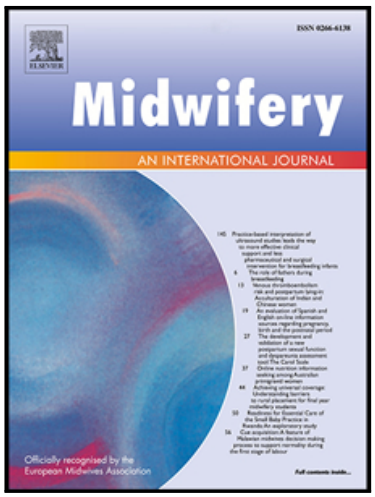

'Just a Midwife': A Qualitative study on perceived barriers and facilitators facing Filipino midwifery students in reaching ICM Standards

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PII: S0266-6138(25)00074-9
DOI: https://doi.org/10.1016/j.midw.2025.104355
Reference: YMIDW 104355

To appear in: *Midwifery*

Received date: 6 August 2024
Revised date: 15 January 2025
Accepted date: 21 February 2025

Please cite this article as: Georgia Leigh Macad , Dr. Lucia Rocca-Ihenacho , 'Just a Midwife': A Qualitative study on perceived barriers and facilitators facing Filipino midwifery students in reaching ICM Standards, *Midwifery* (2025), doi: https://doi.org/10.1016/j.midw.2025.104355

Title Page

Title: 'Just a Midwife': A Qualitative study on perceived barriers and facilitators facing Filipino midwifery students in reaching ICM Standards

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Introduction

Since 2015 the United Nation's (UN) Sustainable Development Goals (SDG) have been placing pressure on nations to reduce maternal mortality rates (MMR) and improve positive childbirth experiences for mothers (UN, 2015). Unfortunately, the global targets for reduction maternal mortality rate (MMR) have not been met and women in LMICs continue to die at an unacceptably high rate from largely preventable causes (WHO, 2023). Access to quality midwifery care during pregnancy and childbirth is widely regarded as one of the most effective methods of reducing maternal mortality and ensuring positive experiences and good outcomes for women and their new-borns (WHO, 2019, Michel-Schuldt et al., 2020).

In the 2021 State of the World Midwifery Report (UNFPA, 2021), the United Nations Population Fund (UNFPA), World Health Organization (WHO) and International Confederation of Midwives (ICM) jointly called for increased investment in the training, scaling up and deployment of midwives worldwide. The report estimated that by implementing high-quality midwifery-led care for all childbearing women, a 67% decrease in global maternal deaths could be attained by 2035 (UNFPA, 2021).

Responding to significant diversity among nations regarding the role, function and scope of a midwife, ICM published the following definition:

> "A midwife is a person who has successfully completed a midwifery education programme that is based on …the ICM Global Standards for Midwifery Education … and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery" (ICM, 2019).

The ICM Global Standards for Midwifery Education (2011, updated 2013 and 2021a) were developed to guide the implementation of adequate midwifery programs worldwide to ensure all who carry the title 'midwife' would have similar skill levels and competencies. However, even with the publication of the standards, many countries face obstacles in their proper implementation (ICM, 2021a). One study, which noted a considerable variability in how ICM education standards were applied globally, indicated

that institutions from High Income Countries (HICs) generally create their own standards while those in LMICs are often unable to reach ICM standards (Barger et al., 2019).

The Philippines has not met targets for reduction in MMR (Worldbank, 2024) and reportedly struggles to ensure adequate access to maternal health services for its population, especially those living in disadvantaged and remote areas (Antonio, 2023, Feng et al., 2023). Midwives are recognised and licensed as maternal health care providers in the Philippines, however as suggested by a national study, they are not supported to work to the full scope of their profession (Canila and Hipolito, 2018). Considering robust evidence that increased access to competent midwifery care significantly improves maternal health outcomes, there is an immediate need to equip and empower Filipino midwives (Antonio, 2023).

This study was designed in response to a current lack of research published on how midwifery programs in the Philippines train and equip students to practice professionally. Through a qualitative approach, the researcher investigated the experiences of a group of graduating midwifery students to evaluate their clinical training against ICM standards for education. The research provided insight for recommendations in several areas such as program governance, clinical instruction practices and the evaluation of student capabilities.

