BIRTH 39:4 December 2012

Every Woman Needs a Midwife, and Some Women Need a Doctor Too

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ABSTRACT: *Global recognition is increasing of the contribution of midwifery services to optimal outcomes for women and babies, and evidence around how to organize services and the roles of maternity providers. However, a sociological analysis can provide some insight into why the role of midwives varies so widely in different countries. Evidence is necessary, but more important is the role of the state in legalizing and financially supporting midwifery practice, how professional boundaries are negotiated in the maternity care domain, and consumer mobilization in support of midwifery and around maternity issues. (BIRTH 39:4 December 2012)*

Key words: *birthplace, evidence, midwifery, model, policy, quality, safety, sociology*

In the last 5 years, emphasis has increased on how women's access to quality midwifery services has become a part of the global effort in achieving the right of every woman to the best possible health care during pregnancy and childbirth. *The State of the World's Midwifery Report* provides new information and data on the 58 countries that collectively represent 91 percent of global maternal deaths (1). Most of these deaths occur in low-income countries and most of them could have been prevented if poor and marginalized women had access to functioning health facilities or to qualified maternal health professionals. In most countries, not enough fully qualified midwives and others with midwifery competencies are available to manage the number of pregnancies and births. In addition, access issues from women's perspectives are often not acknowledged (1). National policies addressing maternity services have often ignored the centrality of the midwifery workforce and how it contributes to quality of care.

As a result, the report urges governments to recognize midwifery as a distinct profession, core to the provision of maternal and newborn health services, and to ensure adequate availability and distribution of emergency obstetric and newborn care facilities, including midwife-led units of care. It urges regulatory bodies to protect the professional title "midwife" and establish a scope of practice, criteria for entry into the profession, educational standards, and practice competencies. In light of the report's implementation, what do we know about current evidence on the best way for maternity care to be organized, and what is our understanding of some of the influences on why the place of midwives in the health care landscape varies so widely across different countries?

The dimensions of care quality have been defined in *Crossing the Quality Chasm* as "safe, effective, patient-centred, timely, efficient, and equitable care" (2). In the United States, the landmark report *Evidence-Based Maternity Care: What It Is and What It Can Achieve* draws on the these indicators of quality and highlights that nearly all women who give birth in U.S. hospitals experience high rates of interventions, with risks of adverse effects. This report suggests that optimal maternity care should follow the principle of "effective care with least harm" and that "numerous beneficial practices that support women's own innate capacities or the physiologic process of childbirth" are underused (3).

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Accepted July 31, 2012

Maternity Workforce Organization, Staffing, and Skill Mix

Research is lacking that looks at the relationship between how the maternity workforce is organized and quality of care. A recent scoping review of international literature explored the relationship between maternity workforce, staffing, skill mix, and deployment practices and the safety of maternity care in middle- and high-income countries (4). It found some evidence of an association between higher consultant obstetrician staffing levels and lower stillbirth rates (5) and an increase in babies needing resuscitation (6) and in adverse events and "near misses" related to midwifery staffing shortages (7).

Not only are actual staffing levels important but so also are the ranges of expertise within the workforce across a 24-hour period, with out-of-hour periods creating particular safety issues (8,9). This problem was exacerbated by the customary practice of using unsupervised junior medical staff in a first on-call position for complications (10). With respect to task shifting, some evidence has been reported of improved outcomes and cost savings when midwives take on tasks previously within the remit of obstetric staff, for example, examination of the healthy newborn, which is usually carried out by junior doctors (11), and the role of advanced neonatal practitioners (12).

Continuous support in labor from a person other than the woman's partner or family member has been shown to be effective (13). In busy maternity units the world over, it is often difficult for midwives to give such one-to-one support. Doulas have been suggested as one way of providing this support, although these roles vary in how they are funded. Concerns have been expressed that if doulas are implemented widely, this approach could diminish the role of the midwife, which, in an ideal world, would be able to provide such continuous care in labor. Nonetheless, more research on the implementation and evaluation of doula programs, particularly those that provide continuity throughout pregnancy, birth, and the postpartum period, should be considered to determine the effect on outcomes, organization, and cost of care, and the implications on women, midwives, and the maternity system in general.

Models of Care

A substantial body of evidence now exists showing that care provided by midwives in continuity-of-care models (defined as care where "the midwife is the lead professional in the planning, organization, and delivery of care throughout pregnancy, birth, and the postpartum period") contributes to high-quality and safe care in high-income countries. A Cochrane review that compared women who received midwife-led continuity of care with shared or medically led care found midwife-led care was associated with significant benefits for mothers and babies, and had no identified adverse effects (14).

Women who received midwife-led models of care were less likely to experience antenatal hospitalization, regional analgesia, episiotomy, and instrumental birth and were more likely to experience no intrapartum analgesia or anesthesia with spontaneous vaginal birth, to feel in control during childbirth, to be attended at birth by a known midwife, and to initiate breastfeeding. They were less likely to experience fetal loss before 24 weeks' gestation, and their babies were more likely to have a shorter length of hospital stay. No differences were observed in perinatal mortality outcomes. In addition, a cost-saving effect was shown in intrapartum care in midwife-led models, which more extensive analyses have also found (15).

