwives Association claims there were about 7,000 midwives in 2023 at the time of the interview. According to UNFPA, in 2019 there were 5,601. UNFPA, WHO and ICM (2021c): [The State of the World's Midwifery, 2021. Country Profile Côte d'Ivoire](#).

74 UNFPA, WHO and ICM, 2021c.

The main task of midwives in Côte d'Ivoire is to support pregnancies without foreseeable complications. They carry out consultations and examinations during pregnancy, birth, and the postpartum period. They assist during labor and birth. The care and counseling of mother and child after the birth is also part of her responsibilities.⁷⁵ Since 2010, the field of midwives' expertise has expanded to include the possibility of treating patients outside of pregnancy by performing gynecological procedures (smear tests, breast examinations, etc.).

Diomande is also responsible for sexuality education and the provision of family planning resources. In Côte d'Ivoire, midwives are allowed to administer injectable contraceptives and intrauterine devices.

Midwives in Côte d'Ivoire are supported by volunteer health workers (*agents de santé communautaire*, ASC), whose work they coordinate. They are primarily responsible for liaising with the community and educational work, including on family planning.⁷⁶ ASC receive expense allowances for their work. If no project funding is currently available from NGOs, midwives often pay for this out of their own pockets, as they are dependent on support from ASC.

“We work with women who help us, the *agents de santé communautaire* (ASC). For example, they take the patients' vital signs, help them to settle into the health center, and also provide follow-up care in the community. We midwives cannot be in the community for every activity. The ASC are our disseminators. The ASC should not take over care; that is the midwife's job.”

Diomande, 34, midwife

In Côte d'Ivoire, 74 percent of all births are attended by qualified health personnel. There are 2.2 midwives per 10,000 people, but only 0.1 gynecologists. Despite the tireless efforts of midwives, and where available, gynecologists and pediatricians, the potential to meet need for SRMNAH is only 39 percent.⁷⁷

Midwives have a particularly important role to play here. In rural areas, the midwife at the health center is the only available specialist for sexual and reproductive health and maternal health for many women. In order to work successfully, they must be accepted by the community and maintain good relationships. After all, whether women go to the health center depends on whether they perceive the midwife as competent, but also whether they are received in a friendly and respectful manner. Midwives also work with traditional birth attendants, so-called *matrones*, to build trust and reduce skepticism about the midwife's support during pregnancy and birth at the health center.

75 ASFI (2023): *Association de Sages Femmes Ivoiriennes (ASFI)*.

76 World Bank, 2020.

77 UNFPA, WHO and ICM, 2021c.



Diomande examines a patient in her treatment room.

“For some time now, there have really been fewer home births. Because we work together with the *matrones*. *Matrones* are the old women who used to accompany women during home births. So we are in contact with these *matrones*. After all, you can’t simply ban them. So we reached out to these ladies and exchanged ideas with them. We explained to the *matrones* why it is good to come to the health center to give birth. As a result, the home birth rate has decreased.”

Diomande, 34, midwife

Primary healthcare is provided in the public healthcare system in healthcare centers that have a catchment area of around 10,000 people. Every rural health center has a maternity ward run by a midwife. There is also a general infirmary run by a nurse practitioner (in

French-speaking Côte d’Ivoire: *infirmier*). Nurse practitioners are nurses with extended competencies who have full clinical responsibility for the medical treatment of patients and are also authorized to prescribe medication. For many women, the health center is the only accessible health facility and the midwife the only specialist for SRMNAH for miles around.⁷⁸

Midwives in Côte d’Ivoire have a wide-ranging field of expertise. However, they are not officially allowed to assist high-risk births, such as twin births. For midwives, this means that they regularly have to enter a legal gray area. In order to save lives, they have to take on tasks for which they are neither authorized, trained nor adequately equipped in the rural health centers.

⁷⁸ Ninety-six percent of the population in Côte d’Ivoire lives within an hour’s travel time of a “maternité” (maternity ward with a midwife). However, only ten percent of the population lives less than an hour away from the nearest Emergency Obstetric and Newborn Care (EmONC) health facility. UNFPA (2021): *Developing networks of health facilities for improving access to functioning emergency obstetric care at national scale: country experience in sub-Saharan Africa*.

“Yes, I’m jeopardizing my work because there are deliveries I’m not allowed to do. For example, twin births or transverse presentation births. All the brochures and protocols here on the wall remind me of that. But it’s like I explained: The women come to me and the baby is almost there. You can’t say, ‘Go back.’ You try to save both mother and child.”

Mariame, 38, midwife

Midwives and Abortions

Abortion and attempted termination of pregnancy are illegal in Côte d’Ivoire under Articles 425 and 426 of the 2019 Penal Code.⁷⁹ Exceptions to this are only possible after rape or if the pregnant woman is in physical danger. The existence of any of these reasons must be determined by authorized healthcare personnel. Parental permission is required for minors. Studies show that, according to official figures, 37 percent of unplanned pregnancies in Côte d’Ivoire between 2015 and 2019 ended in abortion.⁸⁰ This is rather low compared to the global rate of 61 percent. However, due to legal restrictions, very few of these abortions are carried out legally and safely by qualified healthcare professionals. In many cases, unofficial abortions lead to serious, sometimes life-threatening complications, which are then treated by midwives.

