

Results

A nonparametric test showed a correlation of .513, which is significant at the 0.01 level. This confirmed the findings that resulted from running the initial parametric test, which showed a correlation of .543 (also significant at the 0.01 level).

Table 3

Correlations

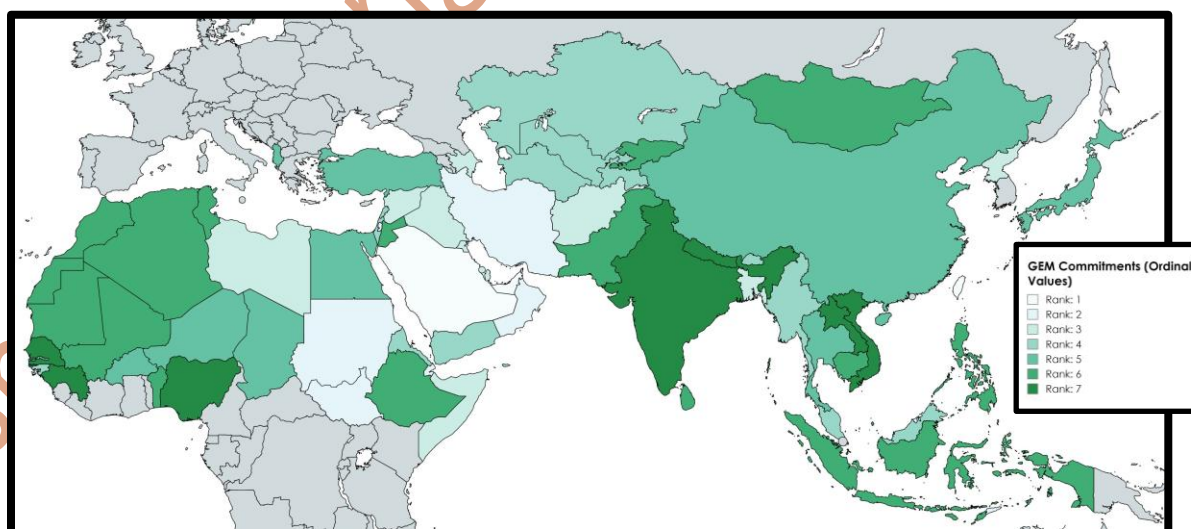
CORRELATIONS				
SPEARMAN'S RHO	INDEPENDENT	CORRELATION COEFFICIENT	INDEPENDENT	DEPENDENT
		SIG. (2-TAILED)	1.000	.513**
		N	.	<.001
			71	71
	DEPENDENT	CORRELATION COEFFICIENT		
		SIG. (2-TAILED)	.513**	1.000
		N	<.001	.
			71	71

** . CORRELATION IS SIGNIFICANT AT THE 0.01 LEVEL (2-TAILED).

A series of maps (Figures 2 through 7) depicts relationships that were identified among the data.

