

University of Dundee

Midwifery is a vital solution

Renfrew, Mary; Ateva, Elena; Dennis-Antwi, Jemima Araba; Davis, Deborah; Dixon, Lesley; Johnson, Peter

Published in:
Birth

DOI:
[10.1111/birt.12442](https://doi.org/10.1111/birt.12442)

Publication date:
2019

Document Version
Peer reviewed version

[Link to publication in Discovery Research Portal](#)

Citation for published version (APA):

Renfrew, M., Ateva, E., Dennis-Antwi, J. A., Davis, D., Dixon, L., Johnson, P., Kennedy, H. P., Knutsson, A., Lincetto, O., McConville, F., McFadden, A., Taniguchi, H., ten Hoop-Bender, P., & Zeck, W. (2019). Midwifery is a vital solution: what is holding back global progress? *Birth*, 46(3), 396-399. <https://doi.org/10.1111/birt.12442>

General rights

Copyright and moral rights for the publications made accessible in Discovery Research Portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from Discovery Research Portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain.
- You may freely distribute the URL identifying the publication in the public portal.

Take down policy

If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

1

2 [Midwifery is a vital solution – what is holding back global progress?](#)

3

4

5 **Commentary**

6

7 **Submitted to Birth**

8

9 **Mary J Renfrew PhD**

10 **Corresponding author**

11 **Professor of Mother and Infant Health**

12 **Mother and Infant Research Unit**

13 **School of Nursing and Health Sciences**

14 **University of Dundee**

15 **UK**

16 m.renfrew@dundee.ac.uk

17

18 Elena Ateva JD Law

19 Maternal and Newborn Health Policy and Advocacy Advisor

20 White Ribbon Alliance

21 Washington

22 USA

23 eateva@whiteribbonalliance.org

24

25 Jemima Araba Dennis-Antwi PhD

26 President, Ghana College of Nurses and Midwives

27 Accra

28 Ghana

29 jdennis_antwi2004@yahoo.co.uk

30

31 Deborah Davis PhD

32 Clinical Chair and Professor of Midwifery

33 ACT Government Health Directorate and University of Canberra

34 Canberra

35 Australia

36 deborah.davis@canberra.edu.au

37

38 Lesley Dixon PhD

39 Midwifery Advisor

40 New Zealand College of Midwives

41 Christchurch

42 New Zealand

43 practice@nzcom.org.nz

44

45 Peter Johnson PhD

46 Director of the Global Learning Office

47 JHPIEGO

48 Baltimore

49 USA

50 peter.johnson@jhpiego.org
51
52 Holly Powell Kennedy PhD
53 Helen Varney Professor of Midwifery
54 Yale School of Nursing
55 Yale University
56 Connecticut
57 USA
58 holly.kennedy@yale.edu
59
60 Anneka Knutsson PhD
61 Chief of Branch, Sexual and Reproductive Health
62 United Nations Population Fund
63 New York
64 USA
65 knutsson@unfpa.org
66
67 Ornella Lincetto MPH
68 Medical Officer, Newborn Health
69 World Health Organisation
70 lincettoor@who.int
71
72 Fran McConville MA
73 Technical Adviser, Midwifery
74 World Health Organisation
75 mcconvillef@who.int
76
77 Alison McFadden PhD
78 Professor of Mother and Infant Public Health
79 Mother and Infant Research Unit
80 School of Nursing and Health Sciences
81 University of Dundee
82 Scotland
83 a.m.mcfadden@dundee.ac.uk
84
85 Hatsumi Taniguchi PhD
86 Professor of Midwifery and Maternal Newborn Nursing
87 Department of Health Sciences
88 Faculty of Medical Sciences
89 Kyushu University
90 Japan
91 hatsumi7@hs.med.kyushu-u.ac.jp
92
93 Petra ten Hoop Bender
94 United Nations Population Fund
95 Geneva
96 Switzerland
97 tenhoop-bender@unfpa.org
98
99 Willibald Zeck PhD

100 Head of Global Maternal, Newborn and Adolescent Health Program
101 UNICEF Headquarters
102 New York
103 USA
104 wzeck@unicef.org
105

