

# Midwifery: a Necessary and Sufficient Solution to Maternal and Infant Mortality?

Soo Downe<sup>1</sup>

<sup>1</sup>Professor in Midwifery Studies, University of Central Lancashire, Preston, United Kingdom

In 2011, the seminal report on the State of the World's Midwifery was launched [1]. This crucial document reviewed current maternity statistics, staffing provisions and policy and strategic documents for 58 countries across the world. It demonstrated the importance of midwifery as a foundation not only for safe motherhood, but also for protecting the physiological processes of labor and birth. The report highlighted the countries where midwifery is currently strong, as well as where it is not. It ended with a call for all the relevant stakeholders to seize the opportunity to strengthen midwifery further, in every country of the world. As such, it is an important instrument for change. However, while necessary, it may not be sufficient.

In parallel with the global movement towards the prioritization of professional midwives as the core 'skilled maternity care providers', there is a growing international awareness of the rise in case reports of disrespect and abuse in institutional maternity care settings, as demonstrated in a recent United States Agency for International Development (USAID) study [2]. Indeed, investigations into why women do not use maternity services tend to highlight this aspect as one of the key reasons for the decision to forgo access to maternity services, even when they are provided, and even when the other known impediments to access are absent [3] [4] [5] [6] [7]. As one of the fundamental tenets of midwifery is that midwives are 'with women' in terms of the creation of positive therapeutic relationships, this raises a serious question about the nature of midwifery that is provided in such settings.

Even in countries that provide adequate staffing levels, well-trained staff, well-resourced hospitals, and plentiful supply of essential drugs and equipment, there is no guarantee that the staff will have the skills to support and facilitate the normal physiological processes that best protect the future well-being of mother and the baby. Rising maternal mortality in some settings where it has been traditionally very low raises questions about the ability of the staff to recognize and act upon imminent or frank pathology when it arises, or crucially, to make positive relationships with laboring women and

with maternity care colleagues [8]. It is even more difficult for midwives and other maternity staff to provide optimum care when they are poorly trained and work in large, extremely busy institutional settings, where essential equipment and drugs are scarce or completely unobtainable. This is compounded when health care staff (midwives and doctors) is caught in oppressive hierarchies, underpaid (or not paid at all), and when they function in difficult or dangerous circumstances. In these conditions, it is unsurprising that the main focus of the staff is to get through the work, rather than to spend time making a positive relationships with women based on 'caritas' – the fundamental philosophy of caring and one of the cardinal elements of good midwifery.

The State of the World's Midwifery report included the following quote:

'I have found – and it was not a finding I expected – that wherever (there was)... a system of maternal care... based on trained licensed, regulated and respected midwives (especially in close and cordial cooperation with doctors and... hospitals), the quality of maternity care was at its highest, and maternal mortality was at its lowest. I cannot think of an exception to this rule... [9].'

There are a number of questions raised by this quote that need to be answered by any maternity care system that seeks to capitalize on the potential of midwifery to bring about positive health gains for mothers and their babies. Firstly, what kind of system of maternity care is necessary for midwifery to be effective? Does a setup that is linear, static, and disconnected (especially between rural communities and centralized institutions) allow for effective midwifery to operate? Or would it be best to work towards a system that is dynamic, self-organizing, networked (especially across community/hospital boundaries), and sensitive to the needs of staff, childbearing women, and their families?

Secondly, are the midwives in the system properly trained, licensed and regulated? The State of the World's Midwifery report talks about the three pillars of midwifery: education, regulation, and association. The International Confederation of Midwives offers support for all

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Correspondence to:  
Professor Soo Downe

Address: University of  
Central Lancashire,  
Preston, United Kingdom

Email Address:  
[sdowne@uclan.ac.uk](mailto:sdowne@uclan.ac.uk)

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three of these pillars. Any jurisdiction that is trying to capitalize on the potential of midwifery to make a difference needs to pay attention to the effective provision of these three pillars. In Pakistan, important moves have taken place towards addressing these issues, through the establishment of the Midwifery Association of Pakistan, the training and support of community midwives, and an increase in the midwifery educational capacity [1].

Thirdly, what is the quality of relationship between midwives and doctors and other agents in the system? Are midwives respected (by doctors, nurses, managers, policymakers, and the general public), and do they work in close and cordial relationship with doctors? If not, they cannot be fully effective. Lack of mutual respect creates toxic environments, in which staff works in fear, distress, and sometimes anger. These are the environments in which disrespect and abuse occurs within and between professional groups, and in which these attitudes spill over into abusive treatment of those using the services. Under these circumstances, the power of midwifery to make a difference is greatly diminished. There are suggestions from background data provided for the State of the World's Midwifery report that this is a concern in Pakistan:

Midwives' morale is an issue. They report feeling subordinate to doctors, are treated as unskilled workers, and their wages are often low [10].

In conclusion, just moving laboring women into institutions for maternity care is not sufficient to improve the health and well-being of mothers and babies. Wherever women give birth, they need fully trained, properly licensed and regulated midwives, and access to obstetricians, all of whom should work in positive and mutually respectful accord with each other, in pleasant work environments, with time to make effective relationships with colleagues, childbearing women and their families, and with adequate financial rewards and living and working conditions.

This may seem like a very difficult set of requirements to reach. However, the alternative is the continuing loss of lives and poor well-being of tens of thousands of women and babies every year across Pakistan, and hundreds of thousands across the world. Childbirth affects every citizen of the world profoundly. It influences the well-being of whole generations, with consequent health and economic consequences for societies and countries. As such, funding good maternity services is arguably the most important

investment any government can make. As Einstein famously said:

'The world we have created is a product of our thinking; it cannot be changed without changing our thinking.'

Maybe the time for that change has now arrived.

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