Figure 2

GEM Commitments

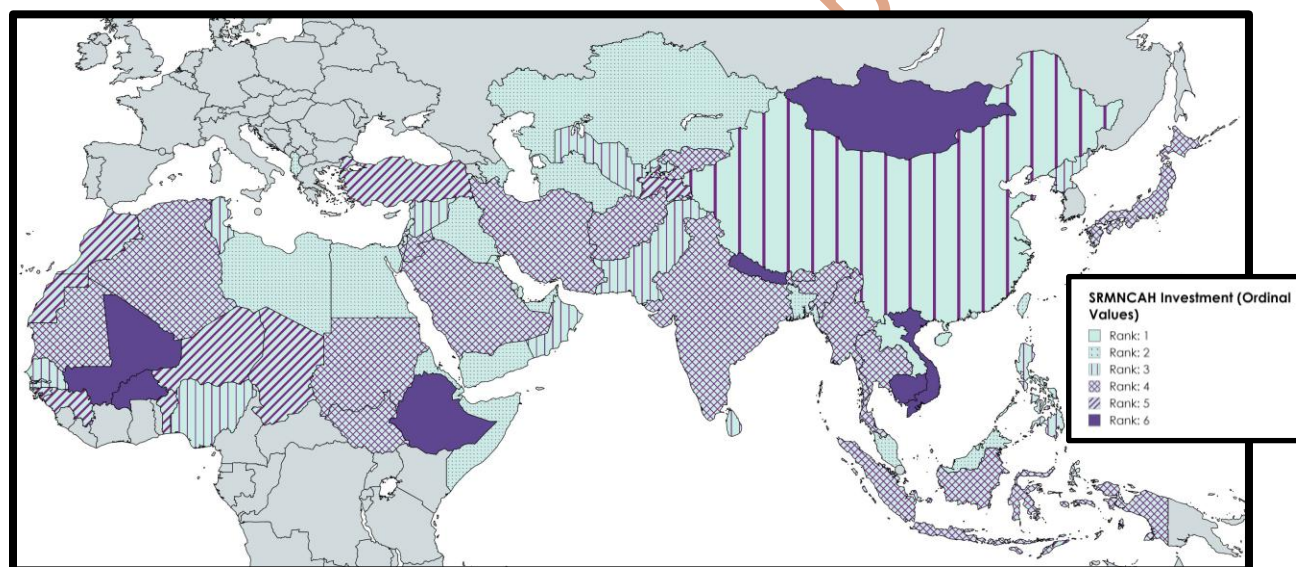


Note. Created using www.mapchart.net.

Countries that ranked highest on the GEM Commitment Index were concentrated in south/southeast Asia (Laos, Vietnam, Nepal, India) and western Africa (Nigeria, Guinea, Senegal). Countries that ranked lowest were concentrated in the Middle East (United Arab Emirates, Saudi Arabia) and eastern Africa (Somaliland, Puntland). Central Asian countries dominated the middle range. Although China and India share a common history of implementing large-scale population programs, their GEM commitment levels were dissimilar (discussed below). China was outranked by multiple African countries (Chad, Gambia, Niger, and others).

Figure 3

SRMNCAH Investment



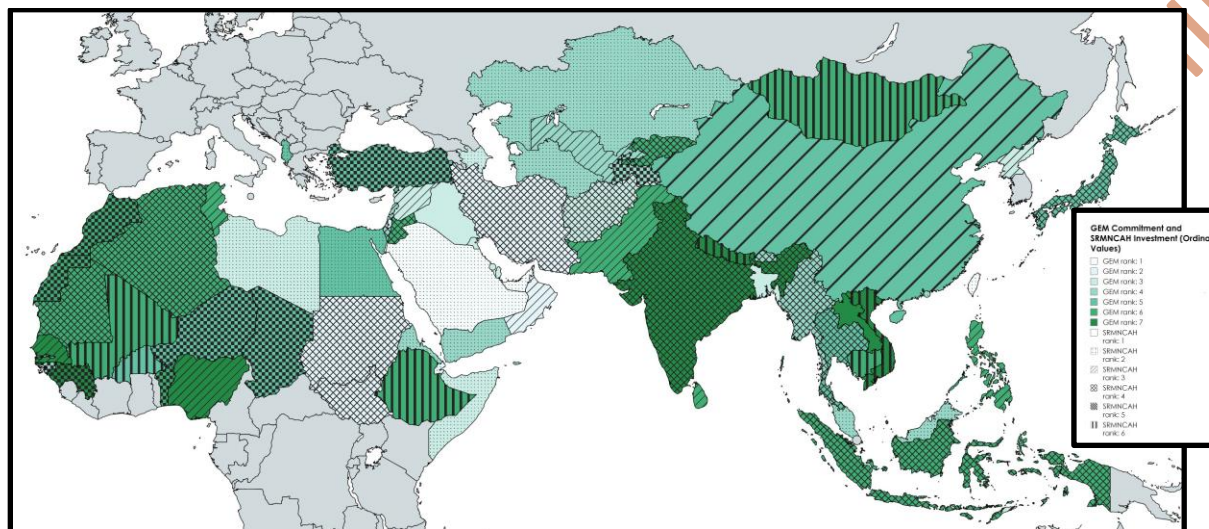
Note. Created using www.mapchart.net.

Countries that ranked highest on the SRMNCAH Investment Index were distributed across Africa (Mali, Burkina Faso, Ethiopia) and Asia (Mongolia, Nepal, Cambodia, Vietnam). As with the GEM Commitment Index, countries that ranked lowest were concentrated in the Middle East and eastern Africa (Kuwait, Qatar, Bahrain, West Bank/Gaza, Somaliland) and southeast Asia (Laos, Brunei Darussalam). While India (12.5 points) again outranked China (8.5

points), both countries were in the middle range for SRMNCAH investment. Otherwise, Middle Eastern and central Asian countries dominated the middle range.