“Last month, an unmarried girl who had had an abortion at home came to see me. Not everything had come out. She came, and I treated her here, but it wasn’t enough. I decided to take her to the general hospital. She was in very bad shape. She underwent surgery and received a blood transfusion. I felt sorry for her. I also hurt for the parents.”

Diomande, 34, midwife



Signpost to the maternity ward (*Maternité*) and the general health center (*Dispensaire*).

What to Do if Complications Arise: Working Together With the Doctors

If midwives reach the limits of examinations and treatments that they are allowed to perform, especially in the case of complications and high-risk births, patients are referred to the nearest district hospital and treated by doctors there.⁸¹

79 WHO (2023c): [Global Abortion Policies](#) (accessed 19.10.2023).

80 Guttmacher Institute (2023): [Country Profile. Côte d’Ivoire](#).

81 World Bank, 2020.



Two volunteer health workers in front of the maternity ward.

Close cooperation between midwives and doctors is important in order to be able to organize referral to a larger clinic well: Mariame describes cooperation with doctors at the hospital as harmonious and full of mutual respect. In case of emergencies, she has a list of contacts for midwives in the district hospital as well as the telephone number of the doctor there.

“If I have to send a woman to the district hospital in Béoumi if there are complications, I call the doctor there. The doctor in Béoumi listens to me at all times, even when I wake him up. He listens to me and then tells me what to do. It often takes a long time to organize the car for transport from here to Béoumi, so he tells me, ‘Do this, do that’ before the car arrives. We have no problems with him.”
Mariame, 38, midwife

There are two major obstacles to referrals: Firstly, there is an average of only 0.22 ambulances per health facility in Côte d’Ivoire, and these are mainly found in urban and structurally stronger areas.⁸² In the rural centers where the midwives Mariame and Diomande work,

there is no ambulance available that they could call. The transfer in case of complications must therefore take place in private cars or on motorcycles. As the birth is often already at an advanced stage at the time of referral, the midwife also regularly accompanies women on the makeshift ambulance into the city.

“In the absence of an ambulance, I had to take a lady with a twin pregnancy to the general hospital in Béoumi on the back of a three-wheeled motorcycle. As she didn’t want to go to the city, she stayed in the village until she went into labor. I couldn’t leave the woman alone. So I went with her. The first baby arrived halfway through. I assisted the birth on the way. The second one came when we arrived in the city. We only went to the hospital for further treatment.”
Diomande, 34, midwife

82 World Bank, 2020.

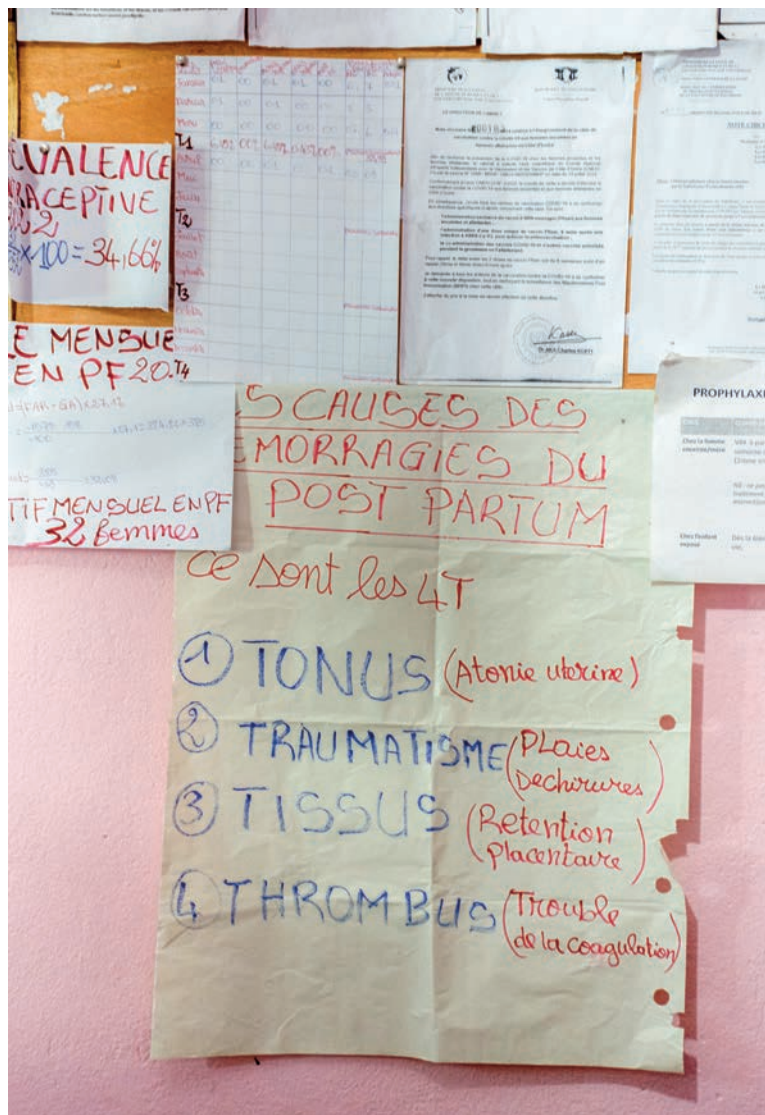
The other problem is financing alternative transport: The cars, motorcycles, or cargo bikes first have to be organized and then paid for. Families often cannot afford this and therefore try to avoid being referred to the city. Here too, midwives are personally committed to fulfilling their responsibility and obligation to reduce maternal mortality and provide good healthcare.

