Summary

In this article we revisit the concept of resilience and what it means for midwifery. We are aware that the idea of ‘resilience’ is receiving increasingly negative coverage within the midwifery community. However, how resilience is defined and understood seems to have shifted significantly from its original meaning. We consider why that shift might have happened and explore what resilience is and what it isn’t. We argue that the original meaning of the concept still has a great deal to offer the profession as we navigate these challenging times.
In 2014 we published our study of resilience in UK midwifery. At the time, ‘resilience’ was something of a buzzword. In the news you would often hear individuals, communities and organisations being described as resilient, and this was always interpreted as a positive characteristic.

However, we have become aware that this no longer seems to be the case. In professional debates and on social media, the concept of resilience has been criticised and even vilified.

In this article we argue that how resilience is defined and understood seems to have shifted significantly from its original meaning. Whilst this type of semantic slippage is common when words become popular and loosely used, it can also be problematic as the original meaning becomes more and more obscure.

But in rejecting the concept of resilience and its potential benefits for both individuals and organisations, could we be in danger of losing valuable insights and strategies that can support us as we respond to the current challenges facing midwives in the UK and globally?

We begin by exploring what resilience is – and what it isn’t. We hope to debunk some of the myths about resilience and change the narrative. We challenge those who interpret resilience as meaning ‘toughening up’ and ‘becoming hard’ to go back to the original meaning of the word and reconsider.

**Definition of resilience**

We start by exploring definitions of resilience and its application to midwifery. Resilience is a term that has been used in physical sciences to describe the ability and capacity of a given material to withstand and absorb energy and return to its original shape. This suggests that, under pressure, a resilient material can simply ‘bounce back’ to its original form. Indeed ‘bouncing back’ is often used when describing resilience and indicates that there is no lasting change.
However, when applied to an individual’s response to pressure, we would argue that this does not really take into account our propensity as humans to learn and adapt to experience. We use a definition of resilience that addresses this: ‘a positive adaptation to adversity […] without residual significant psychological or physiological disruption’.¹

Midwife participants in our qualitative descriptive study¹ indicated three key approaches that, in their experience, enabled the development of resilience. Firstly, self-awareness or ‘knowing yourself’ was seen as important. Pivotal to this approach was having a strong sense of professional identity and purpose; recognising the value of midwifery practice and the ability to make a difference. Secondly, individuals described how they adopted reactive strategies to help cope with and manage day-to-day challenges. These strategies helped them to change their mood and gain perspective on adversities; a key strategy was social support from friends and trusted colleagues. Lastly, more longer-term proactive strategies were recognised as important in building and sustaining resilience in oneself and others. These included learning techniques for self-protection, identifying potential triggers, building self-awareness, and supporting and empowering others.

Importantly, we found that there were particular occasions when adversity would be more keenly felt such as when newly qualified or after a difficult clinical experience. At these times the support of colleagues would be most valuable. Our study findings provide an insight into how midwives describe and develop their personal resilience to adversity.

A critique of resilience

Critics of resilience claim that the concept is problematic as it places responsibility on the individual to toughen up and cope with whatever work throws at them, arguing that it has become something of a ‘badge of honour’ in the midwifery and nursing professions.⁴⁵
There are two points here which we would challenge: firstly, that resilience is a matter for individual action only, and secondly that resilience is about toughening up and becoming hardened to adversity. From our perspective, these critiques indicate a misunderstanding of resilience and its evidence base, which acknowledge the importance of self-care, support seeking and the wider social context.

One particular danger with this line of thinking is that those who become anxious and depressed at work are then seen as weak and inadequate, with the associated risk of ‘resilience shaming’. An example can be found in a Maternity and Midwifery website discussion of the March with Midwives, where resilience was positioned as being in opposition to respect:

‘Far from being broken, we remain strong, are forced into acting out of resilience rather than respect and point the finger back to the broken power systems and our government for not valuing our efforts, despite our continuous demands for improvement.’ Surely it is a sorry state of affairs when we cannot be respectful and resilient!

So why has this change in meaning occurred? We suggest that it may be because the term ‘resilience’ has been misappropriated by organisational imperatives. In a chronically under-resourced and struggling NHS, a focus on resilience that misunderstands its essence could be used to shift responsibility for workplace adversity and emotional wellbeing back to the individual.
Thus the onus is on the individual midwife to cope with excessive workloads, unsustainable working conditions and the undermining behaviours of some colleagues, rather than tackling the root cause of these problems.

As an example: following the publication of our 2014 study, we were approached by many NHS maternity and perinatal services and Health Boards with requests to run resilience training workshops. We quickly realised that what some managers wanted was a quick fix; they would be seen to be doing something in response to staff concerns, but with little attention to the more fundamental systemic problems where the attention was really needed.

Increasingly, we turned down these requests, uncomfortable with the notion that we might be seen to be putting the emphasis on managing adverse working conditions onto the individual and thus negating the need for strategic direction to improve conditions. As we have argued in a later paper, reliance on individual resilient responses to adversity in the absence of addressing systemic issues is not sustainable.⁸

**What resilience is - and isn't**

So - if resilience isn’t about the individual midwife toughening up and coping with whatever work throws at them, what is it? Box 1 provides a simple checklist.

**Box 1 What resilience is and isn’t**
Resilience and Covid-19

The impact of the COVID-19 pandemic on the psychological wellbeing of the healthcare workforce is now well known, with dramatic rises in staff anxiety, depression and post-traumatic stress disorder identified.⁹
Exhaustion, managing uncertainty, worries about one’s own health and that of one’s family, and lack of access to usual social support mechanisms are all critical factors, as is the sense of moral injury and guilt that staff may experience when they cannot give the care that they know is best.\(^\text{10}\)

Understanding how resilience can be nurtured and the role of leadership in supporting this may offer some ways to navigate the greatest challenge that the NHS workforce has ever experienced. But if an incorrect interpretation of resilience is applied, then the risks are profound.

Rather than going it alone and toughening up, experts in trauma prevention\(^\text{9}\) advocate resilient strategies which facilitate reflection and sharing of experiences.

They emphasise the importance of frank discussion, self-care and mutual support within small teams, and also the vital role that organisational leadership plays in enabling and encouraging this approach to psychological wellbeing.

As Greenberg and colleagues argue, ‘healthcare managers in supervisory positions must now acknowledge the challenge staff face and minimise the psychological risk inherent in dealing with difficult dilemmas, and those in charge of resources must provide them with the opportunity to do so’.\(^\text{9}\)

**Conclusion**

Resilience is a misunderstood concept. Its meaning has become distorted because of how it has been embraced (and misused) by organisations in ways that obscure systemic problems within the workplace and place the responsibility for coping with unreasonable workplace demands and environments on the individual.

Understanding what resilience is and what it isn’t is crucial to supporting and nurturing the emotional wellbeing of the
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Summary

Following an article in the October 2021 issue, this is the final of a two-part series on spirituality and midwifery education. In the first article, Jenny and Susan set the scene and explored the inclusion of spirituality into the new Nursing and Midwifery Council (NMC) midwifery educational standards and how this relates to the national and international context; the focus of this second article is on how midwifery education can be incorporated into undergraduate midwifery curricula in more practical ways.