Materials and Method

Qualitative Research Paradigm

A qualitative research design was chosen to gain a deeper understanding of student perceptions than would have been possible with a quantitative design. As suggested by Sandelwoski (2004), because of the depth of understanding qualitative research allows, results can create transformative change in health sciences. Student experiences were explored in depth through both guided Focus Group Discussions (FGDs) and one-to-one interviews. Since the primary researcher was known to the participants and was actively involved in both the interviews and analysis of data, a realist constructivist

approach was employed which supports co-creation of knowledge between the researcher and participants (Crotty, 2008).

Reflexivity and Positionality

As a constructivist philosophy assumes the researcher will be influenced by relationships with participants (Mills et al., 2006), a reflexive exploration of the researcher's positionality was used to investigate and manage potential bias. The primary researcher had lived and worked as a midwife in the Philippines since 2004 and supported hands-on training of newly graduated Filipino midwives since 2009. It was because of these experiences with local midwives that the topic of barriers and facilitators in reaching clinical competency during training was chosen.

Since the primary researcher was known to the participants as a foreign professional midwife and community leader, she was both an insider and outsider during the interviews. Insider knowledge on midwifery in the Philippines may have allowed for more precise questions during interviews and perhaps greater depth in conversation. In contrast, since the researcher is not Filipino, full comprehension of the cultural context was impossible to achieve. Finally, as a leader in the community, the researcher benefited from a degree of power which may have influenced participants' responses during interviews. These biases were considered during data analysis and mitigated through joint the interpretation of data in partnership with primary researcher's academic supervisor.

Context

Participants for this research were recruited from the 2023 graduating class of a publicly funded 2-year Diploma of Midwifery program. The primary researcher visited the program's final class of the year where she introduced the study topic and invited students to participate in interviews. It was emphasised that participation was completely voluntary and would not have any effect on student grades. Students were

likewise assured that any involvement with the research would be confidential with no personal information shared with the university.

Sampling Strategy

A convenience sampling method was used to recruit participants from one local midwifery program as the researcher had limited time and resources to widen the scope to include other institutions. Inclusion criteria required that participants had completed the diploma program, including all clinical placements to ensure participants could discuss all aspects of training. Out of 70 students invited, 20 of them contacted the researcher through private message and were sent digital Participant Information Sheets (PIS) to read and consider. Out of 20 who were sent a PIS, 15 chose to take part in the research. One student backed out on the day of the interviews which left a total of 14 participants. While the number of participants was relatively small, when experiences being discussed are quite narrow in scope, small groups often create greater opportunities for depth in conversation (Malterud et al, 2016).

All 14 participants were local Filipinos with similar cultural and socioeconomic backgrounds and ranged in age from 19 to 36. There was no exclusion for male students, however none chose to participate. In the table below (Table 2) the participants' age, gender, marital status and interview type are summarised. Each participant was assigned a random identifying number used to present their quotes in support of themes.

Table 2: This table organizes the research participants' identifying number, demographics the type of interview they joined.

Ethics

Ethics approval for the research was given on May 25, 2023 (reference number: ETH2223-2012) by the Research Ethics Committee of City University, London where the researcher was enrolled. Declaration of Helsinki and GDPR principles were adhered

to, and the rights and freedoms of participants were upheld. The location for the FGDs and one-to-one interviews was off campus to provide privacy and confidentiality for participants. Furthermore, it was made clear that participation in the research was completely voluntary and all information shared would remain confidential. Participants signed informed consent forms and confidentiality agreements prior to the start of interviews.

Data Collection Methods

Participants were invited to join an FGD and/or a one-on-one interview depending on their preference. Between May 30 and June 2, 2023, the primary researcher led three semi-structured FGDs with three, five and five participants respectively followed by six one-to-one interviews. Although universities in the Philippines routinely use English in at university level (Lourdes and Bolton, 2008, pp.132–134), most participants spoke Ilocano as a first language. As there were no licensed translators available locally, following recommendations (Squires, 2009) a bilingual individual was chosen whose professional experiences indicated competency to allow participants to respond in the language of their choice.