“I had a teenage girl come in with contractions. She had an excessive uterine height, meaning she had a very large baby in her stomach. She was therefore unable to give birth vaginally. She had to be sent to the nearest hospital. And that’s when I spoke with the parents. Her father said that he had no money. Her mother said she had no money. It’s not actually your husband who takes care of you when you’re pregnant, but your parents. The girl’s life is in danger. The baby’s life is in danger. So I called the young man who got her pregnant. He came, but only had FCFA3,000 (appr. US\$5). But transportation to the city costs FCFA25,000 (appr. US\$40); you have to rent a car. I want to save the mother and the baby. And it was a public holiday, January 1st, so there was no car. I then called the father of my children in the city. He has a car. I said: ‘Come. Come and help me.’ He picked her up to drive her into town. And I gave the girl’s parents some money for the primary care before they left.”

Mariame, 38, midwife

2.2.2 Becoming a Midwife: Three Years to Graduation

Midwives in Côte d’Ivoire undergo three years of training at the National Institute for the Training of Health Workers (INFAS) for their work in often remote areas with great personal responsibility. Midwives complete the first year of training together with nurse practitioners, followed by two years of specialization



Information about pregnancy, birth, and possible complications is displayed on the wall in the health center, informing midwives and patients.

as a midwife. After three years of training, every midwife must register with the Chamber of Midwives (*Ordre des Sage-Femmes*) in order to be allowed to practice. State training centers are often inadequately equipped, meaning future midwives receive little training and practice, especially in the practical field.

“There has to be a practical phase. We have dolls and other things in the training centers. But you also need small items, such as thermometers, bandages, and compresses. Only if the midwives can practice their care over and over again will we have competent midwives who are ready to work on the ground. Because if they don’t know how it works in practice, they start working with patients and are distant and sometimes afraid to act. We see that the difference is enormous with midwives who have been able to practice. If you don’t challenge them even more during their training, if you don’t support them, it will be difficult. We must mobilize all resources to train midwives.”

Awa Diallo, midwife, President of the Ivorian Midwives Association (ASFI)

The diploma in midwifery training is not recognized by universities. Midwives in Côte d’Ivoire therefore cannot acquire a specialization that builds on their training. This is only possible with an additional medical degree. The profession regularly loses midwives to higher specialization because they then no longer work as midwives.

Awa Diallo, President of the Ivorian Midwives Association ASFI, has chosen this path herself. In addition to her midwifery training, she has also completed a specialization in public health. She holds the honorary position of association president alongside her main job in the national maternal and child health program.

“In Burkina Faso, there are remote areas where midwives are allowed to perform an emergency caesarean section. In Côte d’Ivoire, you have to be referred for any much smaller procedure because midwives are not allowed to perform them. If midwives could acquire additional qualifications in emergency care, then at least there would be no need for a doctor. And if the doctor is in the operating room or far away, the midwife would be officially authorized to perform the procedure.”

Awa Diallo, midwife, President ASFI

2.2.3 Unattractive Work-Environment: Working in Remote Areas

“Well paid? The salary is what it is (laughs). ... Well, we can cope with it; you get over it. But if you first looked at what the salary is and then decided whether you want to become a midwife? I don’t think you would do it then because I think there are jobs that pay much better than what we make. No, then maybe you should become a delivery person; it’s a job that pays well. So the salary is not the motivation to become a midwife.”

Diomande, 34, midwife

Midwives are employed by the government and are therefore public sector employees. Salary payments are regular but, with a starting salary of approx. FCFA200,000 (approx. US\$330) per month, low overall. Remuneration increases with seniority. However, it remains so low that the Ivorian Midwives Association ASFI even identifies this as a reason for the emigration of qualified midwives. In the past, the trade unions and associations of nurse practitioners, together with the Midwives Association, have negotiated regular, albeit small, salary increases with the government to take account of inflation.

The midwives are on call seven days a week around the clock and are entitled to two weeks’ vacation per year. Many midwives find it difficult to take their annual leave. They feel personally committed to the community and don’t want to leave people without care for too long. During their annual leave, they are replaced by the center’s nurse practitioners, who have no additional training in obstetrics.

Accommodation near the health center is provided for the first midwife of a facility. In the rare cases in which a second midwife is assigned to a center, she must find and finance her own accommodation.



The maternity ward of the rural health center.

“The apartment is right behind the health center; you’re practically at work all the time. So there are no days off. As long as you’re there, you’re working. At any hour, on any day, in any weather. You are available.”

Diomande, 34, midwife

Midwives are assigned to the health center where they work. As a rule, they have no say in their first place of work. Only after a few months can they apply for a transfer to another health center and then have the opportunity to state their preferences. Distribution of midwives according to the needs of the population is not always the case. The Ivorian Midwives Association therefore advocates detailed needs assessments and allowances for difficult locations so that midwives in Côte d’Ivoire, who are, according to the association president, actually available in sufficient numbers, can be adequately deployed as needed.

The locations are as diverse as Côte d’Ivoire’s regions. While demand in the north is increasing, partly due to the refugees from Burkina

Faso, and the infrastructure there has always been weak and the population poor, locations in the capital Abidjan or other structurally stronger areas offer slightly less workload and more amenities, and are therefore more popular as placements.