Introduction

In a previous article about the inclusion of spirituality in the new UK NMC standards, we introduced the meaning of
spirituality, and concepts of spirituality as relevant to midwifery and childbirth. We highlighted that spirituality is a factor to be considered within the holistic paradigm of care within a national and international context. In this article, we address how educators can introduce spirituality throughout the curriculum with a specific focus on the UK.

Figure 1 Spirituality and spiritual care in midwifery education themes

![Figure 1 Spirituality and spiritual care in midwifery education themes](image)

Philosophy of education

Education does not occur in a vacuum and is situated within sociocultural and psycho-emotional contexts. As such, educators will have their own personal beliefs and values influencing their approach to enabling learning due to their history, experiences (professional and personal) and social context. Moreover, they will be influenced by the culture of where they work and practise, as each institution will have its own values and underpinning philosophy.

Curriculum design will be framed around these values, and there may be an organisational or institutional statement of the philosophy present that illustrates this. For example, many global educational institutions have an underlying philosophy based on the United Nations Educational, Scientific and Cultural Organization (UNESCO) principles of Education for Sustainable Development, with the aim to provide a holistic and transformational environment for learning.

In a midwifery-based illustration, Ridley and Byrom describe the development of a new midwifery curriculum based on Antonovsky’s philosophy of salutogenesis, and demonstrate how such philosophical underpinning led to the choice of teaching method; clearly showing the importance of aligning all the strands of the programme (vis-à-vis, constructive alignment). Other authors point to the importance of employing a creative philosophy to encourage self-development within a holistic curriculum.
It may be assumed that any undergraduate midwifery programme currently being validated in the UK will be underpinned by the philosophy of the NMC standards, which are based on the Lancet series on midwifery, the International Confederation of Midwives’ Essential Competencies for Midwifery Practice and the Global standards for midwifery education.

The emphasis of a holistic, whole-person approach to midwifery care is highlighted, which includes addressing spiritual care and honouring spirituality in and around pregnancy, birth and the postnatal period. Holism in this context is characterised by an appreciation that the seemingly independent parts of midwifery and childbirth (e.g. psychosocial, psycho-emotional, spiritual and physical aspects) are actually intimately interconnected and always understood with reference to the whole.

You may want to stop reading right here and investigate where the philosophy of your programme is recorded. Is it a philosophy that is addressed just in your midwifery section or across the whole faculty or university? Is there a clear, truly holistic approach, with spirituality included within? In principle, this should be apparent if the curriculum is based in the UK health service, though it may also be more implicit rather than explicit.

As mentioned in the previous article, standards developed by a European network for education around spirituality have been adopted by all nursing and midwifery programmes across Wales and therefore should be apparent in any documentation. The underpinning philosophy of a midwifery curriculum ought to express the culture and attitude of education within that programme.

**Developing education strategies**

There is currently limited scholarly research on the praxis of midwifery education, particularly any related to spirituality. Why this is the case is unknown and currently a culture of sharing practice across the sector is lacking. In order to provide an understanding of spirituality, any discussion should begin with the individuality of the student. Students come from many backgrounds and cultures, with personal histories.

In recent years much discussion on spirituality has moved from the connotations of religious backgrounds (nursing and midwifery started within religious orders in the West), yet the impact of religion remains a strong influence on personal beliefs. Cultural diversity across the student group brings a wealth of understandings into discussions. It is also relevant that
There is a current focus on the importance of decolonising the curriculum. This is significant because it ensures a truly person-centred and holistic approach to care that not only recognises, but privileges unique individual world views.

Our teaching practices do not always meet the need of the individual student. For example, when Jenny was holding a creative spirituality workshop, she provided lots of different paper-based colourful materials, pens and glue for the students to work with. Early into the session, one of the students ran out very quickly and could not be located. We were concerned something had upset her.

However, a short time later, she returned with materials from the grounds outside: twigs, leaves, flowers etc. She explained during the sharing time that she was part of the Druid religious belief and felt she needed natural materials with which to express her spirituality. It was clear there had been an assumption made of how the workshop would meet the spiritual needs of the students.

It could be argued that any education with a spiritual approach should be transformative. It is an attitude in which educators want a student to become transformed into being a midwife who recognises the importance and meaningfulness of the birth story when face to face with a person situated within their distinctive sociocultural and spiritual context. Patricia Cranton describes transformative scholarship of teaching and learning to be:

’a deep shift in perspective during which habits of mind become more open, more permeable and better justified’.

She points to transformation occurring when:

’a person, group or larger social unit encounters a perspective that is at odds with the prevailing perspective.’

The journey can include critical reflection and self-reflection, imagination, intuition and emotion. She points out that:
‘it is not called transformative until there is a deep shift in perspective and noticeable changes in actions as a result of the shift.’

It can be seen how this theory could be applied to the development of those who experience a light-bulb moment over the understanding of a truly holistic approach to midwifery care, when they see the meaningful special moments of birth that are profoundly transformative.

We recently participated in an inquiry around spirituality and spiritual care. In the first of these two articles we presented an adaptation of the findings of that inquiry (see Figure 1) and how they reflect the midwifery student. This article now returns to these adapted themes and considers the application to education practice.

**Generating reflexivity**

Explaining to students that their individual spirituality matters provides a starting point for them to understand the individuality of each person they encounter when caring and how it is important to address questions of belief rather than making assumptions. The recognition of the student as an individual can lead to a depth of understanding that facilitates personal growth. Holistic methods of learning have shown that deep personal reflection enables an increased understanding of the needs of others when caring.

Looking to methods of learning facilitation that will give students time and space for personal growth increases the opportunity for understanding the sacred or special role of the midwife. Evidence has demonstrated that case-based methods of learning give time to increased reflective practice. Providing these windows for reflexive activities appears to increase the meaningfulness of birth and the role of the students.

**Questions for educators:**

1. Is there regular space in the programme for students to reflect on their personal development?
2. Are you comfortable discussing spiritual beliefs and values?
3. How will you encourage students to reflect more deeply e.g. creative spaces, poetry, journaling?
4. Do you use these yourselves to reflect on your education practice?

**Spiritual midwifing**

In the previous article the theme of spiritual midwifing revealed links to the humanisation of childbirth:

‘and incorporating beliefs/practices within and beyond midwifery, as well as appreciating childbirth as more than professional affiliation, orientation or biomedical understanding. It speaks to our being fully human, about being totally present and not being fearful to embrace the metaphysical and transcendental elements of birth.’

Students require educators and practice supervisors to bring the depth of meaning of birth to life. Demonstrating presence with the student, as well as with the birthing woman or person, enables the student to recognise the power of being alongside someone on their life journey. This is not, however, a dependent relationship but one where the teacher is leading the student to be the leader and empowering them to step into the professional midwife role on qualification.
Students also need to understand the importance of promoting the dignity and respect of women and birthing people. A key theme of the NMC Standards of proficiency for midwives is caring for the ‘...physical, psychological, social, cultural, and spiritual safety of women and newborn infants.’ Being able to link the promotion of a humanised approach to care across the environment of practice is crucial. This is done by nurturing approaches of care that attune to dignity and respect in ways that recognise and ensure spiritual safety for each individual, their families and communities.

