The gender debate: is midwifery education 'women's work'?

Abstract

This series of six articles is inspired by themes arising from the Royal College of Midwives State of Midwifery Education report. The series explores the current landscape and challenges in educating the future midwifery workforce, particularly those that pertain to the higher education workforce. This second article highlights some of the inequalities experienced by the majority female midwifery education workforce and their impact, exploring how these inequalities are symptomatic of many of the inequalities women experience more generally within patriarchal structures. The article examines if midwifery education is 'women's work', and how this can work to impede progression in leadership, research and scholarship for midwifery academics. How midwifery curricula can influence the future academic workforce in dismantling inequality is also considered.

Keywords

Education | Gender | Feminism | Intersectionality | Workforce

Dr Sam Chenery-Morris
Dean of School of Nursing, Midwifery and Public Health, University of Suffolk

Jo Divers
Associate Dean, Learning, Teaching and Student Experience, School of Nursing, Midwifery and Public Health, University of Suffolk

Understanding what it means to be a woman, as well as a midwife and/or birthing person is central to midwifery professional expertise (Newnham and Rothman, 2022). In this article, the focus goes beyond the profession itself to examine the work of midwifery education through the gender lens, a lens that, surprisingly, appeared to be missing from the Royal College of Midwives (RCM, 2023) State of Midwifery Education report that inspired this series.

Midwifery is female dominated, with 99.7% of registered midwives (including specialist community public health nurses) identifying as female (Nursing and Midwifery Council (NMC), 2024). In higher education, midwifery is similarly female dominated; the UK Council of Deans for Health (CODH, 2019) report states that over 90% of the midwifery higher education workforce identify as female. Additionally, while men are in the minority in academic midwifery roles, just as they are in clinical practice, they are better represented in leadership/senior positions in higher education, as they are in leadership within the NHS (CODH, 2019).

This article seeks to explore this in greater detail, taking a feminist approach to examining the social and historical influences on the present-day challenges associated with a largely female workforce, teaching a largely female student body how to provide care to a largely female patient body, under disproportionately male leadership. While previously discussed solutions of attracting more men into frontline nursing and midwifery roles may have value (Clifton et al, 2018; Thompson et al, 2020), this is only part of the solution. Instead, the aim of this article is to better understand and acknowledge the specific challenges that the female workforce faces in order to promote their advancement and progression.

This approach is even more pertinent in view of the male-dominated wider higher education sector data denoting a gender split of 44% females vs 56% males across UK higher education academic roles (Higher Education Statistics Agency (HESA), 2024). Are female midwifery educators starting from the same baseline and afforded the same support to progress as the majority

male higher education workforce? Importantly, this article will explore if, as a female-dominated discipline, curricula are being taught that include feminist theories, literature and research and if social justice for women (be they students or staff) is being sufficiently sought. Students are the future clinical and education workforce, so how far does midwifery teaching transform or support the patriarchal status quo? For the purpose of this article, when gender is referenced, we are including self-identification of gender within the scope.

Snowy white 'male' peaks?

Senior management and leadership in the NHS in the UK have long been described as the 'snowy white peaks of the NHS' (Kline, 2014), acknowledging the race inequalities therein. Crucially, this is an area that will be returned to in the next article looking at diversity in the midwifery higher education workforce. However, it has also long been the case that these white peaks could also be described as predominantly male.

On the 'shop floor', the NHS is a woman-dominated organisation, yet men consistently dominate senior board level positions (NHS Confederation, 2019). Similarly, while there are more women among the midwifery higher education workforce in general, there are proportionally more men in academia than there are caring for patients in clinical frontline roles; 27.7% of the nursing, midwifery and allied health higher education workforce is male compared to only 11% of those in clinical nursing and midwifery roles (CODH, 2019). When in academia, men appear to be in senior roles more frequently than women (Evans, 2004; Cleary et al, 2019). Men are therefore disproportionately represented in senior, management, leadership and specialist roles both in clinical practice and in higher education. This gender divide of labour and seniority is an established barrier to career advancement for women in both the health service and higher education (Zacher et al, 2019). This is (and should be) startling in the context of a profession that is female dominated.