“There are some areas that are very remote. Midwives whom we refer to the north usually come back immediately. And then recently I was in a city center. There are fourteen midwives in one hospital! If you are in Abidjan, you get the same salary as those who are in the difficult locations. So why should I, as a midwife, spend my time in such a remote center? Why should I live and work in such difficult conditions when my colleague in the city has all the amenities and lives in her own home? This is why many then apply for a different location. As part of the hospital reform, we at the association are campaigning for incentives to be created for deployment in remote and difficult areas so that we can also meet the needs of the population there.”

Awa Diallo, midwife, ASFI President

At present, whether or not qualified health personnel are also stationed in remote areas depends on the intrinsic motivation of individual women. The midwives at these locations work without any hardship allowance under difficult conditions, sometimes at considerable risk to their own safety and while suffering personal hardship. Reducing maternal mortality therefore depends largely on women like Mariame putting their own needs aside and being prepared to offer health services in a poorer community.

“After my training, I wanted to work in a village because the women in the village were suffering a lot. I wanted to use my profession to help women and especially children. I have two children, ten and three years old. They live with my mother because my accommodation here at the health center is not safe. It does not keep reptiles and snakes out.”

Mariame, 38, midwife

2.2.4 Social Norms and the Work of Midwives

In their work in educating and providing family planning methods, midwives challenge established roles and harmful norms. Comprehensive sexuality education is based on transformative approaches and an inclusive understanding of the right to sexual and reproductive health, as the president of the Ivorian Midwives Association emphasizes.

“The right to reproductive and sexual health is one of the prerequisites for the provision of healthcare. Everyone has the right to information about their sexual health. Everyone has the right to access sexual health care. That’s what we often say to midwives, and that’s why we place so much emphasis on communication. When we hold our educational events in the community, it is so that women know that they have a right to health. Even if they are married, because here it is still more the husband who makes decisions about his wife’s health. But if women have access to medical care, they can decide freely about their sexual health, know when they want to have a child, when they don’t, and whether they have infections or not. And they can get to know themselves better. This will also enable women to carry out activities independently and without their husbands’ consent.”

Awa Diallo, midwife, ASFI President

Family Planning: Midwives Raise Awareness

The average number of births per woman in Côte d’Ivoire is 4.3 children. Twenty-one percent of all women and 26 percent of married women have no access to contraceptive methods. Only 48 percent of the demand regarding modern family planning methods among women aged between 15 and 49 is met, which is relatively low.⁸³ Advice and provision of family planning is one of the tasks of midwives in Côte d’Ivoire. In order to enable access to family planning and sexual health for all, midwives must take an approach that is intersectionally sensitive and inclusive and break down their own prejudices and those of others.

83 UNFPA (2023b): [UNFPA Côte d’Ivoire](#) (accessed 19.10.2023).

“You shouldn’t be prejudiced against people who want to have sex. No matter how old they are or whether they have a disability. We have to support them and give them guidance. We must not judge them.”

Mariette, midwife

The high rate of early pregnancies presents a particular challenge. One in four women have their first child before the age of 18.⁸⁴ Complications during pregnancy and childbirth are one of the most common causes of death in girls between the ages of 15 and 19. Pregnancies in girls under 20 are much more likely to have complications for mother and child because the expectant mother’s body is not yet sufficiently prepared for pregnancy.⁸⁵ Some of the early pregnancies in Côte d’Ivoire are due to the early marriage of girls: 27 percent of girls are married before the age of 18, even though this is prohibited by law. Seven percent are even married before the age of 15. The figures are considerably higher in rural regions than in urban centers and up to 52 percent higher in the north than in the south. Women from poor families with little education in particular are married early. Early marriage and pregnancy often trigger a cycle of deprivation and disempowerment of girls. Girls who fall pregnant early usually drop out of school and are thus deprived of the opportunity to acquire more education and have better economic opportunities.⁸⁶

According to Ivorian law, a parent must consent to the prescription of contraceptive methods to young people under the age of 18. However, in view of the high number of early pregnancies, midwives usually make pragmatic decisions and advise young people even without parents being present.

“We midwives don’t mind if young people come without their parents. We treat them anyway. Because this also enables us to avoid unwanted pregnancies. Because if you don’t respond to the teenager’s wishes, she will come tomorrow, pregnant. And she may then ask you to perform an abortion for her, but this is strictly forbidden. It is therefore better to talk to them about contraceptive methods so that they can be more free.”

Diomande, 34, midwife

In Côte d’Ivoire, a coalition of civil society organizations is campaigning for the adoption of a new law on sexual and reproductive health and rights to make contraception accessible to young people from the age of 15. So far, the law has not been approved by parliament, mainly because it also wants to legalize abortions. A legal change is particularly necessary for the protection of midwives.

“Healthcare workers are not safe. Every time they give young people contraceptives, they risk criminalization.”

Marie-Paule Yao, Advocacy Manager, CARE Côte d’Ivoire

Women in the Healthcare System: Societal Roles and Self-Organization of Midwives

Midwives are not only confronted with stereotypical roles of men women and men and negative and restrictive norms among their patients. As women, they themselves live in a patriarchal system. This influences their choices and limits their options in some areas.

84 The rate of early childbearing in Côte d’Ivoire is 119 per 1,000 women, more than double the global average of 50. Girls not Brides (2023): Côte d’Ivoire.

85 UNICEF (2022): [Early Childbearing](#) (accessed 19.10.2023).

86 Girls not Brides, 2023.



Diomande explains family planning methods.