FGDs were conducted by the primary researcher prior to one-to-one interviews and were informal, using general open-ended questions based loosely on ICM guidance for meeting global standards (ICM, 2021b) as referred to in the table below. The primary researcher did not direct the participants to answer in any but encouraged them to respond freely.

(Table 3)

Unstructured interview methods were used as they can elevate participant ideas over those of the researcher and highlight areas which may otherwise go unexplored (Holloway and Galvin 2017, pp.87–88). From insights gained during FGDs, the researcher further explored the experiences of individuals through in-depth one-to-one interviews. FGDs and one-to-one interviews lasted between 45 minutes and one hour depending on the preference of the participants and the flow of conversation. At the end

of interviews on the third day, the researcher felt that saturation had been achieved as there was no new information being discussed.

Data Collection Technologies

All interviews were recorded on the researcher's password protected iPhone. The English portions were transcribed verbatim by the researcher and checked against the original recordings to ensure accuracy. Ilocano sections were translated and transcribed into English by the translator and were likewise compared to the original recordings to ensure there were no mistakes or omissions. Due to participants returning to their home communities after graduation, it was not possible to arrange an opportunity for them to review their transcripts for further accuracy.

After transcripts were finalised, all identifying information was removed and they were uploaded into NVivo, a qualitative research software, for analysis. Audio recordings were subsequently erased from the researcher's device.

Data Analysis

A Reflexive Thematic Analysis (Braun and Clarke, 2020) framework was employed to create meaning from the data. This framework allowed the researcher to incorporate personal experiences into the interpretation. Analysis of the data began immediately after transcripts were uploaded to NVivo so the researcher's initial insights would not diminish with time. It began with in-depth familiarisation of the data by thorough and multiple reading of the transcripts during which the researcher made notes and memos throughout.

After initial data familiarization, the primary researcher created a series of 90 separate non-hierarchical codes based on interpretations of the data, each with a precise corresponding definition. The initial codes were further refined and condensed to 37 codes. At this point, the primary researcher consulted her academic supervisor to discuss the strengths and limitations of the present coding. Using a visual representation of the codes, together they identified 12 initial themes which brought clarity and meaning to the research question. The primary researcher and her

supervisor further refined the 12 themes into one central concept in which six themes and 18 sub-themes were encompassed.

Table 4. This table, based on the six steps of Reflexive Thematic Analysis (RTA) (Braun and Clarke, 2020) summarizes how the steps were used to construct themes from the data.

Results

The central concept of a disempowering culture for student midwives due to medical paternalism and the low status of midwifery in the Philippines brought clarity and meaning to the research question. The central concept was supported by the six themes and 18 subthemes presented in the following table (Table 5).

Table 5. This table categorizes, numbers and names the themes presented in this research.

Theme 1. Just a Midwife

Participants described how the lack of respect for midwifery in the Philippines led them to feel they had chosen a low status profession.

1.1 Not My First Choice

When asked why they had chosen to study midwifery, 12 participants divulged that midwifery had not been their primary choice.

*"Um, for me I didn't really want to take midwifery at first. The first course I chose was nursing. That's what I really wanted. We also had financial problems and my older sister said to me to be practical." (*P11)

"*I wanted first to apply for engineering at the university, but my dad said a better course for a woman would be midwifery*." (P12)

Participants further disclosed negative reactions which they received from family members and friends on their chosen field.

"It's like its low ma'am, it's like when they ask what my course is, and I say midwifery, they say, 'oh just a midwife?'" (P6)

"It's like feeling so low when they say, 'Oh you're just a midwife?'" (P3)

Only two of the participants claimed that midwifery had been their first choice.

"… my grandmother she was a midwife. Well, she was a traditional midwife…Midwifery was the most specific to take care of the mother and the baby. So that is why I chose midwifery." (P2)

While all participants interviewed expressed their respect for midwifery developed during training, there was consensus among them that midwifery was considered a low-status profession in the Philippines.

1.2 Our Clinical Instructors are Limited.

Participants described the treatment that academic clinical instructors received during clinical placements at the public hospital.