Many of the barriers to women's progression in midwifery education are well known and reflect the broader challenges that women experience in almost any sector. Women provide twice as much unpaid childcare as men per year (Centre for Progressive Policy, 2022) against a cultural backdrop where the British public believe the best organisation of work and care while children are small is the mother working part time while the father works full time (Allen and Stevenson, 2023). Women also typically shoulder more of the burden of caring for elderly parents and/or family relatives, in addition to the health challenges of pregnancy, birth to consider, breastfeeding and eventually menopause that can contribute to career stagnancy (Centre of Economic and Business Research, 2023). There are other examples of these issues, even before exploring any additional specific challenges in midwifery higher education. It is unsurprising then that there are fewer women in professor, researcher or fellow roles and therefore fewer women influencing research, policy and/or practice at senior levels in midwifery (Cleary et al, 2019; RCM, 2023).

Is midwifery innately gendered?

While the authors do not subscribe to the notion that midwifery is innately gendered, it cannot be ignored that as one of the oldest professions, much of the knowledge that underpins it is based on hundreds of years of gender exclusivity. Everyone is aware of the origins of midwifery and while there is some mention of men assisting in childbirth out of necessity in the Paleolithic era, men were thereafter largely excluded from childbirth (Barnawi et al, 2013). Female midwives combined tradition, medical knowledge and spiritual wisdom to attend women in childbirth until medieval times, when the advent of male physicians led to the exclusion of most midwives. This continued throughout the Renaissance; childbirth shifted towards medicalisation, evidence and a focus on anatomy, physiology and the mechanics of birth (Barnawi et al, 2013).

As scientific knowledge expanded throughout the Industrial Revolution, so too did the domination of men in birth. Birth moved concretely from home into the hospital and the traditional and experiential knowledge and expertise of midwives, which had been gained over centuries, was gradually sidelined. Women were also in the minority in universities and education, where new knowledge was created. The first degrees awarded to women from a British university commenced in 1878 (Dyhouse, 2016). It was not until the Midwives Act of 1902 that midwifery began to be recognised as its own (female dominated) profession; however, this was only achievable by conforming to the standards, regulation and values as defined and overseen by men.

Seminal feminist critique might suggest that this professionalisation merely served to reinforce patriarchal power structures, marginalising women who could not afford or access formal education and reinforcing hierarchical structures within the profession that mirrored broader societal gender hierarchies (Donnison, 1988). Where we have landed is, arguably, a profession that has evolved from and continues to this day to be led by male-informed structures (World Health Organization, 2019). And while women continue to dominate frontline 'caring' and 'nurturing' roles in midwifery (with men disproportionately represented in senior roles and leadership), theory would suggest that this continues to support a sort of 'benevolent sexism' that reinforces gender inequality; women are positively viewed only

if they embody traditionally gendered conventional roles and do not seek to disrupt male power (Glick and Fiske, 2001).

However, midwifery has a long history of just such disruption. Empowering women to take control of their reproductive health against a long history of women's bodies being controlled and medicalised is a disruptive and feminist act in and of itself (Hawke, 2021). Much of this disruption has effected real meaningful change for birthing women, advocating for female bodily autonomy, woman-centred care, informed consent, shared decision making, to name but a few. However, what the gender imbalance in leadership illustrates is that this disruption has not been successfully affected internally, either in the clinical workforce or that of higher education. Midwives are better at advocating for the women in their care than for each other.

Barriers to progression

In addition to the well-documented broader challenges that work against female career progression, there are some specific barriers in midwifery education. This series will explore the perception of midwifery as a 'non-academic' discipline in a future article, but it is worth noting here that there exists an inequality in relation to the qualification baseline expected of academics in subjects such as nursing and midwifery and more 'traditional' male-dominated academic subjects. While it may be common for academics in traditional disciplines to possess a doctoral qualification (HESA (2023) data to 2021–2022 show that 68.7% of UK academics do), this is far from the case for midwifery educators. The RCM (2023) report stated that only 12% of the midwifery higher education workforce have a doctorate and only 43% have Masters level qualifications. While this appears startling, surely the question to ask here is if it should be expected that midwives entering academia hold a doctorate.

Midwives (and perhaps also nurses) typically come into academia from clinical practice, not following years spent, for example, in an archive to obtain a doctorate. Is this clinical experience inherently 'less than' the research experience gained during doctoral study? The authors do not propose that it is, although the RCM (2023) report also indicates that the midwifery education workforce is getting younger and entering academia with relatively less clinical experience. In the absence of either further study or significant clinical experience, there is clearly a gap to fill. This is a point that will be explored in a future article in this series, where the skills needed in the midwifery higher education workforce, in contrast to the legacy perception of more traditional academic roles, will be considered. However, the reality of the sector expectation for doctoral and/or Masters qualification to support career progression pathways may nonetheless have a career limiting effect for those entering higher education from a clinical background (Albarran and Rosser, 2014).

