Midwifery: Making a difference

Caroline Homer
Professor of Midwifery
THE SITUATION

A woman dies every two minutes from childbirth.

99% of these deaths occur in developing countries.
80% of maternal deaths could be averted with access to maternity and basic health-care services.

2 out of 10 women who survive childbirth will suffer from complications that result in injury, illness, or lifelong disability.

A girl growing up in Chad today is more likely to die in childbirth than she is to attend secondary school.
NEEDS AND POSSIBILITIES

FAMILY PLANNING
By meeting family planning needs we could reduce maternal deaths by 30%

1 in 4 women who want to avoid pregnancy don’t have modern contraceptives

SKILLED CARE
Meeting skilled care needs could reduce maternal deaths by 60%

3 out of 4 women needing care for obstetric complications in developing countries do not receive it

EDUCATION
Educating women and girls could increase contraceptive use by four times to prevent adolescent maternal deaths

Uneducated girls are 4x as likely to have a child before their 19th birthday than those with a secondary education
RIPPLE EFFECT

$15 billion – global yearly cost of maternal mortality due to reduced productivity

Every additional year of primary school boosts girls’ future wages by 10-20%

Healthy birth spacing and smaller families improve women’s health, and results in better nutrition and education for children

SOURCES:
http://abcnews.go.com/MillionMomsChallenge/GlobalHealth/

http://www.unicef.org/media/media_58417.html
http://www.unfpa.org/public/home/sitemap/icpd/MDGs/MDGs-ICPD
1 in 5 girls in developing countries who enroll in primary school never finish.

1 in 7 girls will marry before they are 15 in the developing world.

When 10% more girls go to school, a country’s GDP increases on average by 3%.

Girls who stay in school for seven or more years, marry four years later and have two fewer children.
52% of the global total of people living with HIV are women.

43% of the agriculture labor force are women. However, women are less likely to own land, and own fewer amounts of land when they do.

Current approaches to preventing mother-to-child HIV transmission are 98% effective.

When women have the same amount of land as men, there is over a 10% increase in crop yields.
The problem ....

- Every 2 minutes a woman dies in pregnancy or childbirth—287,000 each year.
- Complications from pregnancy and childbirth are a leading cause for death of 15-19 year old girls worldwide.
- 2.9 million newborn babies die and 2.6 million babies are stillborn every year - most deaths are preventable.
- More than one third of all births take place without a midwife or other skilled health staff.
- Midwives are key to a healthy and safe pregnancy and childbirth.
Causes of maternal death—and effective practices

- Pre-Eclampsia & Eclampsia (18%)
- Hemorrhage (35%)
- Unsafe Abortion (9%)
- Sepsis (8%)
- Indirect and Other Direct (30%)

Underlying Causes
- Unintended Pregnancy
- Under-nutrition
- Co-infections

Prevention Strategies
- Magnesium Sulfate
- Calcium
- Aspirin
- Anti-hypertensives
- Caesarean Section

- Active management of the third stage of labor
- Uterotonics: oxytocin & misoprostol
- Blood transfusion
- Balloon Tamponade
- Surgery

Family Planning
- Post-abortion care
- Tetanus Toxoid
- Clean delivery
- Antibiotics

Iron folate supplements
- De-worming
- Malaria intermittent treatment
- Anti-retrovirals

- Family Planning
- Diet, supplementation, and fortification
The global burden of stillbirths: 2.6 million

10 countries account for two-thirds of stillbirths in 2015 and also the majority of maternal and neonatal deaths.

Source: Blencowe et al 2016
Family planning

- One of the most effective ways to improve maternal health outcomes is to reduce unmet need for family planning.
- Additional benefits include improvements in health, schooling and economic outcomes.
- Meeting unmet need for modern contraceptives would reduce pregnancy related mortality by 100,000 deaths, and prevent 20,000 newborn deaths annually.
Global challenges

- Unacceptable rates of mortality and morbidity
- High rates of unnecessary interventions
  - Especially caesarean section
- Inequalities in care and outcomes
- Longer term, psycho-social, cost-effectiveness outcomes often overlooked
- Disrespect and abuse of women within the health system
Balancing medicalisation

... not enough intervention

... too much intervention
Caesarean sections

- Unnecessary CS
  - can increase the risk of maternal morbidity, neonatal death and NICU admission .... and more
  - Costs usually borne by the family
  - Long term concerns including NBAC risks

- Necessary CS
  - not always accessible, even when they are clearly indicated
What is the ‘right’ CS rate?

