Health-care professionals in midwifery care

Published Online
June 23, 2014
http://dx.doi.org/10.1016/S0140-6736(14)60857-6

See Online/Series
http://dx.doi.org/10.1016/S0140-6736(14)60789-3,
http://dx.doi.org/10.1016/S0140-6736(14)60790-X,
http://dx.doi.org/10.1016/S0140-6736(14)60919-3, and
http://dx.doi.org/10.1016/S0140-6736(14)60930-2

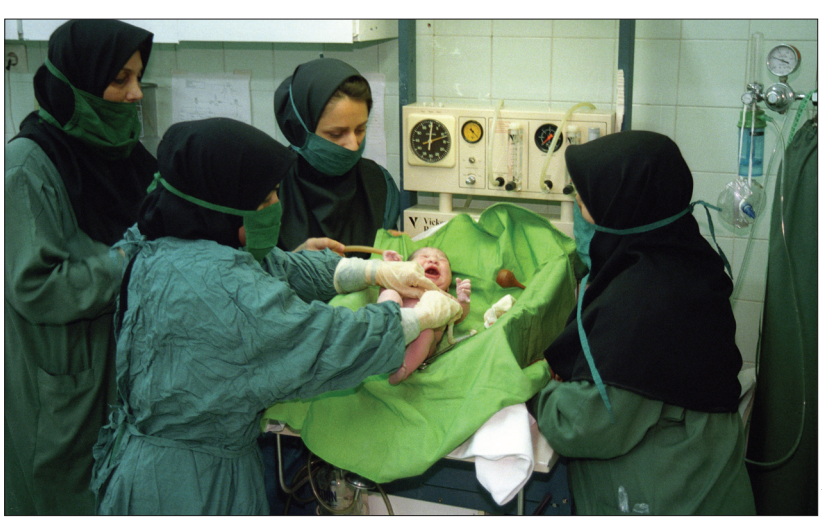
How many clinicians will claim that their daily practice is evidence based? Although systematic reviews are used where available, clinical tradition still dominates. It is therefore reassuring to find that for midwifery practices, as many as 56 outcomes have been shown to be improved by their application, although nine others have been identified as "ineffective".[1] As a caution, intrapartum stillbirth is now recognised as a high priority not just for high income settings, and midwives need the instruments and skills to identify and respond to fetal compromise more effectively.[2] Standards from the International Federation of Gynecology and Obstetrics (FIGO) on fetal monitoring are currently under development, but meanwhile let us not confuse "no evidence for benefit" with "evidence of no benefit".

The Series authors challenge examination of technical elements of care delivered in isolation and highlight the lack of evidence from high-burden countries. Mary Renfrew and colleagues[1] conclude that "Studies of care by midwives in low-income and middle-income settings, integrated into the health system and working in teams with medical staff and with properly trained support staff, are an urgent priority"[1] while the modelling work of Caroline Homer's group[3] shows the huge potential impact of midwifery when provided within a functional health system with referral and transfer. These insights should prompt a rapid response from both implementation researchers and donors for realisation at scale, with investment sufficient to gather robust supporting evidence.

Where does attention need to be focused to strengthen effective team working so as to fully actualise the gains from investments in midwifery? In reality, it is not just obstetricians and midwives who need to work effectively together, but many other cadres including obstetric nurses, doctors in training, paediatric staff, and anaesthetists. In some low-income and middle-income countries, clinical officers or surgical technicians are the main providers of caesarean delivery, with generally good outcomes compared with delivery by medical staff.[4] FIGO has endorsed this "task shifting" approach,[5,6] helping to overcome perceptions of professional resistance and reflecting willingness to go beyond traditional professional boundaries. Clinical officers are usually not involved in intrapartum care and so their working relationships with midwives, who are the decision makers regarding operative delivery in these settings, are crucial to good outcomes and may overcome some reported problems with newborn care.[7] Often it is not so much the intervention itself that is challenging but rather the decision.

In well resourced settings, delivery decisions are sometimes driven by newborn health rather than maternal safety—for example, when a fetal anomaly is identified and these decisions must include the paediatricians. Similarly, anaesthetists now play an integral part in delivery planning. In line with this increasing complexity and diversity of care needs, obstetric nursing and midwifery roles and relationships have evolved. However, it should not be forgotten that those with complex care needs still require humanistic supportive care reflected in the core competencies of the midwife.