Figure 4

GEM Commitment and SRMNCAH Investment



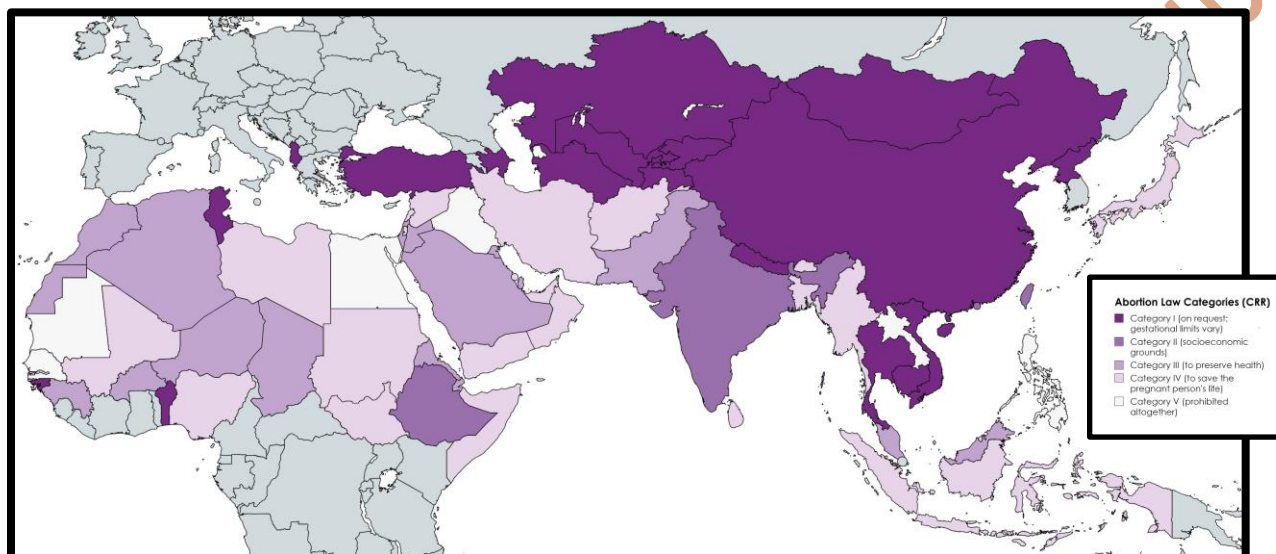
Note. Created using www.mapchart.net.

Country scores (converted to ordinal values) for both variables are visualized together in Figure 4, with GEM commitment represented by depth of color and SRMNCAH investment represented by stripe and hatch marks. Countries that scored highest on both variables (6 or 7 ordinal rank for GEM, paired with 5 or 6 ordinal rank for SRMNCAH) were concentrated in southeast Asia (Vietnam, Nepal, Cambodia) and western Africa (Mali, Guinea, Benin, Morocco); other highest scorers included Mongolia and Ethiopia. The lowest scorers (1 or 2 ordinal rank) included Brunei Darussalam, Somalia, United Arab Emirates, Taiwan, Djibouti, and West Bank/Gaza. China fell in the upper middle of GEM commitment (26 points scaled score) but the lower middle of SRMNCAH investment (8.5 points). India held the second highest score for GEM commitment (38 points, only 0.5 point less than Senegal), but fell in the upper middle of SRMNCAH investment (12.5 points).

A closer look at the dependent variable reveals patterns across the three SRMNCAH indicators.