Questions for educators:

1. How do you walk alongside your students as they develop on the programme?
2. How can this kind of relationship be built into the programme: personal tutoring, coaching, mentoring?
3. How can it be built into practice experiences?
4. Is the curriculum ‘humanised’ in its approach?
5. Does the culture model dignity and respect for the student?
6. Do you teach students what spiritual safety is and why it is important for themselves, their colleagues and the women and families to whom they provide midwifery?

Transforming relationships

The type of relationships that are fostered during a midwife education programme can make or break a student and are dependent in part on the culture of the institution. We previously wrote:

‘Nurturing relationships require experiences in which we and others are seen, loved and respected; it is about mutual and self-support.’

A key theme of the NMC proficiency standards is working in partnership with women and across the multidisciplinary team. Students need to understand the principles of partnership and working well with others. A culture where the student is valued and respected will lead to spiritual self-development and positively sustain their future practice. Cultures where bullying of students is rife, where students are belittled or devalued, must be challenged and transformed.

Academic and practice educators need to be united in actively providing a culture where students are welcomed and accepted so they can personally develop. Likewise, established educators must actively ensure new educators joining their teams are valued, nurtured and included.

Questions for educators:

1. Do you have enough time to check in with colleagues to nurture self-development?
2. What is your relationship with practice educators and other professions, and how may these be strengthened to better support students?
3. How do you deal with evidence of a bullying culture or individual?
4. How do you support students who have experienced bullying?
5. How can you model deeper meaningful relationships to help students grow: mentoring, coaching?
Nurturing interconnectedness

The time of birth is a powerful moment when there are sacred connections across generations. This was revealed in Susan’s thesis Sacred Joy at Birth: A Hermeneutic Phenomenology. Her thesis revealed a time of transcendent interconnectedness. Pregnancy is an opportunity for women to change and find meaningful connection with the unborn baby and across their community.

There has been a loss of this connection over the COVID-19 pandemic as pregnant women and birthing people have been isolated. In the previous paper we discussed the principles of nurturing relationships and the need to slow down from the constant ‘busyness’ of healthcare. Now is a time to reflect and re-imagine ourselves in midwifery and build a community of practice that orientates to meaningful relationships where individual unique voices are honoured.

The digital world has changed the nature of connections and we need to adapt to ensure relationships are maintained. Women and birthing people still need the opportunities to develop a meaningful connection with their unborn baby and nurture bonding. Student midwives need to learn appropriate communication methods and be able to develop a relationship with families, communities and colleagues. Key themes of the NMC proficiencies include communication and partnership across the whole continuum of the maternity journey.

It is encouraging to see how students across the UK are having increased opportunities to follow women through on their pregnancy and birth journey and experience providing continuity of carer. Such opportunities are key in enabling development of connecting relationships. Educators may use methods such as case studies to help students recognise the context and individuality of the stories.
Questions for educators:

1. Why are nurturing connections important?
2. If midwives are social connectors as contended, then how do you inspire students to develop connecting relationships?
3. How do you see this as a spiritual journey?

Transforming practice: encouraging creativity

Patricia Cranton writes of transformative scholarship and learning as an opportunity for critical questioning of ‘assumptions, beliefs, norms and values of the discipline, the institution, the community and the state.’ She continues: ‘Such an approach has the potential to yield a deep shift in perspective on teaching and learning at both an individual level and a social level’. We contend that the spiritual involves the desire to transform and improve practice where there are ‘opportunities for self, colleagues, women and families to shelter and protect the specialness of childbirth and bring guardianship of that which is special around childbirth.’

Educators using creative methods for transformative scholarship may bring students to a depth of critical questioning about current midwifery practices and enable them to bring about change. Enabling them to see the specialness of birth and the whole person context, including spirituality, as in the NMC proficiencies, will be transformative.

Questions for educators:

1. How can you transform practice as an educator?
2. How do you aim to enable students to transform practice?
3. How will you help students become guardians of what is special around childbirth?
4. How will you foster their creativity?

Inspiring self and others to change

Viewing midwifery practice and education through a spiritual lens enables us to see that all is not as good as it should be. It enlightens us and inspires us to bring the best experience to the families in our care and to encourage others to develop in their unique ways. A focus on student leadership has been within education for many years and is included as part of the proficiencies. Nurturing reflexive students emboldens emergent levels of deeper spiritual understanding. This potentially would result in a quality of midwifery leadership that empowers others to deeper development that changes practice reality.

Questions for educators:

1. How will you foster an environment where change can take place?
2. How can you transform your education practice to look through a spiritual lens?

Conclusion

We are conscious that in this short space we have asked more questions than given answers. There is so little evidence to support how to facilitate effective learning of spirituality in the
classroom. There needs to be an increased culture of sharing and scholarly research into education practice. Knowing what is effective in developing each student midwife holistically continues to be uncertain. Yet, it remains educators’ responsibility to facilitate transformation, and to foster relationships in the practice setting to provide appropriate places for meaningful learning. It is evident that there needs to be more time and space created in programmes to enable deep reflexive practice and spiritual development. We know that students need opportunities for such learning, so they can be inspired, be energised and flourish. For this, we need to reignite the passion for midwifery across all areas of practice and manifest a holistic world view that does not allow compartmentalisation of childbirth and midwifery. Action is needed to make this a reality lest we lose something of significance. It is good for midwifery to love what we have proactively willed into the profession as opposed to a profession overwhelmed purely by the will of organisations and societal structures and demands – attuning to the spiritual in midwifery is a gift to ourselves and to all women, families and communities that we touch daily. 

TPM

References


A Positive Birth Experience: Midwives Empowering Women and Their Partners During the Birth of Their Baby With The Steps of the Labour Hopscotch Framework

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Summary

The rates of obstetric interventions, particularly caesarean section during childbirth, continues to rise in Ireland. This is reflective of international trends with concerns that societal confidence for physiological labour is declining. In response to such concerns, a community midwife designed and produced a framework entitled Labour Hopscotch which aims to support physiological birth and evidence-based midwifery practice in Ireland.

Introduction

Childbirth is a significant event in a woman’s life, and the World Health Organization (WHO)\(^1\) advocates for a positive birth experience as an important end point for all pregnant women. It is well documented that women’s birthing experiences have long-lasting physical and psychological effects often reported across a continuum.\(^2,3,5,6,7,8,9\) In fact, it is clear from international evidence that a woman’s birthing experience has a direct impact on maternal self-confidence and self-esteem,\(^10,11,12,13,14,15,16\) and is associated with immediate and long-term negative ramifications during and following birth.\(^17\)

Because of this, there is a growing international drive to enhance empowerment for women during childbirth. Only by working with midwifery knowledge/evidence base can midwives support physiological birth and achieve the recommendations of the WHO’s\(^1\) guidelines for a positive birth. In 2018 the national rate of caesarean section in Ireland was 31.2% from a total of 61,655 births.\(^18\)

In response to the increased numbers of interventions reported, particularly epidural rates which was 57% at the time, senior midwifery management in the research site, a maternity hospital, encouraged midwifery practitioners to consider developing innovations that could reduce rates of interventions and facilitate normal physiological birth for women. Subsequently, one of the community midwives designed and began to reflect and doodle and produced a visual framework entitled Labour Hopscotch.