An additional barrier exists in the long-debated casualisation of the higher education workforce. Once again unsurprisingly, women appear to be more likely than men to be on fixed-term, zero-hours and/or hourly-paid contracts (University and College Union, 2021). This is a topic will be picked up in a future article looking at the pay and conditions of the higher education workforce, where some of the drivers for this casualisation will be examined. Nonetheless, it is a clear obstacle to female progression; casual workers do not have the same career support, progression, mentoring or funding to progress in comparison to permanent colleagues (Halcomb et al, 2010). More specific data relating to this casualisation in the midwifery higher education workforce would additionally inform the RCM's state of midwifery education analysis.

Breadth of the role

The role of a midwifery educator is in and of itself a barrier to progression; it is simply a broader remit enacted over a longer period allowing little scope for research or further study. Midwifery programmes run over a longer academic year, where students are afforded around 7 weeks of annual leave in comparison to circa 18–24 weeks of leave for most standard academic courses (Postgrad.com, 2024). This creates considerable difficulties for both staff and students. In the authors' experiences, their students' ability to work part-time to cope throughout a cost-of-living crisis is severely restricted. For education staff, it makes further study and research more challenging above the teaching load.

In addition, midwifery educators must embody multiple roles alongside teaching and lecturing. They are often academic assessors, tasked with regular reviews of extensive practice assessment documentation, link tutors for NHS trusts, required to be present to support both students and clinical staff in assessing and recording student proficiency, and personal tutors to a student cohort who are often struggling and (even pre-pandemic) require increasing support (Oates et al, 2019). Educators must also meet the requirements of NMC registration and revalidation. This is in addition to the teaching load, outreach work, admissions administration and internal quality assurance and enhancement work that all disciplines must contribute to.

Just as the burden largely falls on women to take on multiple roles and duties in a social context (childcare, caring for elderly relatives, housework and the well-reported 'emotional labour' of managing the domestic and family environment), so too is this

happening in the midwifery higher education workforce. Women appear to do much more, with less downtime, and much of this supportive work for students is 'nurturing', 'caring' work too. This leads female educators to sacrifice personal gain and progression. The pandemic provided the perfect petri dish to analyse this in more extreme circumstances; the increased domestic and education demands resulted in a global decrease in articles and grant proposals submitted by women in comparison to male peers (França et al, 2023).

Despite the evidently broad and comparatively greater workloads experienced by women working in NMC-regulated programmes such as midwifery, women are held to the same standards as academics (both male and female) who have a much less extensive baseline workload (and are thus able to focus on scholarship and progression as they wish, particularly over longer holiday breaks). There is both cultural and structural sexism at play here, first considered by Millett (2000) in the 70s, but evident now over 50 years later. What can be done to begin to challenge and disrupt the endemic sexism at play? The authors suggest that this may start with those we educate.

Teaching to transform or support the patriarchy?

Are women teaching women (and men) in university how to become midwives via curricula that includes feminist theories, literature and research? University knowledge should be individually transformational and collectively support greater social justice. In the health professions, where most of the workforce is female, teaching should centre material about women's experiences. The importance of incorporating both the female voice and feminist theory in midwifery education has been long argued as crucial to understanding and participating in the midwife–woman relationship and core to the profession itself (Walsh et al, 2015; Walsh, 2016; Jefford and Nolan, 2022). This is particularly the case when considering women from different backgrounds: intersectionality reinforces that race, ethnicity, age, class, sexuality and ability overlap with gender and further compound experiences of disadvantage (Crenshaw, 2017). How does the curricula transform or support the patriarchal status quo that inhibits the progression of those doing the teaching?

This article has considered the feminist perspective that the professionalisation of midwifery merely served to force midwifery to conform to patriarchal power structures. It is interesting to consider midwifery curricula through this lens, to observe the structures that are still at play. One of the tenets that is core to the profession is that of reflection, it being a requirement of both the NMC (2021; 2023) standards and of continuing registration that both student midwives and registered midwives engage in practice reflection. Interestingly, this reflective requirement seems to be mirrored in other professions where women dominate frontline roles that are perceived as 'caring', such as nursing, social work, counselling, allied health roles and education (Kinsella 2010; Connolly, 2018). Invariably, however, the heavyweights who dominate the reflective frameworks that students are directed to are those developed by white men (think Gibbs, Johns, Schon, Driscoll, and Kolb). While this is not to say that these models do not have value, it is fair to say that feminist perspectives considering elements of power, control, intersectionality and social justice for women are not standard foci in the reflective cycles described.