In many cases, the (mostly male) nurse practitioners take on the managerial role (*chef de service*) in the health center. The position involves communicating the center’s needs in terms of equipment and medicines to the district authority, and is normally assigned to the most senior person on duty. Midwives usually reject this position.

“The midwife can also be *chef de service*. But she usually does not accept the offer. Because it’s a lot of work. And there are no transportation vehicles to get to the city. So you have to go by motorcycle. This is difficult for a woman if the road is not very good. So we give it to the men.”

Syntiche, midwife

Cooperation with nurse practitioners in the centers is usually good. The two professional groups, who spend the first year of training together, have the same salary scheme, the same work locations, and, therefore, similar challenges and interests in many respects. The respective professional associations work together in solidarity. However, according to the president of the Midwives Association, the professional association of nurse practitioners usually takes a stronger position vis-à-vis the government and defends its positions more vehemently than the Midwives Association. Societal norms also play a role here, as the mostly male nurse practitioners see it as their responsibility to care for their families.

“The nurse practitioners help us a lot when they strike. They receive the same salary. We fight together, but they are stronger in the fight. And we follow them. They are men. They are confronted with expenses. As a midwife, as a woman, you may have someone who can feed you. You don’t think it’s that urgent. But at the end of the month, the man has to pay his bills; he has to pay this and that. So the nurse practitioners have to be more demanding. And when they make demands, we form a coalition: The midwives union and the nurse practitioners union.”

Awa Diallo, midwife, ASFI President

Midwives’ self-organization is generally strong: The Ivorian Midwives Association (ASFI), which has been in existence for 25 years, counts raising the profile of the midwifery profession and improvement of the quality of SRMNAH services for the population among its central tasks.⁸⁷

“We communicate the standards and procedures to everyone. The state does that too, but it’s not so widespread, and if there are problems, they say you didn’t comply and then you’re punished or suspended. It must not come to that.”

Awa Diallo, midwife, ASFI President

87 ASFI, 2023.

The ASFI regularly organizes training courses and other activities for midwives where they can network and exchange ideas. At national level, the national health development plan and exchange with other SRMNAH health personnel, especially gynecologists, is supported. The ASFI has also been organized at district level in Côte d'Ivoire for several years. For midwives, who otherwise mainly work on their own, these regional associations are an important place for networking.

2.2.5 Difficult Conditions: Working Without Electricity, Water, Equipment, and Ambulances

Many health centers in Côte d'Ivoire lack basic infrastructure. In 2017, 45 percent of primary and secondary healthcare facilities had no electricity and 35 percent had no water.⁸⁸ Midwives carry out their work under difficult conditions. The lack of access to clean water, in particular, means an additional workload. Health workers are dependent on support from the community, or have to fetch water from wells that are sometimes miles away. The lack of water is also a major problem for compliance with hygiene standards and the sterilization of medical equipment.

“We often have a problem with the electricity. Yes, so every couple of days you can be in the middle of a birth, and the electricity is suddenly gone. So when I receive a woman, I put my headlamp on straight away. And if the power goes out, I can still carry out my deliveries. But it's not easy.”

Mariame, 38, midwife

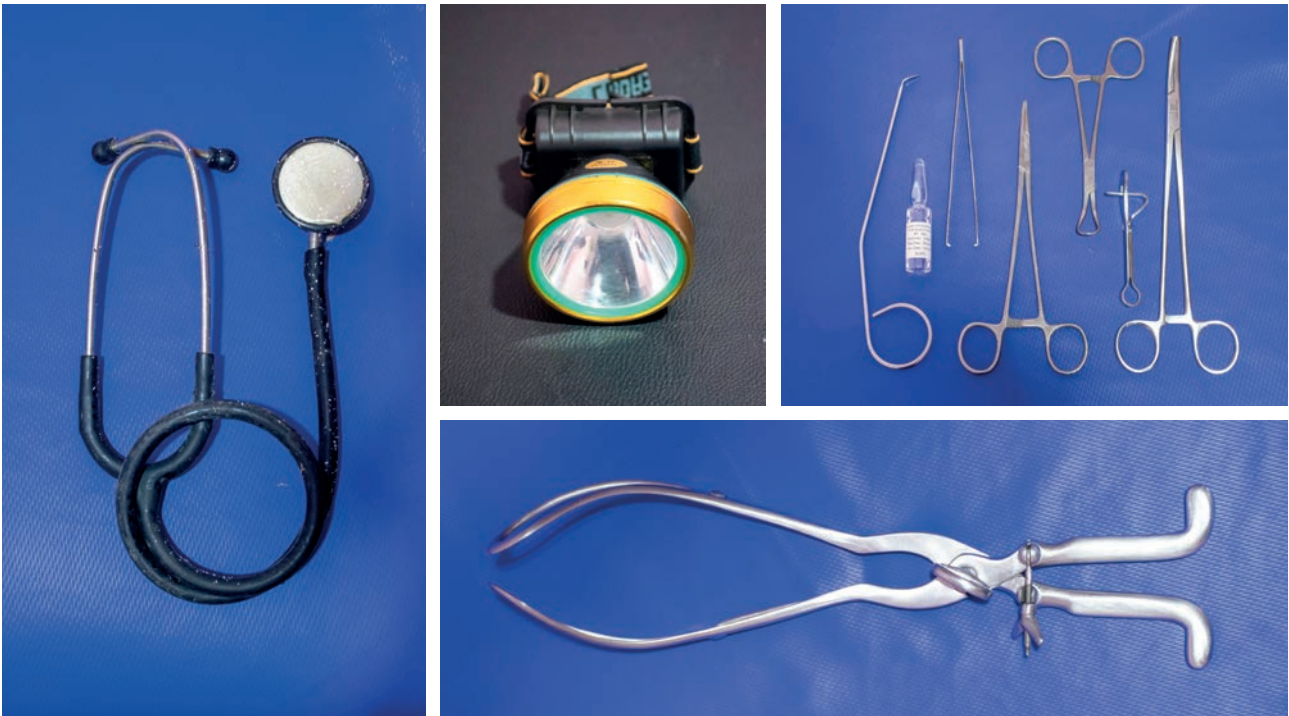
The Ivorian state has standardized how health centers should be structured and which rooms and associated equipment should be available. Diomande works in a health center that was built according to these standards. The two maternity ward buildings are grouped around an inner courtyard. There are two delivery niches (*boite d'accouchement*) in the delivery room so that two women can give birth at the same time on birthing chairs. There is also a separate room where Diomande carries out antenatal and postnatal examinations and provides advice on family planning. On the other side of the inner courtyard is a room with four beds that serves as a maternity ward for mothers with their newborns.