"…like the public hospital, they don't allow the clinical instructors to really do anything so the clinical instructor is limited in what they can teach you…" (P12)

They even shame the clinical instructor…The instructors don't have the right to oppose them. It's like, it's because they are the affiliating agency, they are lower." (P1)

Students felt that training opportunities were severely restricted when their instructors were not seen as competent healthcare providers.

1.3 Oh No, We Have Students Again

Another barrier associated with a low view of midwives was how students were treated by facility staff on rotation.

"I feel like they thought we were in the way…they just really push us to the side and tell us not to move. My first duty, I heard them say 'oh, no we have students again'…" (P7)

"For me mam, I don't think they feel anything that we are there. They just leave us or ignore us." (P12)

Experiences of being ignored by facility staff affected the self-esteem of students and created a negative environment for them.

Theme 2. Shame and Blame

The following theme explores how the use of shame impacted students during hands-on training.

2.1 My Hands Were Shaking

All participants interviewed noted experiences of being shamed during their clinical training.

"Like sometimes for me, I know how to do something, but then when I am with my clinical instructor, I can't do it… it's like my hands are shaking when she is there watching me." (P7)

"… when we did the demos, of course we didn't know how to do it at first and they would get angry and scold us. They would say "Oh my god, why don't you know this? You should know how to do this!" (P9)

Participants shared that fear of making mistakes impacted their ability to perform and learn during clinical rotations.

2.2 She Was So Ashamed, She Quit

Public blame and scolding by facility staff at training sites caused significant distress.

"*There was one time when they blamed a student. The doctor dropped the chromic* (suture material*) and blamed it on the student. The student was ashamed so much so that she quit school." (P4)*

In contrast to harsh treatment, positive experiences with clinical staff in out-of-hospital settings were also reported.

"However, mam, in private clinic 1, I felt very comfortable mam. The staff talk to us like we are friends…They are approachable, and they really teach us." (P14)

Environments where students were at ease and could participate in patient care were conducive to learning.

2.3 I Have to Get Used to It

Participants disclosed they felt they had to accept poor treatment from instructors during training.

"*During my first experiences I even got to the point where I cried. I even thought to myself that I really can't do this. And then I got used to it and I learned that I have to get used to it." (P9)*

Two participants asserted that negative treatment had motivated them during training.

"Ma'am for me, that time when my instructor yelled at me, I took it as a learning process, that I should really learn what I need to so that next time I can be perfect…" (P4)

These experiences suggested the normalization of disempowerment for student midwives.

Theme 3. Mentorship

This theme explores student experiences of mentorship during their clinical placements.

3.1 She Taught Us Just Among Ourselves

During the first FGD, two participants shared a similar experience with the same clinical instructor.

"For me, I appreciated Mam as a clinical instructor because she took us students in a separate room and taught us." (P9)

Personalized and private instruction positively impacted participants, creating an effective learning environment for them.

3.2 They Really Know What to Do

Participants expressed appreciation for staff midwives from partnering facilities who acted as built-in instructors during clinical rotations.

"So, for me I really prefer the built-in clinical instructors because they really know the facility well and what to do there." (P1)

"I also prefer the built-in clinical instructors because they are familiar with the facility, and they have a better attitude. They let us do more, they let us handle." (P9)

Participants disclosed that built-in instructors often had more clinical expertise than the instructors from the university and routinely gave them more clinical opportunities.

3.3 We Don't Have Anyone to Guide Us

In contrast to positive experiences of mentoring, there were reports of students being left unsupervised.

"There are some clinical instructors that just take you to your facility and then they are gone…If we are left there without a clinical instructor, we don't have anyone to guide us." (P1)

Participants disclosed that without a clinical instructor present they felt insecure and missed out on opportunities to learn important skills.

Theme 4. Adequacy of Governance

Experiences of inadequate governance within the program were linked to unmet student expectations.

4.1 There are Too Many Students

Participants felt frustrated about a lack of facilities available for their clinical training.

"…sometimes there are too many students. If the facility needs to accommodate 50 students in one year… they just give you your schedule and then there are so many of you." (P6)

In addition to inadequate numbers of clinical facilities, participants reported that scheduled clinical rotations would often be cancelled by the university.