Feminist approaches to reflection are far less established or well known but ultimately aim to centre the female experience to challenge gender-based inequalities (Clegg, 1999; Ackerley, 2008; Coia and Taylor, 2017; Connolly, 2018). These approaches to reflection are messy, however, not falling into neat sequential diagrams or NMC templates. They are more reflective of the conversations (both internal and external) that students might have in response to their experiences. There is work to be done here in making something both representative but more accessible and usable for students.

Language in teaching, particularly that which pertains to anatomy and physiology, also merits consideration. Midwifery has a sexist problem with both eponyms and negative derivative terms. Reference to 'sims forceps', 'fallopian tubes' and the 'pouch of Douglas' remain in common use; these are descriptions of female anatomy or instruments used on female anatomy that are named after deceased white men, one of whom has had serious

Box 1. Things to consider for student midwives, midwives and midwifery educators

- Transform approaches to student reflection by using feminist approaches, models and frameworks where possible, rather than relying on male-dominated, traditional models without further question (Clegg, 1999)
- Consider removing eponyms from the midwifery lexicon; resources such as the 'Eponymictionary' (Cadogan, 2024) can be used to find alternatives to anatomical and physiological structures named after historical male figures. Consider using more meaningful functional descriptive terms (such as 'uterine tube' over 'fallopian tube')
- Cast a critical eye over education reading lists, links and employed resources; is the female voice centred? Are diverse female groups represented among authors and creators?
- Leaders in academia should seek to review rigid academic progression pathways to ensure clinical skills and experience can be considered alongside more traditional academic scholarly activity where appropriate
- Higher education institutions should consider how they support female educators who are balancing family/caring responsibilities; this may positively influence a move away from casual working and thus support better female progression in the discipline

Key points

- Women dominate both the midwifery clinical and higher education workforces; however, men are proportionately better represented in senior leadership and specialist roles in both arenas.
- While midwifery and midwifery education are not innately gendered, they are based on a history of knowledge built by gender exclusivity and highly influenced by benevolently sexist concepts of women as 'carers'.
- Many of the constructs and frameworks in midwifery and midwifery education support the patriarchal status quo rather than celebrating, empowering and developing the majority female workforce.
- Midwifery higher education can begin to transform this by applying a critical lens to curriculum content, questioning the origins of knowledge and the theoretical frameworks used with students.

ethical concerns raised relating to forced surgical procedures on black female slaves (Spettel and White, 2011). The Latin origins of female anatomical structures are similarly alarming; the Latin verb 'pudere' (the root of 'pudendum' and 'pudendal nerve') translates as 'to be ashamed'. Even 'hymen' and 'vagina' have uncomfortable origins when their etymology is analysed (Draper, 2021). While students may not necessarily know this or be affected by it, surely it is our duty to seek to change language, reference points and revered historical figures to those that support, reflect and promote female equality and empowerment? At the very least these terms would be better understood if they were descriptive of function over fame; 'uterine tube' saying far more about the purpose of the structure for a learner than 'fallopian tube'. These are simple examples but there are many more once we begin to view curricula through a feminist lens.

Conclusions

This article highlights some of the inequalities experienced by the majority female midwifery education workforce and the impact of these inequalities, exploring how they are symptomatic of many of the inequalities women experience more generally in patriarchal structures. Midwifery education is not necessarily 'women's work', although it is founded on female knowledge and embodies elements of caring and nurturing that, as in midwifery itself, contribute to benevolent sexism that keeps women at the caring coalface. These elements combined can impede progression in leadership, research and scholarship for midwifery academics. This article also suggests how we can begin to unpick elements of the midwifery curriculum, to practice what we preach in developing feminist midwives who can contribute to dismantling inequality for both the women they care for and women in the profession as educators. The aim is not to misalign men or the male contribution to midwifery, nor is it to give women unfair advantage; women make great leaders universally and this must be reclaimed for midwifery by more fully understanding and removing the unique blockers to progress. **BJM**

Funding: *No funding has been received for this work.*

Declaration of interest: *The authors declare that there are no conflicts of interest.*

Peer review: *This article was subject to double-blind peer review and accepted for publication on 7 February 2024.*

Ackerly B. Feminist methodological reflection. In: Klotz A, Prakash D (eds). Qualitative methods in international relations: a pluralist guide. London: Palgrave Macmillan UK; 2008