The Labour Hopscotch Framework (LHF) offers women and their partners practical steps to take to support physiological birth and reduce childbirth interventions. The Labour Hopscotch Framework is now readily available on Google as a midwifery innovation that supports physiological birth for women and their birthing partners – see Figure 1.

Figure 1 The Labour Hopscotch Framework: ‘From doodle to Google’
The LHF provides women and midwives with a visual depiction of the steps they can undertake to remain active and, in this way, promote optimal fetal positioning which is paramount to achieving a physiological birth. The steps are illustrated in a sequential manner that is matched with the progression of labour, as demonstrated in Figure 1 and Figure 3.

These steps include the use of mobilisation, positioning, water therapy, and non-pharmacological methods of pain relief. An appropriate period of 20 minutes is suggested for each step. Flexibility is encouraged around this timeframe and consideration is given to maternal comfort levels and equipment/resources available. The framework is also designed in a manner that ensures the steps can be used antenatally by women with their partners as part of training and coaching for an active birth.

Following a presentation of the project research findings, the Department of Health Ireland, through the National Women’s Infant Programme (NWIP), supported a national implementation of the LHF across all maternity units in Ireland. Subsequently during 2020/2021, educational training and workshops were offered and LHF is available in 10 of 19 maternity units in Ireland. The planned implementation of the LHF was delayed and impacted by the current COVID-19 pandemic, so virtual education occurred when necessary.

**Methods**

**Setting**

The setting for this study is a national referral centre in Dublin, which has an annual birth rate of approximately 8,000 births (8,434 in 2018). Women attending can avail of three care pathways, namely: obstetric-led care, midwife-led care, and Domino midwifery, which includes a homebirth service.

**Aim**

The overall aim of the study was to ascertain the benefits that can be gained for women and their birthing partners that use...
the steps offered within the LHF.

**Approach**

The team involved in this study were members of a Joint Research Network (JRN) group of midwives, academics and students from the research site and the affiliated university. The aim of the JRN is to translate evidence-based midwifery and nursing knowledge into practice. Midwives working within the research site were involved in the development, design and completion of the study. This project was conducted over an 18-month period. A two-phased mixed-method sequential explanatory design study consisting of a survey [women, n= 809 and partners, n= 759] and a focus group meeting [n= 8 midwives] was completed to evaluate the LHF following its implementation.

Ethical approval was sought and gained from the hospital research site on 25 June 2017. Prior to the onset of the pilot study, information days about the LHF were provided to midwives. Information was then offered by midwives to women and their birthing partners about the LHF at the booking appointments and throughout antenatal appointments. The LHF was then incorporated into antenatal education classes to enable women and birthing people to practise the steps of the LHF with their birthing partner during pregnancy.

This was an important aspect of the study design as it meant women and their partners could learn together about the use of breathing techniques, lunges and squats, and active birth during pregnancy. Women could also learn about the use of the rebozo scarf and non-pharmacological pain methods, all of which are important aspects of physiological active birth. The pilot study was conducted from August 2017 to January 2018. Firstly, the research instrument (survey questionnaire) was circulated to clinicians.academics for pre-testing (n= 5), and minor changes were made to the wording of the questionnaire.

Following this the survey was piloted for two months (n= 100). The survey was completed over an eight-week period in 2018. Written and verbal information was provided to all participants and written consent was gained. Birthing partners were also invited to participate. In total, 809 women and their birthing partners participated in the survey.
Analysis

The primary focus of this paper is a presentation of the qualitative findings from responses to the open-ended questions. An inductive, data-driven content analysis approach was adopted to interpret the qualitative data. The primary researcher coded information relevant to the research question and aims and objectives of the study. The second researcher was invited to check all the coding. As a new concept or theme was identified, it was coded as a node. All the nodes were then reviewed again, and similar nodes were coded together as a theme or subtheme and the relationship between themes and subthemes were examined and sorted into categories. The codes and categories were refined and finalised after discussion.

Findings

Demographics

Participants had five choices in terms of packages of care to attend; the majority attended public obstetric-led care (n= 283, 35%). This percentage of women receiving care in public obstetric-led service is reflective of the population attending the hospital, but significantly lower than the national average of 81.0% (Healthcare Pricing Office, 2019) – for further details see Figure 2.

Figure 2 Choice of care package

For 47% (n= 381) of women, this was their first birth. 40% of women (n= 309) reported that the LHF had influenced their decision-making about pain relief. The rate of epidural analgesia during labour (38.5%) was substantially lower than the overall hospital epidural rate (57%). 90% (n= 715/765) of women reported that the steps of the LHF helped them to feel either very confident or somewhat confident to cope with labour.

A significant association was found between mobilisation and mode of birth. Of the 641 participants who identified mobilising as being the most beneficial, 500 (78%) women had a normal birth, while 96 (14%) women had a forceps/vacuum birth, and
45 (8.7%) women had a caesarean section (p= 0.002). Birth partners supported the use of the LHF with 79% recommending it should be used by women during childbirth. Midwives also suggested the LHF inspired women to take initiatives and play an active role in their birthing experience.

**Themes identified**

**More prepared for labour**

A theme that emerged was that the Labour Hopscotch gave participants a structure and a variety of activities to manage their experiences during the first stage of labour. These activities, with clear time frames, helped them focus and made the time pass quicker.

‘I found that I used it as a guide to help me focus and use suggestions every 20 minutes, it offered variety and choices of what to do next.’

‘Labour Hopscotch is amazing, while in the antenatal ward instead of sitting around I had lots to do, it provided me with a plan and distractions.’

A recurring theme described by participants was that Labour Hopscotch increased participants’ confidence to stay at home.

‘It helped at home in pre-labour, using the Labour Hopscotch gave me the confidence to pass my long hours of labour at home. I did not feel the need to rush to the hospital.’

**Labour Hopscotch is empowering**

Participants presented detailed accounts of the way the Labour Hopscotch supported them psychologically during childbirth.
'I felt greater confidence without pain relief due to the Labour Hopscotch, I think it’s empowering for women, you know, it makes you feel more useful.’

‘Felt like I was helping to progress labour with gravity to get my baby out. It was so useful to have many suggestions to try at home. I felt very empowered, it really took attention away from panic and fear, I felt very calm using it.’

Midwife as guide and coach

Participants relayed accounts that depicted their understanding of the role of the midwife, including detailed accounts of ‘midwifery presence’ throughout their birthing experience as indicated in the following statements:

‘One of the most important things for me was the coaching through labour by midwives, midwives didn’t force me, just reminded me.’

‘Good distraction during natural birth, with assistance of [an] amazing midwife.’

Did your birth partner become involved and support you to use the steps of the Labour Hopscotch?

In total, 207 participants responded to this open question. Participants acknowledge that the Labour Hopscotch promoted the involvement of their partner during childbirth as indicated below: ‘Continuous involvement in a supporting role, allowed him to provide tangible physical and emotional support.’

It seemed that the Labour Hopscotch supported and strengthened the mother/partner relationship during the labour proves
as indicated in the following two statements:

‘being involved helped with the intimacy of the experience and brought us closer.’

‘He felt part of the experience and felt useful, it made the experience more personal and empowering.’