However, there are also health centers such as Mariame's. Wealthy members of the community built the health center on their own initiative because the nearest accessible delivery room was 45 kilometers away. State standards were not met during construction, and the municipality lacks the funds to renovate the building. Mariame only has one delivery chair in the delivery room and has to move the second woman to her consultation room if she gives birth at the same time. It is difficult to get advice or give birth in privacy, as the consultation room for family planning does not have door.

“We are performing miracles in Africa. Do you see under what conditions we are supposed to prevent infections in hospitals? Here in this health center, cardboard boxes are used to close the window, there is a single, non-adjustable delivery table, and the floor is not tiled. None of this meets hygiene standards. Even the walls are in very poor condition.”

Ndri Yao, CARE Côte d'Ivoire

88 World Bank, 2020.



Some of the instruments used by midwives in rural Côte d'Ivoire. Including a headlamp so that work can be continued in the event of a power failure.

2.2.6 Free Care: Expectations of Midwives

“The hands I use to treat them are free, but the medication they have to take costs money. Many women cannot afford this.”

Mariame, 38, midwife

Midwife services are free of charge for patients. Every Ivorian woman is therefore entitled to free prenatal and postnatal care as well as obstetric care in the state healthcare system. Officially, prenatal ultrasound and laboratory examinations, prenatal consultations, delivery in health facilities, cesarean sections, and the provision of materials for childbirth are among the free services in Côte d'Ivoire.⁸⁹ However, as very few rural health centers have the necessary equipment, ultrasound examinations, for example, have to be carried out in urban private clinics. Women have to pay for the services there and transportation out of their own pockets.

The state also promises to provide so-called birth kits (sterile gloves, gauze, baby soap, etc.) free of charge for every birth. In order to convince more women of the benefits of an

assisted birth in a health center, the state promotes this nationwide with campaigns. The reality in the health centers is often different due to irregular deliveries. There are often too few and incomplete kits in stock. Midwives then lack the equipment to care for women and newborns during and after birth. It happens that midwives, as representatives of the state health system and the only professional on site, are exposed to aggression and violence when families do not receive the birth kit promised to them by the state because the health center no longer has any in stock.

“At the moment, there is always talk of free healthcare. Yes, it's free, but are the kits always available everywhere? And if they don't exist, what do we do then? What should the midwife do if there are none? If there are no stitches to suture after a perineal tear, what does she do? If it happens in the city, it's easy; you write a prescription and then the patients can buy it. But we're talking about working in the village, where there's no pharmacy for miles around.”

Awa Diallo, midwife, ASFI President

⁸⁹ World Bank, 2020.



A woman with an infant in front of the maternity ward of the Fari M'babo Health Center in Côte d'Ivoire.

The greatest needs identified by midwives are therefore medical equipment and the provision of medication. This also applies to family planning. Contraceptives are often too expensive for the rural population, who live mainly from agriculture or low-paid jobs. Women in particular have little money at their disposal. Some women therefore avoid visits to health facilities for fear of incalculable, unforeseen costs. Maternal health in Côte d'Ivoire therefore depends heavily on socio-economic characteristics.⁹⁰

“And when the women come, they come and want everything for free. But we didn't get the medication for free and that's my big problem here. But I treat many women here free of charge, and I pay for the medication with my own money. There are some women who only come to me when they are already six months pregnant. They don't come to the health center because they don't have money, so I go to their house and talk to them to convince them. Not all of them, but a great many. This makes me very tired.”

Mariame, 38, midwife

⁹⁰ World Bank, 2020.

2.2.7 CARE Project: Transforming Norms Through the Social Analysis and Action (SAA) Approach

CARE implemented an SRHR project in the Gbêkê region in central Côte d'Ivoire.⁹¹ The project objective was to improve access to SRHR services for women and teenagers with a particular focus on young people with disabilities. In particular, women and youth-friendly services for comprehensive sexuality education and sexual and reproductive health services in the Gbêkê region were to be improved, thereby increasing utilization. Among other things, measures were taken to improve access to contraceptives and information for women and young people. This took place in particular by strengthening the skills of midwives and volunteer health workers (*agents de santé communautaire*) as well as through cooperation with community authorities and youth organizations.