Albarran JW, Rosser EA. The challenges facing midwifery educators in sustaining a future education workforce. Midwifery. 2014;30(8):949–955. https://doi.org/10.1016/j.midw.2013.07.016

Allen J, Stevenson I. British social attitudes: gender roles. 2023. https://natcen.ac.uk/sites/default/files/2023-09/BSA%2040%20Gender%20roles.pdf (accessed 15 March 2024)

Barnawi N, Richter S, Habib F. Midwifery and midwives: a historical analysis. 2013;2(8):114–121. https://doi.org/http://dx.doi.org/10.14303/JRNM.2013.064

Cadogan M. De-eponymification. 2024. https://litfl.com/eponym/de-eponymification/ (accessed 29 January 2024)

Centre for Progressive Policy. What women want: tackling gender inequalities in unpaid care and the workplace. 2022. https://www.thewomensorganisation.org.uk/wp-content/uploads/2022/04/WiW-2-final-report.pdf (accessed 18 March 2024)

Centre of Economic and Business Research. The consequences of neglecting women's health in the workplace. 2023. https://www.axahealth.co.uk/globalassets/menopause-support/corporate/axa-health-workplace-report.pdf (accessed 2 January 2024)

Cleary M, West S, Arthur D, Kornhaber R, Hungerford C. Women in health academia: power dynamics in nursing, higher education and research. J Adv Nurs. 2019;75(7):1371–1373. https://doi.org/10.1111/jan.13999

Clegg S. Professional education, reflective practice and feminism. Int J Incl Educ. 1999;3(2):167–179. https://doi.org/10.1080/136031199285101

Clifton A, Higman J, Stephenson J, Navarro AR, Welyczko N. The role of universities in attracting male students on to pre-registration nursing programmes: an electronic survey of UK higher education institutions. Nurse Educ Today. 2018;71:111–115. https://doi.org/10.1016/j.nedt.2018.09.009

Coia L, Taylor M. Let's stay in the swamp: poststructural feminist reflective practice. In: Brandenburg R, Glasswell K, Jones M, Ryan J (eds). Reflective theory and practice in teacher. Singapore: Springer Singapore; 2017

Connolly B. Reflective practice and the feminist lens: the other side. 2018. https://files.eric.ed.gov/fulltext/EJ1197434.pdf (accessed 16 January 2024)