"Then they give us 3 days a week of duty, but it becomes 1 day a week. How will we learn that way? We experienced that…Instead of having one month of duty we ended up only having 2 days." (P11)

Due to insufficient clinical rotations provided by the university, students were expected to complete program requirements on their own time.

"For us to complete our cases, these girls are staying for 24 hours in one facility and then to other facility. Just to have one case." (P6)

Each participant interviewed reported the need to personally arrange additional clinical opportunities to complete their required cases.

4.2 We Don't Have Enough Knowledge

Participants disclosed disappointment that they were not proficient in skills they considered essential to midwifery practice by the time they graduated.

"Mam, we learned some, but we don't have enough knowledge or experience to be able to work as a midwife and we are graduating. Because there are some of us, like me, who hasn't even tried catching a baby." (P10)

While all interviewed participants had completed their documentary requirements to graduate, none felt clinically competent.

4.3 No Opportunity to Share Our Experiences

When asked about opportunities given to evaluate their training, participants responded in confusion.

"Like you mean to give a testimony mam? Or? Like to share about our experience? No ma'am. To share our experience? … there is really no opportunity mam." (P2)

The researcher tried a variety of ways to clarify the question, however participant responses suggested there was a lack of formal program evaluations provided by the university.

There was one outlying experience in which clinical instructor personally requested feedback from a student.

"Like with mam, she said, 'Tell me, negative or positive.' So, we told her the negative and positive, we wrote it on paper… But because she asked for feedback, I wrote even the negative things about her, so now when we see her, she smiles, she changed!" (P1)

Through this interaction, the student felt empowered because her input was valued, and the instructor gained insights to strengthen her performance.

Theme 5. Conflicting Obstetrical Practices

The fifth theme is focused on the impact of conflicting and violent obstetrical practices observed during clinical rotations.

5.1 Then They Hit Her

Participants reported being unprepared to see poor treatment of birthing women in the public hospital setting.

"And then they hit her. We were so shocked to see this happen mam. We just stepped back in shock because we can't believe what we are seeing." (P12)

Discussions on obstetric violence were often highly emotional as participants shared feelings of guilt for not being able to help the women. No participant interviewed indicated that they viewed obstetric violence as appropriate or acceptable.

5.2 I'm Afraid to Ask

Being present during obstetric violence reportedly caused participants to feel personally fearful.

"When I see the staff screaming, I'd be scared to ask questions for fear that she would scream at me also." (P2)

Fear was a substantial barrier for students during training as they felt unable to ask questions about what they observed.

5.3 We Don't Know the Right Thing to Do

Participants recalled witnessing obstetrical practices which contradicted what they had been taught in class.

"There's just some things that we're confused about whether to do, like for example, fundal push, because they said that in the hospital, it's not allowed anymore, but with us, they still taught it to us." (P5)

Due to the varying practices and protocols across facilities, participants reported they were often scolded for making errors.

"…they got mad at me when I opened the plastic…she smacked my hand because she said we shouldn't open it. They said, 'weren't you taught?' … So, it's confusing for us, we don't know which is the right thing to do." (P5)

Participants felt that the short periods of time spent in multiple facilities during training, lowered their confidence in learning clinical skills.

Theme 6. Resilience of Students

The final theme is focused on the resilience of student midwives in the face of many barriers encountered during training.

6.1 I Want to Work Harder

Participants revealed a desire to use the negative experiences faced during training as motivation for future practice.

"For me mam, it's like when I have those experiences and see those things, I feel like I want to work harder so that when I am a midwife, I will be more helpful to the mother. I will work a different way." (P3)

Participants remained hopeful about the possibility for them to bring about change in the way women are treated during labour and birth.

6.2 I Want to Be Just Like Her

Participants reported being inspired by some of the professional midwives they encountered during rotations.

"For me I want to be like 'Mam E' at the private birthing home. She is very kind to the patients, and she knows very well what she is doing." (P1)

"There was a midwife at private birthing home2. She was the only one working there but she could do it all on her own." (P8)

Experiences at midwife-led birth centres were perceived by participants as beneficial to their clinical development and inspired them for their futures as midwives.

6.3 It's a Good Feeling to Be a Midwife

At the conclusion of interviews, participants were asked how they felt about graduating and becoming midwives.