At the same time, sustainability was to be achieved by strengthening the government and civil society in their commitment to improve sexual and reproductive health and rights. The focus here was on social behavioral changes in the communities. Improved knowledge and skills among women and men helped them to make more independent and informed decisions regarding sexuality and family planning. CARE worked with two established program approaches: the *Community Score Card (CSC)* and *Social Analysis and Action (SAA)*.⁹²

The *Community Score Card* is a citizen-centered approach to accountability. It enables community members, healthcare providers, and government representatives to work together to identify barriers to quality healthcare and equal opportunities and develop approaches to overcome them.⁹³

Social Analysis and Action is a participatory approach to reflection and dialog that explores and questions social factors that negatively

impact individual lives and well-being. The aim is to promote a more equitable environment and to question and transform negative norms and stereotypes. SAA involves an ongoing facilitated process of reflection and dialog that enables communities to explore, challenge, and change social norms, beliefs, and practices related to relations between the sexes and power.⁹⁴

The awareness campaigns focused in particular on the very high rate of early pregnancies. They were carried out by youth representatives, women's organizations, and, in particular, volunteer health workers (*agents de santé communautaire*) and midwives.

“The educational work we have done has broken down barriers. Whether they were boys or girls, they were ashamed to come to the center at first. They thought, ‘When I go to the hospital, I’ll meet a member of my family. It will let my parents know that I have a boyfriend or girlfriend.’ They were afraid. And they were also embarrassed to ask for information about the different activities of the health center, especially about family planning. We have broken through this barrier with our educational measures. The shame has been removed.”

Diomande, 34, midwife

Midwives, the district health administration, the community, and also the young people themselves emphasize the positive change that has been triggered by the educational work. The number of early pregnancies has fallen drastically in the project area. The educational work was accompanied by the subsidization of contraceptives. The free contraceptives were well received and contributed to the success of the measures.

While the knowledge imparted in the training courses will have a lasting positive effect on the midwives' ability to work and the impact of their work, the fact that the subsidization of contraceptives will also stop at the end of the

91 The ENSEMBLE project (*Éducation nécessaire à la santé sexuelle et reproductive équitable pour devenir maître de son bien-être et libre de ses choix* – “Education necessary for equitable sexual and reproductive health to take charge of personal health and make free choices”) was implemented in Côte d'Ivoire from February 2020 to June 2023 by Humanité & Inclusion, CARE and the RAES NGO with funding from Global Affairs Canada. CARE worked in twelve locations in the Béoumi department, in conjunction with the Béoumi Health District as principal partner.

92 CARE (2020): *Technical guidance for pairing CARE's Community Score Card & Social Analysis and Action approaches*.

93 CARE (2023b): *Community Score Card® (CSC)*.

94 CARE (2023c): *Social Analysis and Action (SAA)*.

project points to the structural problems. Côte d'Ivoire is one of the countries that have committed to accelerating the use of family planning services as part of the Family Planning 2020 (FP2020) program. However, the financial resources made available for this purpose are still low.⁹⁵

“When the project comes to an end, it will be difficult. Especially with regard to contraceptives. Education about family planning, yes, we can do that. The contraceptives themselves will be the problem. Because we are already doing the education and we will continue to do so. But if we raise awareness and the products are not there, that becomes a problem.”

Diomande, 34, midwife

Results of the project activities to raise awareness

98 % of respondents were aware of at least three good sexual and reproductive health and rights practices at the end of the project.

74 % of the female adolescents surveyed (aged 15-19) named talking to their partner about contraception as a good practice (increase of 64 per cent).

70 % of respondents used contraception to prevent pregnancy. This corresponds to a threefold increase compared to the initial figure.

47 % fewer teenage pregnancies in the project area.

⁹⁵ World Bank, 2020.

3

Summary and Recommendations

Midwives are key figures in the implementation of sexual and reproductive health and rights. This study has shown that this applies in times of peace and stability, but becomes all the more important in fragile contexts and crises. Through their tireless efforts and direct contact with the population, midwives, as frontline health workers (FLHWs), make a significant contribution to reducing maternal and neonatal mortality. They ensure that particularly marginalized groups also have access to healthcare and support women and young people through education to give them more decision-making power over their own bodies.

As they are often the only SRMNAH specialist in remote areas, midwives compensate for the lack of equipment and the poverty of the population by going far beyond their job description: Midwives in structurally weak areas and crisis contexts are often faced with the decision of either paying for medication or transportation themselves or leaving the woman in question to her fate. For all of the midwives interviewed, this decision was clear; they invested their own resources. This is also closely linked to the motivation behind their choice of career: saving lives and helping people.

In many places, midwives compensate for structural problems by assuming responsibility for situations for which they are neither trained nor authorized: Births supervised alone, where no doctor is available even in the event of complications, or referrals without suitable means of transport present them with difficult decisions. On the one hand, the national healthcare systems in the contexts studied offer too little support in the form of practice-based training, further training, and specialization opportunities. On the other hand, existing potential is also limited by legal restrictions on the competencies of midwives.

The country examples of Iraq and Côte d'Ivoire illustrate the risks and hardships that women in fragile contexts take on in order to practice the profession of midwifery. They also document the systemic barriers that women encounter as midwives in the healthcare system and the individual ways they find to overcome them. There are certainly parallels between Côte d'Ivoire and Iraq in terms of these coping mechanisms: These include a high level of personal commitment, including putting one's own needs aside, exceeding the legally permitted areas of responsibility for the benefit of the patient being treated, and also an understanding of the profession that

goes beyond the physical care of the women to include a psychosocial element.