Figure 5

Abortion Law Categories

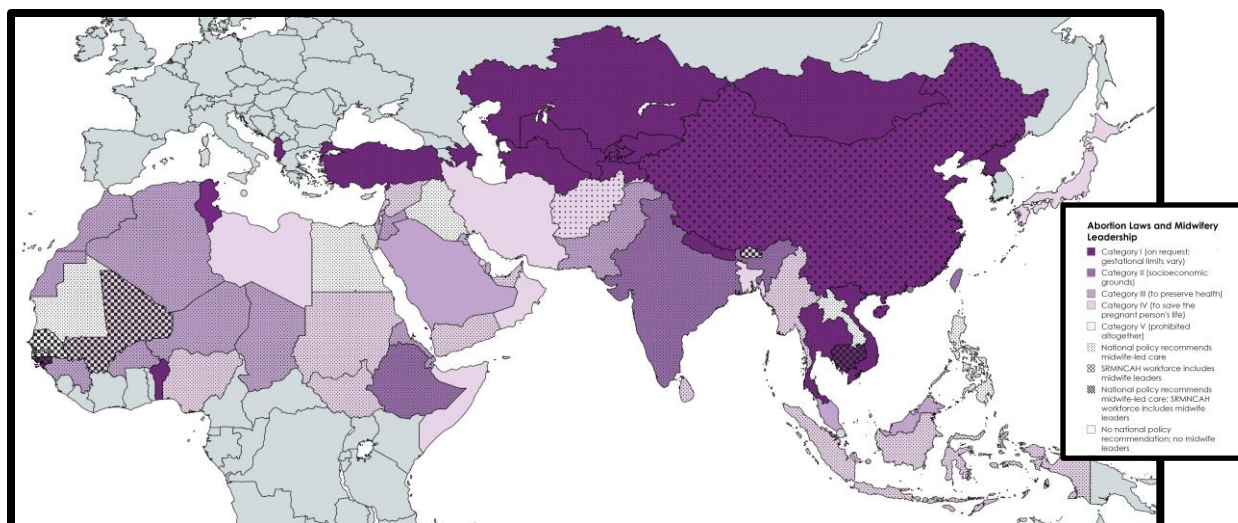


Note. Created using www.mapchart.net.

Figure 5 (Abortion Law Categories) shows a concentration of less restrictive countries in eastern, southern, and central Asia and more restrictive countries in Africa and the Middle East. With respect to abortion liberalization, China (Category I) outranked India (Category II); both, however, are less restrictive. The majority of countries fall into Category I (21 countries or 29.6%) and IV (26 countries or 36.6%); the remainder are split among Category II (3 countries), III (15 countries), and V (6 countries).

Figure 6

Abortion Laws and Midwifery Leadership



Note. Created using www.mapchart.net.

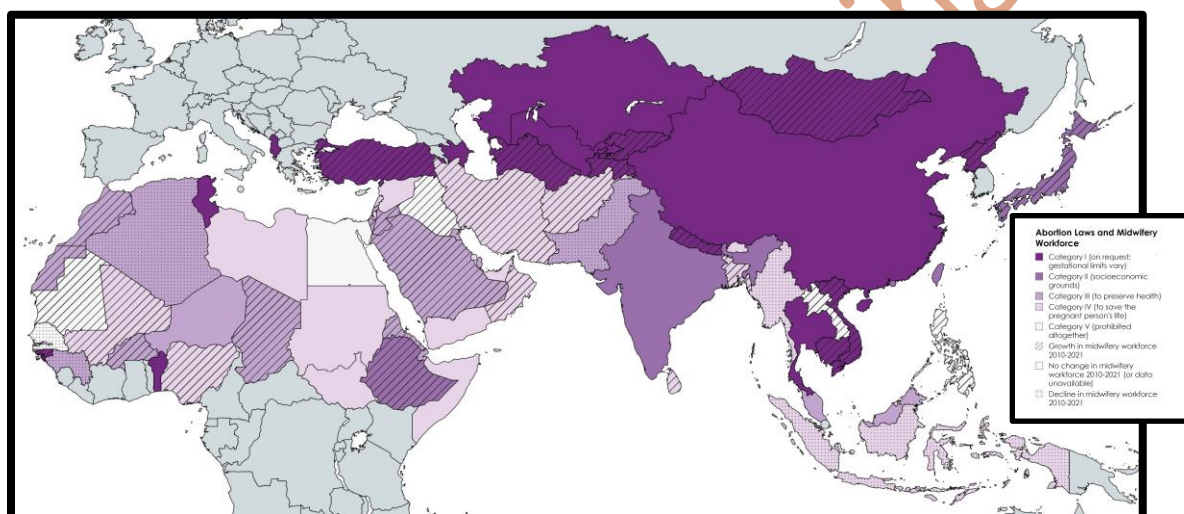
Figure 6 (Abortion Laws and Midwifery Leadership) shows the intersection of abortion law with midwifery leadership. Midwifery leadership is indicated by two factors (a national policy recommending midwife-led care and the measurable presence of midwife leaders in the SRMNCAN workforce). While a small number of countries in southern Asia (Bhutan, Cambodia) and western Africa (Guinea-Bissau, Mali, Senegal) achieved both, the majority or 66.2% of the sample (47 countries) achieved either a national policy or the presence of midwife leaders; 21 countries (29.6%) achieved neither (or data was unavailable). Of the 21 countries that achieved neither, most were more restrictive; one third were Category IV countries (Bahrain, Brunei Darussalam, Iran, Libya, Oman, Somalia, West Bank/Gaza), followed by Category III (Israel, Kuwait, Malaysia, Qatar, Saudi Arabia). Of the 47 countries that achieved either one but not both, one third were Category I countries, followed by Category IV. The countries that achieved both a national policy and the presence of midwife leaders were mostly split between Category I (least restrictive) and Category V (most restrictive).