"Ma'am it's really good! (laughs) It's a good feeling to be a midwife and be able to help other people." (P1)

Despite the barriers which were shared during interviews, participants were proud to become registered midwives. In fact, two participants discussed their desire to work in their home communities.

"… but then I remember our place, our small place, there is no lying-in and no place for women to give birth. Even if life is hard there … I am willing to work there." (P2)

All participants interviewed encountered emotional, financial, and professional barriers during training, however they remained resilient in their desire to become midwives and improve maternal health outcomes in the Philippines.

Discussion and Recommendations

The aim of this research was to compare student experiences of midwifery training in the Philippines with ICM educational standards. Research participants were not aware of the ICM guidelines for clinical training; however, their training did not meet the standards for various reasons connected to medical paternalism and low status of midwives in the Philippines.

Research suggests that lack of recognition and respect for midwifery produces negative and disempowering atmosphere for midwives and aspiring midwives alike (Sangy et al., 2023). In line with ICM recommendations (2021b), this study supports the need for improved clinical training, enabling environments and increased recognition for the midwifery profession.

The results of this study indicate that when shame is used as a teaching method in clinical training it leads to loss of confidence and poor self-esteem among midwifery students. The use of shame in clinical instruction has also been noted among student midwives in similar settings where midwifery is undervalued (Panda et al., 2021). These findings align with recommendations of Bogren et al.'s (2021) that there is an immediate need to improve in the skills and capacities of midwifery instructors in the Philippines.

Concerns regarding the university's coordination of training were shared widely among participants. Feelings of anxiety about graduation were expressed as participants felt they lacked essential skills to work as midwives. These experiences parallel reports of student midwives in other LMICs where programs routinely fail to provide adequate clinical experiences (Bogren et al., 2021, Dewar et al., 2020). To meet ICM standards, midwifery programs must provide sufficient clinical placements for students to become competent midwives (ICM, 2021a). Restructuring enrolment practices may be required to ensure there are adequate clinical opportunities for the number of registered students. In addition, due to the lack of clinical competency reported by participants, implementation of adequate and formal assessments of student skills prior to graduation should be considered. Objective structured clinical examinations (OSCE) have been used with good results within similar midwifery training settings (Kolivand et al., 2020) and may be an effective evaluation method for low resource settings.

Student confusion and emotional distress experienced caused by harmful obstetrical practices have been noted in similar studies of midwifery training in LMICs (Ahmadi et al., 2018, Dewar et al., 2020). ICM guidelines state that clinical training environments for student midwives should follow women-centred care (ICM, 2021a), however the

obstetric violence and medical paternalism that were experienced in many clinical settings, contradict these standards. In contrast, experiences with competent midwives in midwife-led facilities had a positive impact on students. These experiences align with the results of a study which suggested midwife-led facilities are linked to positive client experiences as well as professional satisfaction for midwives (Rocca-Ihenacho et al., 2020). Although this research was focused on high-income countries, increased training opportunities at midwife-led facilities could improve student experiences while promoting women-centred care.

Conclusion

The findings from this study suggest both the need for improvement in the quality of midwifery training in the Philippines and the implementation of policies to support and raise the status of professional Filipino midwives. Although midwifery education in the Philippines recently progressed from 2-year diploma to 4-year bachelor's degree (CHED, 2023) this study supports the need for significant adjustments in current clinical training practices to meet ICM standards. Continuing education for instructors, increased mentorship opportunities for students in midwife-led settings, and improved evaluations of clinical competencies are all recommended for national midwifery programs to meet ICM standards. The determination and resilience of midwifery students which was evident in this research indicated that with adequate support and investment, Filipinos midwives may be the most effective way to significantly improve maternal health outcomes in the Philippines.

Study Limitations

The researchers acknowledge that this study is limited in scope by a small number of participants from one institution and therefore may not be representative of Filipino midwifery students' experiences in general. There is also a possibility that students with negative experiences were more willing to participate in discussions and therefore

positive experiences were not adequately accounted for. More research to determine whether these findings are shared more broadly by students from other institutions in the country is warranted.

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Acknowledgements

The primary researcher would like to acknowledge the generosity of the student midwives who participated in this study and thank them for sharing their experiences so bravely. Appreciation is also given to the local university for permitting their students to be interviewed.