- Much debate around “optimal” caesarean rate
  - At least 1-2% for maternal indications?
  - At least 5% for newborn indications?
  - WHO: not more than 15%?

- Consider the longer term consequences


[http://www.who.int/bulletin/volumes/91/12/13-117598/en/](http://www.who.int/bulletin/volumes/91/12/13-117598/en/)
CS rate per country

Global CS rates

- 1 in 5 women in the world now give birth by CS
- 40.5% in Latin America and the Caribbean
- 42.9% in Southern America
- 7.3% in Africa
  - 3.5% in sub-Saharan Africa
  - 27.8% in Northern Africa
Country-specific caesarean section rates

Disparate rates between (and within) countries
Both “too little, too late” & “too much, too soon”

Too little, too late

- Lack of evidence-based guidelines
- Lack of equipment, supplies, and medicines
- Inadequate numbers of skilled providers
- Women delivering alone
- Lack of emergency medical services and delayed inter-facility referrals

Too much, too soon

- Unnecessary caesarean section
- Routine induced or augmented labour
- Routine continuous electronic fetal monitoring
- Routine episiotomy
- Routine antibiotics postpartum
What do women and newborns need in all countries?
The evidence - what women and newborns need. Framework for quality maternal and newborn care

Ref: Renfrew, McFadden, Bastos et al The Lancet 384, 19948; 1129 – 1145, 2014
http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(14)60789-3/fulltext
Framework for quality maternal and newborn care (QMNC): The scope of midwifery

For all childbearing women and infants

- Education
- Information
- Health promotion

- Assessment
- Screening
- Care planning

- Promotion of normal processes, prevention of complications

For childbearing women and infants with complications

- First-line management of complications
- Medical obstetric neonatal services

Practice categories

Organisation of care
- Available, accessible, acceptable, good-quality services—adequate resources, competent workforce
- Continuity, services integrated across community and facilities

Values
- Respect, communication, community knowledge, and understanding
- Care tailored to women’s circumstances and needs

Philosophy
- Optimising biological, psychological, social, and cultural processes; strengthening woman’s capabilities
- Expectant management, using interventions only when indicated

Care providers
- Practitioners who combine clinical knowledge and skills with interpersonal and cultural competence
- Division of roles and responsibilities based on need, competencies, and resources
Care for women before and during pregnancy, childbirth and the postnatal period and between pregnancies and for the newborn is best provided by a dedicated health professional qualified in midwifery.

**Care should be respectful and should optimize normal biological processes.**

In most cases, the person providing care will be a professional midwife, who will need support from a team composed of other health professionals, such as nurses, obstetricians and paediatricians, when complications arise.

The team could provide all aspects of care in settings where there are no professional midwives: for these settings, the term “midwifery personnel” is used.

Source: WHO Every Newborn Action Plan 2014
… to do this, we need to have midwives as part of a functional health system
No health without a health workforce
No reproductive, sexual, maternal and newborn health without a reproductive, sexual, maternal and newborn health workforce
What do we need ...

- A full reproductive, sexual, maternal and newborn health workforce
  - to save lives
  - optimise outcomes
  - to provide family planning/modern contraception
- Midwives/nurse-midwives are an essential component
- Global focus on strengthening midwifery
  - Education, Regulation, Association
Midwives ensure healthy outcomes for women and babies.

Midwives provide a continuum of care:
- Pregnancy
- Birth
- Childhood
- Motherhood
- Post-natal (newborn)

They practice in a variety of settings:
- Clinics & hospitals
- Private homes
- Birth centers

Midwives change the world by caring for mothers and babies. By ensuring that women and infants are healthy, midwives contribute to a strong community, economy and family.

Sources:
- https://www.jnj.com/our-giving/midwives-save-lives
- http://www.mama.org


For more information visit:

Investing in midwives:
- 60% of all women in developing countries
- 34% in the least developed countries have access to midwife care

Maternal mortality is the highest health inequity in the world.

350,000 midwives are needed

Midwifery services are highly cost effective

A mother who lives will contribute to the livelihood of the family and raise healthy children.
Bringing it all together

- Provide quality care to all women
  - Respectful care is a critical component

- Address high rates of intervention
  - Only use continuous monitoring when indicated
  - Support women to be mobile and upright
  - Address fear in labour – one to one care
  - Only do episiotomy if clinically indicated
  - Do not do unnecessary CS
  - Keep mothers and babies together
The power of midwifery – the power of midwives