The findings described above invite further investigation of whether the political will to liberalize abortion is correlated with the political will to invest in midwife leaders and increase

the midwifery workforce. In the sample, investment in midwife leaders was divided between more restrictive and less restrictive countries, and when counting all countries that achieved either one or both (a national policy and/or the presence of midwife leaders), the more restrictive countries were almost as likely to do so (32 out of 47, or 68.1%) as the less restrictive (19 out of 26, or 73.1%). Only in countries that achieved no investment in midwife leaders was there also a clear association with more restrictive abortion laws (but not Category V).

Figure 7

Abortion Laws and Midwifery Workforce



Note. Created using www.mapchart.net.

Figure 7 (Abortion Laws and Midwifery Workforce) shows the intersection of abortion law with growth of the midwifery workforce. Almost equal numbers of countries (32 and 30 countries, respectively, or 45.1% and 42.3%) achieved growth or saw no change in the midwifery workforce between 2010 and 2021; 11 countries (15.5%) saw a decline (or data was unavailable). In each of these groups, the prevalence of abortion law categories roughly followed the prevalence of categories in the overall sample. Countries that saw decline were primarily from Category I (27.3%), III (27.3%), and IV (36.4%). Countries that saw growth were primarily

from Category I (32.3%), III (22.6%), and IV (25.8%). Finally, countries that saw no change were primarily from Category I (26.9%), III (23.1%), and IV (34.6%). China (Category I) and India (II) saw no change.

Taking a closer look at China and India, the following comparisons are noted. Table 4 highlights relevant items rather than listing all items on which countries were scored.

Table 4

China vs. India Comparison

	China	India
GEM Commitment		
<u>Ranked ordinal score</u>	<u>5</u>	<u>7</u>
raw scaled score	26	38
CEDAW signed	yes	yes
ratified	yes	yes
Beijing compliance	high	high
natl. machin.	yes	yes
NAP	yes	yes
reports	yes (6 submitted, 0 unsub.)	yes (3 submitted, 1 unsub.)
IFP partnerships	no	yes
ICPD+25	no (1 of 7 items)	yes (6 of 7 items)
SRMNCAH Investment		
<u>Ranked ordinal score</u>	<u>3</u>	<u>4</u>
raw scaled score	8.5	12.5
Abortion law category	I (less restrictive)	II (less restrictive)
enumerations	no gestational limit	fetal diagnosis exception
limitations	sex-selective prohibited	rape exception
Midwifery leadership		parental authorization
natl. policy	yes	yes
midwife leaders	no	no
Midwifery workforce	no growth	no growth

China's GEM commitment score was significantly diminished compared to India's by its lack of action on IFP partnerships, but comparatively increased by China's Beijing compliance; overall, both countries showed a high level of commitment to the GEM. India's SRMNCAH investment score surpassed China's because of its relatively greater investment in the other areas of

midwifery status (education, regulation, and associations) not depicted in Table 4. Both countries showed the expected correlation between GEM commitment and abortion liberalization. On the other hand, both countries failed to achieve a measurable presence of midwifery leaders, and both countries had insufficient data on growth of the midwifery workforce (recorded as a “no” and leading to a 0 score). Given the size and rapid growth of these two countries and their history of using UN technical assistance to implement population programs, this finding departs from expectations: first, the expectation that a high GEM score will correlate with a high score across all areas of SRMNCAH (and that investment will be roughly level across SRMNCAH indicators), and second, that countries with a proven interest in reducing population growth via abortion and contraception will have the capacity to document the increase of all types of SRMNCAH providers who perform those services. The finding suggests that, although countries may find it easy to commit to expanding abortion access as the core of SRHR and gender equality in service of development goals, they find it harder to commit to expanding midwifery, despite the IFP community’s insistence that midwives are essential for abortion provision and the ultimate success of the SDGs.