Conflict of Interest and Funding

The authors claim no conflict of interest.

No funding was received for any part of this project.

The following table (Table 1) summarizes the issue being researched, what is already known about the issue and what this paper adds to the subject.

Table 1. Statement of Significance

Problem or Issue	There is currently a lack of published research on whether midwifery training in the Philippines meets International Confederation of Midwives standards.
What is Already Known	Registered midwives are a legally recognized cadre of health professionals who provide care for pregnant women in the Philippines.
What this Paper Adds	Based on the experiences of a group of student midwives during training, the author discusses possible areas of improvement for the development of competent midwives in the country.

Table 2. Participant Characteristics and Interview Types Given

Participant Number	**Sociodemographic details**		**Type of Interview given**
(P1-P14)	Age	Gender	FGD and/or One-to-One Interview
P1	36	Female	FGD #2 and One-to-one interview
P2	20	Female	FGD #3 and One-to-one interview

P3	22	Female	FGD #3 and One-to-one interview
P4	26	Female	FGD #3 and One-to-one interview
P5	26	Female	One-to-one interview
P6	31	Female	FGD #3 and One-to-one interview
P7	28	Female	FGD #1
P8	21	Female	FGD #1
P9	19	Female	FGD #1
P10	20	Female	FGD #2
P11	20	Female	FGD #2
P12	21	Female	FGD #2
P13	21	Female	FGD #2
P14	22	Female	FGD #3

Table 3. General Questions based on ICM guidelines that were used to facilitate conversations during FGDs.

1. Think back to the beginning of your clinical training – how did you feel before you began your training?
2. Tell me about your experiences with the staff (doctors, midwives, nurses) working at your various placement sites?
3. How do you feel that the women were treated at your placement sites?
4. Can you tell me about some of your experiences with your clinical instructors during your training.
5. In what ways were you included in direct patient care and decision making during your placements?
6. How would you change the clinical training if you could?

Table 4. This table, based on the six steps of Reflexive Thematic Analysis (RTA) (Braun and Clarke, 2020) summarizes how the steps were used to construct themes from the data.

Phase 1 – Familiarization with Data Creating memos and notes throughout data.
Phase 2 – Generating Initial Codes During this stage, 90 codes were generated.
Phase 3 – Generating Initial Themes 90 codes condensed to 37 initial themes generated – reviewed with supervisor
Phase 4 – Developing and Reviewing Themes 12 themes developed and reviewed with supervisor
Phase 5- Defining and Naming Themes 1 central concept generated, 6 themes and 18 subthemes finalized in partnership with primary researcher and academic supervisor.
Phase 6 – Writing the Report Using the concept and themes to answer the research question.

Table 5. This table categorizes, numbers and names the themes presented in this research.

Central Concept	*Themes*	*Subthemes*

A disempowering culture for student midwives due to medical paternalism and the low status of midwifery in the Philippines.	1. Just A Midwife	1.1 Not My First Choice
		1.2 Our Instructors are Limited
		1.3 Oh No, We Have Students Again
	2. Shame and Blame	2.1 My Hands Were Shaking
		2.2 She Was So Ashamed, She Quit
		2.3 I Have to Get Used to It
	3 Mentorship	3.1 She Taught Us Well
		3.2 They Really Know What to Do
		3.3 When We Don't Have Anyone to Guide Us
	4. Adequacy of Governance	4.1 There Were Too Many Students
		4.2 We Didn't Gain Enough Knowledge
		4.3 No Chance to Share Our Experiences
	5. Conflicting Obstetrical Practices	5.1 Then They Hit Her
		5.2 I'm Afraid to Ask
		5.3 We Don't Know the Right Thing to Do
	6. Resilience of Students	6.1 I Want to Work Harder
		6.2 I Want to Be Just Like Her
		6.3 It's a Good Feeling to Be a Midwife

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Ethical Statement

The author received ethical approval for this research from the City University, London, Board of Ethics with approval number: ETH2223-2012 on May 25, 2023.

Conflict of Interest and Funding

The authors claim no conflict of interest.

No funding was received for any part of this project.