106 1051 words

107

108 Disclaimer: Any opinions stated are those of the authors and not of UNICEF

109

110 We need look no further than midwifery for compelling evidence of gender
111 inequalities blocking progress in global health. Despite growing evidence of the
112 extensive impact of midwifery,¹⁻⁶ midwives and the women they care for are
113 disempowered by patriarchal structures and professional, socio-cultural and
114 economic barriers.⁷⁻⁸ Widespread misunderstanding of the role and scope of
115 midwifery exists at all levels of policy, health services, academia, and funders.⁹ The
116 consequence is the fragmentation of care, with inevitable safety and quality gaps.⁸
117 This retards progress on universal health coverage and efforts to improve quality,
118 equity and dignity, and contributes to adverse outcomes including the unprecedented
119 rise in unnecessary and unsafe interventions.¹⁰ These barriers disable the human
120 rights of women and children, and ultimately harm families, communities, and
121 economies.¹¹

122 The evidence

123
124 Science has played a part in this. Most research has focused on obstetric areas of
125 interest: the clinical and emergency interventions needed when complications
126 arise.^{1,12} Much less research exists on enhancing respectful, supportive, women-
127 and newborn-centred, high quality care for all. There is a serious lack of investment
128 in examining the contribution that quality midwifery care can make. Community-
129 based studies in low-income countries have focused on non-professional health
130 workers with more than 100 trials, compared with a dearth of trials on professional
131 midwives in these countries.¹ Science, in this case led predominantly by women, has
132 also provided answers. Growing evidence using a range of methods shows that
133 midwifery – knowledgeable, skilled and compassionate care across the continuum
134 from pregnancy to birth and beyond - saves lives, reduces preterm birth, promotes
135 health and well-being, and improves sustainability.^{1-3, 5} While disruptive to the status

136 quo, midwifery is a vital, bold, constructive solution to the challenges of providing
137 high quality care for all women, newborn infants, and their families.

138

139 Systemic barriers to midwifery

140

141 Why has the global community been so hesitant to act on all of the evidence on the

142 benefits of midwifery from many different sources¹⁻⁶? We argue that the

143 intersectionality of gender, social, professional, and economic disempowerment,

144 fuelled by powerful precedents and perverse incentives, constrains momentum.^{7, 13,14}

145 The population midwives serve, women and children, are often disempowered,

146 discriminated against and seen as low priority by decision-makers.¹⁵ Midwives, who

147 are predominantly women, are subject to the same discrimination as other women in

148 their societies.¹⁶ The work of midwives may be valued less than other health

149 professionals, concerned with the intimacies of sexual and reproductive health and

150 therefore contentious or ignored. Many midwives are inadequately remunerated or

151 supported, overwhelmed by workload, and working in situations that expose them to

152 sexual and other forms of violence. Midwives may work in less accessible, low-

153 income areas where there are few other health professionals. Hence they

154 experience the exclusion associated with vulnerable communities while providing an

155 essential service for the women and children who are likely to experience the worst

156 outcomes.^{6, 17} Complicating this gender and social inequality is an underlying related

157 professional bias.⁷ Health services and global agencies are often administered by

158 public health practitioners or medical doctors who bring their own experiences and

159 professional perspectives to decision-making. The common conflation of midwifery

160 and nursing causes confusion about roles and responsibilities. Even in countries

161 where midwifery is strong midwives may have to fight for their full scope of practice
162 and few senior leadership positions are available to midwives.⁷

163 The transformative potential of midwifery

164
165 Yet midwifery can be transformative for women, families, communities, and health
166 systems alike. Countries with long-established midwifery such as the Nordic
167 countries have very low rates of maternal and newborn mortality. Countries that have
168 strengthened midwifery as part of the health system have seen a fall in maternal
169 mortality, and improved quality of care.³ Midwifery addresses the challenges both of
170 ‘too little too late’ and of ‘too much too soon’, providing accessible and appropriate
171 care where it is needed, be it in communities or large hospitals.¹⁸⁻²⁰ High quality
172 midwifery makes a key contribution to reducing unacceptably high maternal and
173 newborn mortality,²¹ stillbirth, and preterm birth; increasing access to care in remote
174 and rural areas; preventing the escalating use of interventions conducted without
175 medical indication;⁵ reducing disrespect and abuse in childbirth²²; improving early
176 childhood development; and strengthening the sustainability of health systems.
177 Midwives, enabled by quality midwifery education, professional regulation,
178 embedded in an enabling health system, and working in the context of
179 multidisciplinary teams, provide a cost-effective strategy to address these problems
180 and more. Midwives working in this way act as powerful human rights defenders for
181 women and children.