The stories of Diomande, Diyana, and their colleagues in Côte d'Ivoire and Iraq highlight what structural changes need to take place in

society and in the state healthcare system, and how these changes can be supported by project work. In order for midwives to realize their full potential as agents of change, changes at various levels are recommended:⁹⁶



General conditions:

- The responsibility that midwives bear for their communities and the work they do must be reflected in **fair pay and improved working conditions**. To ensure demand-oriented distribution of midwives, their deployment in remote areas and contexts with a volatile security situation must be remunerated with appropriate allowances.
- The **basic, advanced, and further training** of midwives must be **adequately equipped and more practically oriented**. This includes teaching content that enables midwives to provide emergency care independently if no doctor is available. Midwives must also be prepared for **special challenges in crises** during their training in order to be able to provide psychosocial support for traumatized patients, for example. Continuing education and training must be mandatory and accessible for all midwives in order to continuously improve their work and ensure that it is based on the latest knowledge. To meet the demand for midwives, more midwives need to be trained overall.
- The **legal framework** in which midwives operate must be **adapted** to the contexts in which they work. Midwives who work in remote areas, fragile contexts, and humanitarian emergencies, even without the direct support of doctors, need both targeted further training and legal protection. This must be accompanied by additional training in the field of emergency obstetric care or specialization in the field of emergency medicine.
- Extensive **competencies in family planning**, both in education and in the administration of contraceptives, are crucial to realizing the potential of midwives in the area of sexual and reproductive health and rights. Their position in the community and their nursing/medical role predestine them to play a prominent role in the transformation of harmful norms and access to SRHR.

⁹⁶ The recommendations which follow were influenced by the needs and demands expressed by the midwives interviewed, the Association of Ivorian Midwives (ASFI) and the demands of UNFPA, WHO and the International Confederation of Midwives (ICM). They are also guided by the State of the World's Midwifery 2021 report, which calls for investment in four areas: (i) planning, management and regulation of the health workforce and its work environment, (ii) quality education and training for midwives, (iii) midwife-led improvements in SRMNAH service delivery by midwives and (iv) strengthening midwifery leadership and representation.

- Health centers, delivery rooms, and maternity wards must be **equipped adequately and demand-oriented** with medical equipment. Basic infrastructure, such as water and electricity, as well as patient transportation for referrals and at least basic laboratory tests must be guaranteed.
- The continuous **availability of supplies, medication, and contraceptives** must be guaranteed. Essentials for the basic care of women during childbirth must be available free of charge. Family planning methods and contraceptives must be available continuously and inexpensively in order to meet increased demand resulting from the educational work of midwives.
- **Midwives** must be **significantly involved** at all levels of the healthcare system, in shaping the framework conditions for their profession and in crisis prevention and response. To this end, it is important to **strengthen the midwives' associations** so that midwives can represent their interests with a strong voice. In humanitarian crises, midwives need to be involved in the crisis response as they are often best placed to be aware of existing needs due to their unique position in the community.

Recommendations for programmes:

- The **potential of midwives as agents of change** must be expanded and better utilized through the **support of midwifery associations and a focus on networking and advocacy by midwives** to improve their position as frontline health workers (FLHWs) in the health system.
- SRHR programs must be based on solid **intersectional analyses** in which midwives are closely involved. This is the only way to ensure that access to sexual and reproductive health and the realization of associated rights are also promoted for the most vulnerable members of society.

- There must be sufficient **projects focusing on training and strengthening midwives in the field of family planning**. The examples from Côte d'Ivoire and Iraq have shown that this leads to direct successes (such as the reduction of early pregnancies) and sustainable change (midwives as disseminators of transformative approaches).
- Project concepts should always also consider approaches to **improve the equipment and supply of health facilities**, especially with medicines and contraceptives, and also develop an exit strategy that aims for sustainability.

Donors:

- Donor countries should explicitly advocate for the **recognition and appreciation of the exposed and challenging role of frontline health workers (FLHWs)**, and midwives in particular, at international level, especially against the background of feminist foreign and development policy. Midwives make up a large proportion of the mostly female FLHWs in patriarchal health systems.
- Donors must guarantee **sustainable and longer-term funding in the area of sexual and reproductive health and rights (SRHR)**, including family planning and the strengthening of frontline health workers (FLHWs), and focus their support on structural causes in particular. In addition to strengthening the position and improving the working conditions of midwives, investments in access to contraceptives, in health services for pregnant women and mothers, and in young people's access to services and information on sexual and reproductive health are important.
- Midwives must be **supported politically and financially in representing their rights and positions** to ensure that their important insights are heard when decisions are made.

- **Longer-term funding for SRHR in crises is necessary at an early stage** in view of the fact that harmful social norms and practices are usually reinforced in crisis and conflict situations and sexual and reproductive health needs therefore increase.
- Against the backdrop of increased and prolonged crises, donors must also **provide adequate, transparent, and reliable funding**

for approaches in the **health sector** that can support midwives in the sense of a **nexus approach**. This includes, for example, training and involving midwives in crisis preparedness, working directly with midwives in providing the Minimum Initial Service Package (MISP) in crisis response, and strengthening midwives as part of sustainable and inclusive health care in the stabilization and post-conflict phases.

Display board in the health center in Côte d'Ivoire providing information on available contraceptives.



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