The Labour Hopscotch was also reported to benefit the birthing partner by providing additional supportive knowledge and guidance as indicated in the following statements:

‘My husband knew from the classes and set up a room at home for me with all the stages done out for labour.’

‘Gave clear instructions to my partner, he understood how to support me practically.’

Promoted partner engagement

Participants suggested that, during labour, the Labour Hopscotch gave their partner a ‘coaching’ job: the partners ‘kept them going on the hopscotch’, offered instructions on what to do next, encouraged and prompted them to complete steps, and timed each step as indicated below:

‘My husband was very in favour of Labour Hopscotch and coached me throughout, he found it useful to have a job and telling me what to do next.’

‘My partner really found it good. He liked it for providing him [with] a role, he found it helped him provide support and encouragement, liked the timing and he encouraged me to complete each step.’

Participants described steps and activities their partner helped them with. The activities included stool, showers, acupressure, counter pressure, TENS, water pool, toilet, breathing, lower back heat pack, massage, squats, lunges and mobilising, almost covering the full spectrum of the framework. Participants described the effects of the LHF on the birthing process as ‘useful to have a job and telling me what to do next’ as indicated in the following statements:

‘Counter pressure and acupressure worked, husband and midwife laboured with me.’

‘Able to assist me move positions into the pool and onto the toilet, helped with squats going up and down stairs on the stool.’

When engaged in these activities together, partners offered physical and/or emotional support when needed, especially in terms of ‘mobilising’ so that the women did not ‘get stuck in one position’.
Discussion

This paper reports the findings from an evaluation of a midwifery innovation, the LHF. The findings were incredibly positive and women found the framework useful; it helped them prepare for early labour and childbirth. This is important because a systematic review\(^2\) revealed that women report a lack of preparation for birth. This is not a new finding,\(^21\) highlighting that women consider that the latent phase of labour is undervalued. Central to women’s experiences of the LHF was the information and preparation they received provided them with the confidence to stay active throughout labour and kept their minds focused on positive actions rather than contractions and anxiety.

A key finding from this study was the Labour Hopscotch supported participants psychologically, enhancing self-confidence and helping them feel in control during their labour. This highlights the value of midwifery-led interventions and care. The psychological benefits for women attending midwifery care have been reported elsewhere.\(^22\) Building women’s confidence to stay at home is a critical element of antenatal care as this confidence is lacking in many women.\(^23,24\)

During the antenatal period, there are many opportunities for healthcare professionals to include and involve fathers/birthing partners. Despite this, healthcare professionals are slow to include and involve fathers/birthing partners in the antenatal period.\(^25\) Poor communication from healthcare professionals and pain medication such as epidural has been identified as a barrier to partners’ involvement during childbirth.\(^26\) One of the aims of the study was to ascertain if birth partners were actively involved in supporting women during the steps of the Labour Hopscotch Framework.

Findings from this study revealed that the Labour Hopscotch was useful for partners, indeed participants reported that the Labour Hopscotch promoted the involvement of their partner during childbirth. Such involvement was considered of great benefit for them, supporting their birthing experience using the steps of Labour Hopscotch together was reported to add intimacy and indeed nurtured and nourished their relationship. This is important, because the international evidence reveals that a supportive birthing partner has a calming manner for women, increasing her feelings of internal and external control, and importantly, reducing feelings of panic.\(^4,27,28\)

Equally important, was the finding that using the
steps of the Labour Hopscotch together had positive effects on the psychological wellbeing of the birthing partner. This is a key finding and adds to findings from a recent systematic review exploring paternal anxiety. A recurrent theme in the literature is that birth partners experience feelings of helplessness, powerlessness and frustration which intensifies their anxiety. Findings from this study revealed that the Labour Hopscotch was useful for partners; indeed participants reported that the Labour Hopscotch promoted involvement of their partner during childbirth.

A central and key theme that emerged from women’s narratives was the important role of the midwife, the importance of the mother-midwife relationship and continuity of carer to the success of the LHF. This supports international evidence around the importance of quality mother-midwife relationships to enhance positive birthing experiences. Internationally, midwifery philosophy is underpinned by an assumption that maternity care should be woman-centred. The implementation of the LHF enables midwives to fulfil this philosophy.

Limitations

This study was undertaken in one maternity unit in urban Ireland. Extending this study nationally to include multiple maternity sites and alternative birth settings would increase transferability.

Conclusion

The LHF is a midwifery package of care with a philosophy embedded in the inherent normality of childbirth and the natural ability of women to achieve this. The findings have revealed that when used in conjunction with midwifery-led care it can increase confidence to stay at home in early labour, and to cope during childbirth, increase rates of physiological childbirth, improve psychological wellbeing and partner participation during childbirth.

The Labour Hopscotch enhances the contribution of midwives, makes their role more visible and facilitates midwives to be ‘truly present’ to support women to remain active during childbirth. Since being implemented across maternity units, the Health Service Executive Ireland included the LHF into the National Standards for Antenatal Education in Ireland (2020).

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Summary

Being a midwife, this experience – stewarding the passage into life of a new person, and the birth of a family – is no ordinary job. It requires training, expertise, and exceptional concentration and stamina. It also requires incomparable sensitivity and awareness of your body, your presence, your movement, and your interactions in the space, particularly in relation to the woman or birthing person.

To compare this to a dance or a choreographic sequence can seem reductive, but the parallels are there. The story unfolds through the bodily processes and interactions that happen repeatedly over time. Both the birthing person and the midwife are pushed to extremes and go through rites. This is a special place, an arena where extraordinary things occur and we are in an altered state.

Introduction

The idea of the choreography of care first came into my vocabulary after attending a symposium organised by dancer Rosemary Lee titled ‘On Taking Care’ in 2012, run by arts organisation Artsadmin in London. It was introduced by Professor of Nursing Policy and former President of the Royal College of Nursing, Anne Marie Rafferty, who used it in relation to the care she was providing for her elderly mother. It resonated with me so strongly that it is often the first thing I think about at the beginning of a shift. The dynamic of the space and my place in it is a vital consideration, and the notion helps me to bring a level of attention to my actions that I would not otherwise bring.

Birth story

It’s 7.45am and I walk purposely into a birth room – a midwife at the start of a shift in a busy London hospital.

Inside the room there is a birthing person, who is naked apart from an open hospital gown, labouring on the bed and moving freely. Another person, male presenting who appears to be her partner, is sitting next to her, and an older person (her
mother, I think) is agitated, holding her body tightly.

There is a hospital bed in the middle of the room. A curtain, half hanging off its fixture, is partly drawn diagonally across the space, and the white blinds on the windows are closed – some are broken. The harsh fluorescent lights are on full.

I take all this in, in a minute, scanning for anything significant, such as a missing bit of equipment, something unfamiliar or alarming. I watch the labouring person move in time with the flow of contractions.

In this way, I assess the scene before really entering or engaging. I quickly say good morning to everyone and excuse myself, and go into a huddle with the midwife to get a handover.

The labouring person, who identifies as cis female, only arrived an hour or so ago. She’s in established labour so I listen with one ear, while paying attention to the midwife with the other.

How I interact, how I move around the space, the tone of voice I use, the noises generated by my actions and the actions of the machines I use, can profoundly affect the woman, her labour and ultimately the birth itself."