Birthplace

Evidence with respect to birth settings is also increasing. A Cochrane review of midwife units located alongside an obstetric unit compared with conventional hospital labor wards found increased likelihood of spontaneous vaginal birth, labor and birth without analgesia or anesthesia, breastfeeding at 6 to 8 weeks postpartum, satisfaction with care, and decreased likelihood of oxytocin augmentation, assisted vaginal birth, cesarean birth, and episiotomy. Although no difference occurred in infant outcomes, substantial numbers of women were transferred to standard care either before or during labor, because they no longer met eligibility criteria for the alternative setting (16).

Less evidence is available about freestanding midwife units and birth centers, but what does exist results in similar findings (17). A recent prospective study in Denmark found important benefits, such as improved experience, reduced maternal morbidity, reduced use of birth interventions including cesarean sections, and increased likelihood of spontaneous vaginal birth compared with women who planned to give birth in an obstetric unit (18). No differences were observed in perinatal morbidity among infants of low-risk women who intended to give birth in the freestanding midwife unit or birth center compared with infants of low-risk women who intended to give birth in the obstetric unit. However, 37 percent of primiparas and 7 percent of multiparas were transferred during or less than 2 hours after birth (19).

A similar pattern has been found with planned home birth for "low-risk" women (20,21). A recent observational study in the United Kingdom, *Birthplace in England,*

assessed outcomes by intended place of birth for women at low risk in midwife unit and birth centers located alongside an obstetric unit, a freestanding or stand-alone midwife unit and birth center, home, and obstetric units (22). For "low-risk" women, the overall incidence of adverse perinatal outcomes was low in all birth settings. For "low-risk" multiparas, no differences were reported in adverse perinatal outcomes between settings. However, the risk of an adverse perinatal outcome appeared to be significantly higher for nulliparas who planned to give birth at home compared with those who planned to give birth in an obstetric unit. For all women, the incidence of major interventions was significantly lower, including intrapartum cesarean section, and normal birth increased in all settings outside the obstetric unit. The overall intrapartum transfer rate ranged from 21 to 26 percent for all women, but was higher for nulliparas (36–45%). The study also found that the cost to the National Health Service of intrapartum and related postnatal care, including costs associated with clinical complications, was lower for birth planned at home, in a freestanding midwife unit and birth center and in an alongside midwife unit compared with planned birth in an obstetric unit (23).

Thus, overall, both the model of care and the place of birth are important influences on a range of health and clinical outcomes for mothers and babies, and have economic implications for the health system. It is also clear that the possibility always exists that women will need to transfer into an obstetric unit from an out-of-hospital setting, and that systems need to be in place to allow safe and timely transfer to obstetric care and expertise without financial, professional, and organizational barriers.

Understanding the Position of Midwifery in Health Systems

The global need for greater midwifery coverage has been identified together with an increasingly robust research base, suggesting beneficial effects on clinical and health outcomes for women and babies in addition to evidence of cost-effective care. Large variations are also evident in the role, scope, and funding of midwives, particularly in middle-to-high-income countries such as the United States, Australia, Canada, and rising power countries such as Brazil, India, and China. Even in countries with public health systems, the role and scope of midwives vary far more than that of other health professionals in the health care landscape.

What might be the reasons for this variation? de Vries et al explore sources of this diversity and show how midwifery, as a female-dominated occupation serving an exclusively female clientele, is seen as a *touchstone* for explaining this variation. They suggest that the social location of midwifery within a health system can reveal a society's fundamental cultural ideas about women as, first, autonomous (or not) professionals in the maternity division of labor and as, second, legitimate (or not) recipients of midwifery care services across the childbearing period. In understanding the scope of practice of different maternity caregivers, this analysis highlights the importance of three characteristics: 1) welfare state approaches to legalizing and financially supporting midwifery, and the role of the midwife in the division of labor; 2) the way that professional boundaries are negotiated in the maternity care domain; and 3) consumer mobilization in support of midwifery and around maternity issues (24).

A sociological analysis can help us better understand the operation of jurisdictional claims in maternity care and the way that governments, professionals, and clients shape maternity care systems. It draws attention to the unequal relationships among occupational groups within the health care division of labor and the ensuing struggle over license and mandate. Central to this analysis has been the power of the medical profession to subordinate midwifery, to limit its work to peripheral tasks, and in some instances to ban it from legal practice (25). But it also highlights the ways in which those who use maternity care services have made organized efforts to change how care at birth is given. Consumer organizations have played an important role in the debate about changing maternity care practices, resulting in media and government interest (26).

A new emphasis has arisen on the contribution of midwifery, supported by increasing evidence about outcomes and cost containment. However, it remains to be seen how much influence evidence has, when the "design of maternity services remains an outcome of often-times competing welfare state interests, professional boundary struggles and changing consumer interests surrounding pregnancy and childbirth" (27, p 735).

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