Council of Deans for Health. The academic workforce in health

faculties. 2019. https://councilofdeans.org.uk/wp-content/uploads/2020/01/CODH.ASC.report_v4.pdf (accessed 16 July 2023)
Crenshaw KW. On intersectionality: essential writings. New York: The New Press: 2017
Donnison J. Midwives and medical men: a history of the struggle for the control of childbirth. Oxford: Taylor & Francis; 1988
Draper A. The history of the term pudendum: opening the discussion on anatomical sex inequality. Clin Anat. 2021;34(2):315–319. https://doi.org/10.1002/ca.23659. doi:10.1002/ca.23659
Dyhouse C. No distinction of sex? Women in British universities, 1870-1939. London: Routledge; 2016
Evans J. Men nurses: a historical and feminist perspective. J Adv Nurs. 2004;47(3):321–328. https://doi.org/10.1111/j.1365-2648.2004.03096.x
França T, Vicente M, Godinho F, Padilla B, Amâncio L, Alexandre AF. The cost of "care" in neoliberal academia during the COVID-19 pandemic: Women academics, teaching and emotional labour. Eur J Womens Stud. 2023;30(4):470–485. https://doi.org/10.1177/13505068231205096
Glick P, Fiske ST. An ambivalent alliance: hostile and benevolent sexism as complementary justifications for gender inequality. Am Psychol. 2001;56(2):109–118. https://doi.org/10.1037/0003-066X.56.2.109
Halcomb EJ, Andrew S, Peters K, Salamonson Y, Jackson D. Casualisation of the teaching workforce: implications for nursing education. Nurse Educ Today. 2010;30(6):528–532. https://doi.org/10.1016/j.nedt.2009.10.022
Hawke M. Subversive acts and everyday midwifery: feminism in content and context. Women Birth. 2021;34(1):e92–e96. https://doi.org/10.1016/j.wombi.2020.05.013
Higher Education Statistics Agency. Table 8 - HE academic staff by HE provider and highest qualification held 2014/15 to 2021/22. 2023. https://www.hesa.ac.uk/data-and-analysis/staff/table-8 (accessed 27 January 2024)
Higher Education Statistics Agency. Higher education staff statistics: UK, 2022/23. 2024. https://www.hesa.ac.uk/news/16-01-2024/sb267-higher-education-staff-statistics (accessed 27 January 2024)
Jefford E, Nolan S. Two parts of an indivisible whole - midwifery education and feminism: an exploratory study of 1st year students' immersion into midwifery. Nurse Educ Today. 2022;119:105589. https://doi.org/10.1016/j.nedt.2022.105589
Kinsella EA. Professional knowledge and the epistemology of reflective practice. Nurs Philosophy. 2010;11(1):3–14. https://doi.org/10.1111/j.1466-769X.2009.00428.x
Kline R. The "snowy white peaks" of the NHS: a survey of discrimination in governance and leadership and the potential impact on patient care in London and England. 2014. https://www.england.nhs.uk/wp-content/uploads/2014/08/edc7-0514.pdf (accessed 12 March 2024)
Millett K. Sexual politics. Urbana: University of Illinois Press; 2000
Newnham E, Rothman BK. The quantification of midwifery research: limiting midwifery knowledge. Birth. 2022;49(2):175–178. https://doi.org/10.1111/birt.12615
NHS Confederation. Chairs and non-executives in the NHS: The need for diverse leadership. 2019. https://www.nhsconfed.org/system/files/media/Chairs-and-non-executives-NHS-diverse-leadership.pdf (accessed 17 July 2023)
Nursing and Midwifery Council. Written reflective accounts. 2021. https://www.nmc.org.uk/revalidation/requirements/written-reflective-accounts/ (accessed 28 January 2024)
Nursing and Midwifery Council. Standards framework for nursing and midwifery education. 2023. https://www.nmc.org.uk/globalassets/sitedocuments/standards/2023-pre-reg-standards/new-vi/standards-framework-for-nursing-and-midwifery-education.pdf (accessed 10 November 2023)
Nursing and Midwifery Council. Equality, diversity and inclusion data tables 2022-2023. 2024. https://www.nmc.org.uk/globalassets/sitedocuments/annual_reports_and_accounts/edi/2023/edi-annual-data-tables_2022-2023.xls (accessed 30 January 2024)
Oates J, Topping A, Arias T, Charles P, Hunter C, Watts K. The mental health and wellbeing of midwifery students: an integrative review. Midwifery. 2019;72:80–89. https://doi.org/10.1016/j.midw.2019.02.007
Postgrad.com. UK University Holidays & Term Times 2024-25. 2024. https://www.postgrad.com/study-in-uk/uk-postgraduate-study/university-holidays/ (accessed 27 January 2024)
Royal College of Midwives. State of midwifery education. 2023. https://www.rcm.org.uk/media/7001/rcm-state-of-midwifery-education-2023.pdf (accessed 3 November 2023)
Spettel S, White MD. The portrayal of J. Marion Sims' controversial surgical legacy. J Urology. 2011;185(6):2424–2427. https://doi.org/10.1016/j.juro.2011.01.077
Thompson DR, Quinn B, Watson R. Getting more men into nursing: an urgent priority (too little, too late). J Nurs Manage. 2020;28(7):1463–1464. https://doi.org/10.1111/jonm.13021
University and College Union. Precarious work in higher education. 2021. https://www.ucu.org.uk/media/10899/Precarious-work-in-higher-education-May-20/pdf/ucu_he-precarity-report_may20.pdf (accessed 27 January 2024)
Walsh D. Midwives, gender equality and feminism. Practis Midwife. 2016;19(3):24–26
Walsh D, Christianson M, Stewart M. Why midwives should be feminists. Midwifery Digest. 2015;25(2):154–160
World Health Organization. Delivered by women, led by men: a gender and equity analysis of the global health and social workforce. 2019. https://cdn.who.int/media/docs/default-source/health-workforce/delivered-by-women-led-by-men.pdf?sfvrsn=94be9959_2 (accessed 30 January 2024)
Zacher H, Rudolph CW, Todorovic T, Ammann D. Academic career development: a review and research agenda. J Vocational Behav. 2019;110:357–373. https://doi.org/10.1016/j.jvb.2018.08.006

CPD reflective questions

- What is the gender landscape in your place of work, particularly in leadership roles?
- How are barriers to women's progression acknowledged and managed? What can you do to facilitate this?
- How can you role model feminist values for students of midwifery?
- Consider the language, theory, references and resources you use with women, students and colleagues; how can these better represent and centre the female experience?