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The labouring person, who identifies as cis female, only arrived an hour or so ago. She’s in established labour so I listen with one ear, while paying attention to the midwife with the other.

After handover I rearrange things in order to establish a safer, more nourishing atmosphere that respects her privacy. I
quickly rehang and close the curtains at the front of the room so no one can walk straight in, and close the door properly so sounds from the corridor are muffled. I move bits of equipment around so there is space, order and I don’t trip on them. I sort out the blinds so that the room is dark and feels more cloistered, and switch off the main lights. I move the tray from the bed and get rid of a deflated birth ball.

I move quietly and smoothly, making sure I don’t knock into anything or make unnecessary noise. I have become an expert at putting on a blood pressure cuff, silently, but the machine makes its familiar mechanical sound as it revs up, and then removing it – the tear of the Velcro – is grating. I speak softly but assertively – maintaining a balance in order to reassure her, not dominating, and seeking consent for everything I do.

The woman is constantly moving, reacting to the wave of contractions and I don’t want to disturb this, but in order to check the baby’s heart rate, I need to position myself and the monitor in the right spot. This involves a negotiation – again I speak, touch her arm and seek consent. We move together, me circling the bed as she moves, finding an accommodation together.

All clinical recordings are logged on the partogram – like a musical score. Each contraction brings pain which she rides, arching her back, breathing deliberately and heavily, bringing oxygen in and expelling carbon dioxide.

Sensing the birth is imminent, I stop and observe the dynamic in the room; how she is moving, the noises she’s making, even the smells.

The woman is now making the kind of sounds I recognise as a signal that birth is imminent – low, guttural and sustained, and I see a slither of the baby’s head poking out between her legs. A dark, wet and glistening spectre.

The baby’s head appears, coming forward with each contraction as she pushes, and then moving away as it subsides. I speak in an upbeat way – each midwife has her own script, developed over time – key words, intonations and phrases that encourage and reassure.

The woman doubts herself – ‘I can’t do it’ she says, with desperation, arching her back and burying her head into a pillow – we all chorus back ‘you can’.

More pushes, and now a change in position.

In left lateral, we all realign ourselves – midwife, partner, mother. The woman lifts one leg, which we support, bracing ourselves to take the weight and acting like scaffolding around her, as she pushes hard – the baby’s head emerges further. A tantalising effigy, emerging bit by bit, like the pointed end of a hat.

This scenario continues for an hour – we operate like props around her body as she moves into different positions, sometimes using the handles on the bed as buttresses to push against, sometimes her partner’s body or mine. We shift as she travels across the bed, responding to her actions and movements.

Protocols dictate that if the baby is not born after one hour of pushing, we need to call in the doctors for a review.

Two doctors enter the space.

It’s decided to try an instrumental delivery. The baby has to navigate through the woman’s pelvis, making exquisite twists and turns to find a way through the narrow spaces, flexing its head to wriggle through the narrow opening.

Suddenly the intimate, close relationship between everyone is broken – disrupted by the presence of a different energy and intent of the doctors. We all step back and make space for them. They enter with an air of authority and power and take
control of the space, which was previously shared between us.

We shift the woman now, guiding her into the lithotomy position. We flatten the bed, bring her down towards the end and raise her legs into stirrups. This is the most undignified and vulnerable posture in the birth room – I bring sheets and cover her as best I can to protect her in this stark situation. The suction cap is attached to the baby’s head. Then in tandem, the doctor pulls with each contraction and the woman pushes.

After three pushes the baby is born – and delivered straight onto the woman’s chest. Slick, slippery and writhing, covered in a thick layer of creamy white vernix. Everyone clusters close and there is an immediate shift in the room – a pause and silence that seems to last forever as we wait for the baby to cry – it comes, and everyone exclaims, congratulates the woman and tears flow.

I come close to quickly assess the baby – she seems fine – breathing, crying, moving. Her colour slowly changes from blue and black to a lighter shade, and her eyes are blinking. The woman clutches the baby to her, and the partner embraces them both – there is an ambience of relief, joy and celebration in the space.

Meanwhile the doctor administers an injection and pulls the placenta out. She then assesses the damage to the woman’s perineum and prepares to stitch it up – sitting on a stool and whizzing back and forth to the trolley to get equipment. When finished we meticulously count the swabs and needles, and document that everything is correct. The doctor then leaves, her bleeper going off as she is called into another room.

I help the woman latch the baby onto her breast, bending over, twisting to get good sight of the baby’s mouth attaching to the breast, and she immediately starts sucking.

After a while I gently and deliberately clean the woman’s body – tenderly washing off the blood and other bodily fluids using hot water and cloths. I change the bed sheets and arrange pillows and blankets so she is clean, comfortable and cosy. I offer a clean hospital robe. I also scour the room, on my hands and knees, mopping blood off the floor and collecting all used pads, gloves and other bits of debris, which have been discarded, putting it in the array of different bins, depending on its status.

After a while I take the baby over to the resuscitaire and check her over. She’s wrapped in a blood-streaked towel, feet poking out, warm against my stomach. I ask if they want to dress the baby and the partner comes over to do this.

Next, I help the woman get up and out of bed. We walk unhurriedly across the room together and into the bathroom with deliberate and slow steps, one at a time, with a pad held between her legs. I support her physically and she leans on me. She uses the toilet and then has a shower.

Then with everything done and the family safely back together, I withdraw and exit the space. This time is precious – a new family has been born, and they need time to be together, quietly, intimately, without me constantly interacting and interfering.

I feel exhausted but exhilarated – at the end of a seemingly endless list of tasks and negotiations. I sit down in the safety of the staff area and decompress. My body is tired and aching after the constant moving, bending, washing, cleaning and tidying.

I’m also emotionally tired, after the constant mediation between actions and words – and assessment of risk.
Now I need to finish my documentation, and arrange the transfer of the mother and child to the postnatal ward. I book a bed for her downstairs and call for a porter.

We transfer the woman into a wheelchair and hand her the baby wrapped in blankets.

As we exit the labour ward, everyone waves and wishes the family well.

We travel down together in the lift, the partner encumbered by bags and suitcases, the woman in the wheelchair holding the newborn. The porter chatting and asking about potential names.

As we arrive on the postnatal ward, the last vestiges of my care are completed. I help the new mother into a clean bed in a four-bedded bay, bring a water jug and cups and say my goodbyes. The intimacy we shared and the intensity of the experience are acknowledged as we embrace, and I wish them luck.

Today, the dance went well – we were mostly in sync with each other and rode the unpredictability of the process to a beautiful outcome, and like with all great art, we leave feeling emotionally and culturally uplifted.

I go into the office space and hand over, as the midwife did to me around 10 hours previously. I tell her the story of the birth and I feel like I also outline the ‘performance’ of the dance – a series of choreographic sequences; a duo (me and the woman), a trio (with her partner) and sometimes more complicated multiple improvised sections (with other healthcare workers). How well these were structured, performed and completed influence the outcome of the birth and the dynamic created in the space.