182

183 Moving forward – global action

184
185 The message is beginning to be heard. The broader concept of quality that
186 encompasses equity, dignity, and preventive and supportive care is gaining ground
187 and the evidence of midwifery’s contribution to evidence-informed quality strategies

188 is being acknowledged.^{8, 13} Together global agencies, governments, funders and
189 universities are working to strengthen the implementation of high quality midwifery
190 education²³ and identifying ways to mobilise resources for research to examine how
191 best to scale up more effective, compassionate and sustainable models of care.²⁴
192 The 2019 report on the Global Strategy for Women's Children's and Adolescent
193 Health²⁵ focusses on midwifery education, with a seven-step action plan for
194 countries working towards international-standard midwifery.²⁶ At the global and
195 country level, evidence-informed midwifery competencies, tools for programmatic
196 measurement and evaluation, and guidance for strengthening midwifery are being
197 developed.²⁷ Countries in sub-Saharan Africa (eg Ghana, Zambia and Somalia) and
198 South Asia (eg Bangladesh, Nepal and India) are making progress on strengthening
199 midwifery and implementing international standards. Midwives are needed in
200 leadership positions globally, regionally and locally to promote, prioritize and
201 implement this ambitious agenda.

202

203 Gender equality is fundamental to the system-wide change needed; the voices of
204 women must be heard and valued more clearly.²⁸ Without exception, countries that
205 have successfully strengthened midwifery in recent years such as Canada, New
206 Zealand, Australia, the UK, and Malawi have done this by also strengthening
207 midwifery-led academic leadership and through working in partnership with women
208 and forming alliances with women's advocacy groups.²⁹ Interdisciplinary support has
209 also been key.

210

211 There is a long road ahead towards the equitable implementation of quality care³⁰,
212 meeting the health-related United Nations Sustainable Development Goals³¹ and

213 universal health coverage. Science shows us that the journey would be considerably
214 shortened through the implementation of midwifery that meets the international
215 standards set by the International Confederation of Midwives. Tackling the systemic
216 barriers that are rooted in gender inequality is fundamental to achieving this.

217

218

219

220

221

222 References

223

224 1. Renfrew MJ, McFadden A, Bastos MH et al. Midwifery and quality care: findings
225 from a new evidence-informed framework for maternal and newborn care. *Lancet*
226 2014; **384**:1129–45.

227 2. Homer CS, Friberg IK, Dias MA et al. The projected effect of scaling up
228 midwifery. *Lancet* 2014; **384**: 1146–57.

229 3. Van Lerberghe W, Matthews Z, Achadi E et al. Country experience with
230 strengthening of health systems and deployment of midwives in countries ten
231 with high maternal mortality. *Lancet* 2014; **384**: 1215–25.

232 4. ten Hoop-Bender P, de Bernis L, Campbell J et al. Improvement of maternal and
233 newborn health through midwifery. *Lancet* 2014; **384**: 1226–35.

234 5. Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity
235 models versus other models of care for childbearing women. *Cochrane Database*
236 *Syst Rev* 2016; **8**: CD004667.

237 6. Vedam S, Stoll K, MacDorman M et al. Mapping integration of midwives across
238 the United States: impact on access, equity, and outcomes. *PLOS One* 2018; **13**:
239 e0192523.

240 7. WHO. Midwives voices, midwives realities. Findings from a global consultation on
241 providing quality midwifery care. Geneva: World Health Organization, 2016.

242 8. Kinney MV, Boldosser-Boesch A, McCallon B. Quality, equity, and dignity for
243 women and babies. *Lancet* 2016; **388**: 2066-67.

244 9. Horton R, Astudillo O. The power of midwifery. *Lancet* 2014; **384**:1075-6.

245 10. Boerma T, Ronsmans C, Melesse DY, Barros AJD, Barros FC, Juan L et al.
246 Global epidemiology of use of and disparities in caesarean sections. *Lancet* 2018
247 Oct **13**; **392**:1341-1348.

248 11. UN Human Rights Council. Resolution 11/8. Preventable maternal mortality and
249 morbidity and human rights. Geneva: United Nations, 2009.

250 12. Kennedy H, Yoshida S, Costello A et al. Asking different questions: research
251 priorities to improve the quality of care for every woman, every child. *Lancet*
252 *Global Health* 2016; **4**: e777-e779.