Two "blind-spots" were identified in the *Lancet* Midwifery Series: respectful care and overmedicalisation.[3] The first of these is very much a preoccupation of the associations of health-care professionals, and let us hope that, as related standards and guidelines are developed and disseminated, they are taken seriously by those designing and commissioning services so that they are not seen as an optional extra. With regard to overmedicalisation, it is unfortunate that the evidence base is so scarce: to blame obstetricians and the rise of private practice is too simplistic. Rather, systematic examination of models that have succeeded in containing the rise of caesarean delivery while assuring safety is needed.



Kaveh Kazemi

The Series' authors have concentrated on publicly mandated provision. We need to know more about the differential influence of service models on costs, quality, and outcomes in low-income and middle-income countries. In many countries "public" does not mean free, a substantial proportion of provision is not under government authority (other than as a regulator) and "private" spans individual private practice, private hospitals, social business, and faith-based institutions. Charging might be direct, donor-supported, or insurance-based whether social or commercial. Private facilities might operate with government-funded staff, and vice versa. We need to learn how midwifery services can flourish in these different service settings, with special reference to terms of service, in-service training, and career progression. Coverage of midwives against norms is a starting point but does not reflect how midwives are deployed in relation to clinical need and protected from inappropriate rotation to other clinical areas.

Clinicians will support the emphasis reflected in this series of papers from numerical coverage towards quality of care. However, to offer quality there is a need to nurture the underpinning elements that form the so-called health-care professional: clinical competence and accountability for the wellbeing of mothers and babies. Both elements require investment: competency-based training is resource intensive and requires repetition, reinforcement, and development as new techniques and instruments become available. Midwifery educators might need to consider how to build continuity through integration of classroom and clinical experience, and of pre-service with in-service education. Unfortunately, in many countries these roles have become separated so that the teachers are not often seen in clinical areas and are not involved in service decision making or subsequent training and career development, allowing the hidden curriculum of tradition to prevail.

Finally, accountability is strictly theoretical when health-care professionals do not have the necessary resources at their disposal or are not given the authority to fulfil their professional mandate for quality improvement. Practical examples that should be but are not the norm are devolved budgets held at maternity unit level and authority to make changes in the organisation of care to enhance quality and safety. Those commissioning or funding scale up of maternity care are well placed to consider how to build in the means to achieve accountability via this capacity for professional responsiveness, so as more rapidly to move forward the list of "pragmatic actions",[8] which might otherwise remain a wish list.

William Stones, Sabaratnam Arulkumaran
University of St Andrews, School of Medicine, North Haugh, St Andrews KY16 9TF, UK (WS); University of Malawi, College of Medicine, Zomba, Malawi (WS); and International Federation of Gynecology and Obstetrics, London, UK (SA)
rws6@st-andrews.ac.uk

We declare no competing interests.

1 Renfrew MJ, McFadden A, Bastos MH, et al. Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care. *Lancet* 2014; published online June 23. http://dx.doi.org/10.1016/S0140-6736(14)60789-3.
2 FIGO Committee for Safe Motherhood and Newborn Health. Management of the second stage of labor. *IJGO* 2012; 119: 111–16.
3 Homer CSE, Friberg IK, Bastos Dias MA, et al. The projected effect of scaling up midwifery. *Lancet* 2014; published online June 23. http://dx.doi.org/10.1016/S0140-6736(14)60790-X.
4 Wilson A, Lissauer D, Thangaratinam S, Khan KS, MacArthur C, Coomarasamy A. A comparison of clinical officers with medical doctors on outcomes of caesarean section in the developing world: meta-analysis of controlled studies. *BMJ* 2011; **342:** d2600.
5 FIGO Committee for Safe Motherhood and Newborn Health. Human resources for health in the low-resource world: collaborative practice and task shifting in maternal and neonatal care. *IJGO* 2009; **105:** 74–76.
6 FIGO Committee for the Ethical Aspects of Human Reproduction and Women's Health. Task-shifting in obstetric care. *IJGO* 2013; **120:** 206–07.
7 Hounton SH, Newlands D, Meda N, de Brouwere V. A cost-effectiveness study of caesarean-section deliveries by clinical officers, general practitioners and obstetricians in Burkina Faso. *Hum Res Health* 2009; **7:** 34.
8 ten Hoope-Bender P, de Bernis L, Campbell J, et al. Improvement of maternal and newborn health through midwifery. *Lancet* 2014; published online June 23. http://dx.doi.org/10.1016/S0140-6736(14)60930-2.