Today, the dance went well – we were mostly in sync with each other and rode the unpredictability of the process to a beautiful outcome, and like with all great art, we leave feeling emotionally and culturally uplifted. TPM

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Using Heideggerian Hermeneutic Phenomenology For Midwifery Research Studies

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Summary

The aim of this article is to encourage midwives to reflect on hermeneutic studies in relation to their own practice or to consider using it for qualitative research, discussing the applicability of Heideggerian hermeneutic phenomenology. Hermeneutic approaches take into account the subject’s prior experience and knowledge, making it useful for working with women and understanding their perspectives. This article is grounded in my experience of undertaking my own PhD - a study on the transition to parenthood for couples with an in vitro fertilisation (IVF) pregnancy. It explains some of the broad concepts of hermeneutic phenomenology and how they align with the practice and underlying theoretical concepts of midwifery.

Introduction

Many readers may be wondering why a midwife would choose to use the work of a white, middle-class male philosopher from 1930s Germany (moreover, one with troubling associations with the political climate of the time) to study the experiences of pregnant women in contemporary Britain. Within this article, I hope the rationale for that becomes evident as the work of Heidegger is explored and its applicability to both my own study and midwifery research will be demonstrated.
Identifying an appropriate methodology

On commencing my PhD six years ago, I knew what I wanted to study but had no firm methodology underpinning how. The study focused on the experiences of couples with an IVF pregnancy through the transition to early parenthood, so by definition, it had to be qualitative. In working through a range of possible methodologies – all of which could have been utilised for the study – I found that I was being drawn between a more sociological perspective – social constructionism or ethnography, for example – or a more psychological one such as interpretive phenomenological analysis. In considering methodologies, it is useful to reflect upon what exactly is the focus of the study – differing methodologies are better suited to drawing out different aspects to a study, or indeed to different researchers’ personalities. Thus, there is no one correct or ideal methodology, only the one that best fits both the research question and the researcher themselves. When I was first reading about Heideggerian phenomenology, there was an immediate resonance with it; a sense of ‘I also think like that’. Phenomenology is the study of phenomena and the experiencing of that, whilst also recognising the socio-cultural environment in which the experiencing takes place.

Take for instance, a Pinard stethoscope. Some people may not recognise one – if asked, ‘What is its purpose?’, they may struggle. Is it a toy telescope? Could you put it on a shelf with a plastic flower in it? Others may recognise it as a medical instrument that is used by practitioners to hear a fetal heart. Yet for ourselves as midwives, it represents our profession – we recognise it as not just a tool we use regularly, but a historic symbol of our profession; its meaning for us embraces our personal psychosocial understanding. Phenomenology seemed to reflect the balance between psychology and sociology that I had been seeking, and that I’d argue midwives also recognise within their work. It does not seek to give answers or build a theory, but to aid understanding of how an experience may affect an individual.
Descriptive and hermeneutic phenomenology

Phenomenology may be either descriptive or hermeneutic (interpretive). Descriptive phenomenology comes from the work of Husserl. A key aspect of descriptive phenomenology is ‘bracketing’ – being able to identify and suspend prior beliefs and suppositions to avoid contamination of the data, which may initially appear an appropriate, if difficult, aspect. However, within hermeneutic phenomenology, prior beliefs, whilst also being acknowledged, are used rather than ignored completely and form, together with the data from participants, a co-constitution of findings. Dahlberg refers to this acknowledgement as ‘bridling’ – recognising and managing prior experience for the benefit of the study. This concept derives from Gadamer’s acknowledgement of prejudice, not in the contemporary understanding of the word as pejorative, but as ‘pre-judgement’ or prior understanding. As midwives, we bring with us a wealth of previous experience as well as prior reading and research which may be pertinent to a study. Within hermeneutic phenomenology that is considered of value and, whilst not overwhelming the insight and experiences of participants, is used to extend understanding in a ‘fusion of horizons’.

Existing hermeneutic phenomenological studies of midwifery highlight the importance of working with women, as they uncover women’s experiences and feelings beneath previous assumptions. From my own study of couples becoming parents following IVF, the tentative nature of pregnancy and the differing points at which they felt back on the planned trajectory to parenthood were significant; through understanding a parent’s perspective, one can start to address their needs. Similarly, Feeley’s study of freebirthing was able to uncover how freebirthing enabled women to claim their birth as their own and highlighted perceived coercion; a finding which may challenge midwives to reflect upon their own practice of information sharing.

Heidegger was a student of Husserl’s, and whilst Husserl considered that experience could be understood in isolation from context, Heidegger emphasised the importance of time and place as influences on our experience (exemplified in the title of his major work Being and Time). In considering our previous suppositions, he refers to forestructures as the basis of interpretation which include: forehaving – our familiarity and understanding of the phenomena; foresight – the interpretive approach; and foreconception – our expectation of what may be found reflecting the past, present and future of our thinking. This links with a reflective approach that underpins our professional development.

Whilst acknowledging the influences on our thinking, it is important that subjectivity should not unduly influence the gathering of data through interviews. Within hermeneutic methodology, interviews should be open-ended and unstructured using only occasional ‘encouragement’ prompts such as ‘tell me about when...’; ‘could you tell me more’ to elicit the participants’ understanding of what mattered to them. For my own study, I used couple interviews which revealed a specific perspective; not his, nor hers, but theirs. This may differ from the responses that just the mother or just the father may offer, but hermeneutic phenomenology recognises that there is no absolute truth – everything is subjective and dependent upon time and place. For example, within midwifery, a woman’s perspective on epidural analgesia may change from the antenatal period, during labour and in her postpartum reflections – one would not dispute that she was expressing the truth of how she felt at those differing points in time. Similarly her accounts will change if she is discussing it with her own mother, a pregnant friend or her midwife - one would not claim that they were untruthful accounts.

In considering methodologies, it is useful to reflect upon what exactly is the focus of the study – differing methodologies are better suited to drawing out different aspects to a study, or indeed to different researchers’ personalities.
Philosophy as a research method

Heidegger was a philosopher; he did not propose methods of research, and it lies with researchers themselves to consider appropriate data analysis. For my own study, I used Diekelmann et al. which I adapted to reflect the time point and longitudinal trajectories of the data. Whilst focusing on individual interviews it also considers the whole – reflecting the concept of the whole being made up of constituent parts and the parts making up the whole. This reflects person-centred care. Themes arising do not relate to how often an idea is mentioned, but instead to its significance of meaning, with interpretation beginning during the interview itself in the areas that are encouraged and followed and those that are not. Data analysis requires technical process and rigour, but also intuitive insight in considering meanings; thus it is both a science and an art – reflecting the midwifery profession itself.

Heidegger and his philosophy encourage us to think for ourselves, not replicating others’ views. This ‘dwelling with’ the data, whilst initially daunting, can enable differing insight than that gained by traditional thematic analysis. The concepts behind the meanings arise from Heideggerian philosophy with findings comprising participants’ insight, the researchers’ understanding and application of philosophical ideas. Thus, it is a unique piece of work itself and its applicability is evidenced in the ‘phenomenological nod’ as others relate to and acknowledge the resonance within the findings. Hermeneutic work is not supposed to develop theory, nor prove a point – instead it is about suggesting how individuals may perceive and interpret their experience, assisting the intuitive health professional to understand and propose support for a mother or parents. Hermeneutic studies of midwives’ experiences enhance management and understanding of possible support needed. Rather than broad data of retention rates and sickness levels, it can drill down to indicate how midwives feel, prior to how they may then respond, to enable proactive intervention. This is why it is useful for midwifery research and knowledge.