253 13. De Brouwere V, Richard F, Witter S. Access to maternal and perinatal health
254 services: lessons from successful and less successful examples of improving
255 access to safe delivery and care of the newborn. *Trop Med Int Health* 2010; **15**:
256 901-9.

- 257 14. UNFPA. Worlds apart: reproductive health and rights in an age of inequality. New
258 York: United Nations Population Fund, 2017.
- 259 15. Freedman LP, Waldman RJ, de Pinho H, Wirth MA. Who's got the power?
260 Transforming health systems for women and children. Sterling, VA: Earthscan,
261 2005.
- 262 16. UNFPA. State of the World's Midwifery: a universal pathway, a woman's right to
263 health. New York: United Nations Population Fund, 2014.
- 264 17. Lori JR, Rominski SD, Gyakobo M, Muriu EW, Kweku NE, Agyei-Baffour P.
265 Perceived barriers and motivating factors influencing student midwives'
266 acceptance of rural postings in Ghana. *Hum ResourHealth* 2012; **10**:17.
- 267 18. Miller S, Abalos E, Chamillard M et al. Beyond too little, too late and too much,
268 too soon: a pathway towards evidence-based, respectful maternity care
269 worldwide. *Lancet* 2016; **388**: 2176–92.
- 270 19. Graham W, Woodd S, Byass P et al. Diversity and divergence: the dynamic
271 burden of poor maternal health. *Lancet* 2016; **388**: 2164–75.
- 272 20. Koblinsky M, Moyer CA, Calvert C et al. Quality maternity care for every woman,
273 everywhere: a call to action. *Lancet* 2016; **388**: 2307–20.
- 274 21. UNICEF. Every child alive. The urgent need to end newborn deaths 2018. New
275 York: UNICEF, 2018.
- 276 22. Freedman LP, Kruk ME. Disrespect and abuse of women in childbirth:
277 challenging the global quality and accountability agendas. *Lancet* 2014; **384**: e42-
278 44.
- 279 23. WHO. Strengthening quality midwifery education. WHO meeting report. July
280 2016. ([https://apps.who.int/iris/bitstream/handle/10665/259278/WHO-FWC-MCA-
281 17.12-eng.pdf?sequence=1](https://apps.who.int/iris/bitstream/handle/10665/259278/WHO-FWC-MCA-17.12-eng.pdf?sequence=1), accessed May 12th 2019)
- 282 24. Kennedy HP, Cheyney M, Dahlen HG, Downe S, Foureur MJ, Homer CSE, et al.
283 Asking different questions: A call to action for research to improve the quality of
284 care for every woman, every child. *Birth*. 2018 **31**(4):242-243.
- 285 25. The Global Strategy for Women's, Children's and Adolescents' Health (2016-
286 2030). New York: Every Women Every Child; 2015
287 (<http://www.everywomaneverychild.org/global-strategy/>, accessed 26 March
288 2019).
- 289 26. WHO, UNFPA, ICM, Unicef. Strengthening Quality Midwifery Education for
290 Universal Health Coverage 2030: a framework for action. Geneva: WHO; 2019
- 291 27. ten Hoop-Bender P, Nove A, Sochas L, Matthews Z, Homer CSE, Pozo-Martin
292 F. The 'Dream Team' for sexual, reproductive, maternal, newborn and adolescent
293 health: an adjusted service target model to estimate the ideal mix of health care
294 professionals to cover population need. *Hum Resour Health* 2017; **15**: 46.
- 295 28. Sakala C, Newburn M. Meeting the needs of childbearing women and newborn
296 infants through strengthened midwifery. *Lancet* 2014; **384**: e39-40.
- 297 29. Guilliland K, Pairman S. and New Zealand College of Midwives. Women's
298 business: the story of the New Zealand College of Midwives 1986-2010.
299 Christchurch NZ: New Zealand College of Midwives, 2010.
- 300 30. Kruk ME, Gage AD, Arsenault C, Jordan K, Leslie HH, Roder-DeWan S, et al.
301 High-quality health systems in the Sustainable Development Goals era: time for a
302 revolution. *Lancet Glob Health*. 2018;**6**(11)
- 303 31. UN. Transforming our World: the 2030 agenda for sustainable development. New
304 York: UN 2015.
- 305
306

307
308
309
310