Heidegger makes no differentiation about the roles of women or men – only of people, and rarely directly refers to
healthcare. The value of using his philosophy within research is that it encourages deeper thinking, maintains a focus on meaning rather than responses and provides a structure in which application to practice becomes possible. As a research methodology it is immersive and reflective, which can appeal to those midwives who seek insight into what may lie behind an individual’s actions or behaviours. The person Heidegger was may not seem relevant to contemporary midwifery studies, but the concept of the nature of being is pertinent to any study seeking to understand experience.

Practice and critical learning points

- Consider how your own experiences and perspectives influence the care you provide – in acknowledging this, recognise how it may influence the advice and guidance you may offer women in your care.
- Reflect upon how you interact with those in your care – do you always consider how they may perceive their past and current experiences?
- When reading or undertaking research, maintain a critical approach and consider the synergy between underlying methodology and research aims. **TPM**

References

Being Empowered to Reduced Unnecessary Medicalisation of the Latent Phase

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Summary

Medical care saves lives, but the biomedical model of care should not be the dominant model in maternity. By offering some insight into global definitions of the latent phase and associated outcomes of a prolonged latent phase, this article highlights how the unnecessary medicalisation of the latent phase occurs within the UK. Discussion surrounds how midwives as a group can claim empowerment and prevent unnecessary medicalisation through leadership, thinking beyond guidelines, constructing midwifery knowledge and listening to women. It acts as an introduction for midwives to suggest how they can change their practice as a professional group.

Introduction

It is important to recognise that the appropriate use of medical care in maternity saves lives. However, it is equally imperative to note that unnecessary medicalisation can result from non-evidence-based practice, leading to harm and abuse. Therefore, it needs to be considered how midwives, the experts in normality, can be empowered to challenge unnecessary medicalisation. As midwives, we are challenged by our experiences; with the majority of UK births being in hospitals, midwives and students are accustomed to a highly technological environment that can result in over-medicalisation. Although the structure of maternity care is changing nationally, it cannot be assumed that midwives will feel more empowered to challenge care by working in continuity of care models. This article considers the unnecessary
medicalisation of the latent phase, deliberating the definition of the latent phase itself, and how to be empowered to embrace knowledge and change practice

The latent phase

The term ‘prolonged latent phase’ is one midwives are familiar with, where parameters of time and cervical dilatation are set, and when women’s bodies do not conform, they are referred to an obstetrician. However, to identify a prolonged latent phase, there needs to be a definition of where the phase begins and ends. There are global disparities in what constitutes the latent phase. Systematic reviews\(^2,3\) have reported significant heterogeneity in global definitions of latent phase onset. The definition for the end of latent phase and the beginning of active phase has similar challenges, with definitions by the National Institute for Health and Care Excellence (NICE)\(^4\) and the World Health Organization (WHO)\(^5\) focusing on different cervical dilatations; definitions that are problematic in themselves as they assume the woman or birthing person requests examination. Interestingly in the Netherlands, guidance\(^6\) states that there is no evidence to support the term latent phase, asserting it can only be recognised in retrospect and is not clinically relevant.

Do you think defining a latent phase is clinically relevant?

Despite the global heterogeneity in latent phase definitions, studies have been carried out to review the effects of a prolonged latent phase. There are reports that a prolonged latent phase causes higher rates of intervention for augmentation,\(^7,8\) higher rates of caesarean sections\(^9\) and increased risk of poor neonatal outcomes.\(^7,9\) Despite each of these studies defining a prolonged latent phase differently, all reported the increased use of intervention when a prolonged labour was diagnosed. Therefore, it could be questioned if the negative effects documented, such as poor neonatal outcomes, are due to the diagnosis of a presumed prolonged latent phase and the subsequent interventions, rather than the hypothetical prolonged latent phase itself. The existence of the latent phase and its relevance to practice could be incessantly debated, but whilst the term latent phase is noted to be of clinical importance in UK guidance, midwives need to consider how we can be empowered to reduce unnecessary medicalisation.

Claim empowerment

‘If midwifery practice is to empower women, then midwives must experience empowerment themselves.’\(^10\)

Midwifery, as a caring role, is societally associated with the woman, a gender that has been consistently disempowered through UK history. In addition to this, midwives have historically been in a gendered professional hierarchy with male obstetricians. Whilst gender roles are changing, both in midwifery and obstetrics, there is still an argument that midwives work within a gendered hierarchy. A critical discourse analysis\(^11\) reported in one maternity unit that midwives used language that reinforced their own lower hierarchical position by referring to each other as ‘girls’. It is interesting to note that the use of infantile language between midwives (but not towards female obstetricians) is reflective of a study exploring language in relation to infant feeding,\(^12\) whereby using infantile references was a way of creating power in a midwife-woman relationship. By referring to one another as ‘girls’ or other language associated with a power imbalance, midwives are potentially disempowering themselves further, therefore diminishing our ability to challenge medicalisation. It could be suggested that through language alteration, midwives could claim empowerment by changing socially constructed views of womanhood and the role of the midwife, thus promoting destruction of a gendered hierarchy.

Have you ever been referred to in a way that causes you to feel disempowered?
Leadership in midwifery is expanding, with the Chief Midwifery Officer, directors of midwifery and consultant midwives. Whilst these are positive changes, consideration needs to be given to how leadership can affect empowerment. Recently, the Royal College of Midwives’ Chief Executive stated she would no longer talk about ‘normal birth’. For some, this is challenging the integral role of the midwife. It risks midwives being disempowered by authoritative figures and thought needs to be given as to how we can be empowered by our social group, as all midwives have the ability to be a leader.

Whilst not specific to the latent phase, the ‘Birth outside the box’ forum at the University Hospitals of Derby and Burton provides an exemplar of a midwife claiming empowerment, and the benefit of social media to enable instant sharing of leadership ideas. The initial idea of one clinical midwife to improve birth experience in theatre rippled into the involvement of the whole multi-disciplinary team, changes in local practice and national recognition of the #theatrechallenge campaign.13 It could be suggested that debate surrounding the latent phase on social media could act as a platform to empower midwives, as we may accept conformity of other midwives who highlight the need to demedicalise it. This could enable midwives to claim empowerment of the latent phase as a global group.

*Can you think of leaders you work with who have helped to change practice and consider what qualities they possess?*

**Think beyond guidelines**
It is questionable whether midwives are empowered to reduce unnecessary medicalisation of the latent phase when constrained by obstetric-based guidelines. Encoded knowledge, such as guidelines, is based on limits and definitions, a result of Cartesian dualism (the split between body and mind, and the basis of the biomedical model of care). As midwives caring for women in labour, we recognise this divergence within guidance where labour parameters are set by cervical dilatation, promoting the woman’s body as a machine, with non-conforming measurements showing a flaw in the physiological process. It has been asserted that utilising guidelines can decrease the incidence of unnecessary medicalisation. However, in latent phase where there is such heterogeneity in definitions, the guidelines are weak and the biomedical data they are based upon does not account for the psychological, social, cultural and spiritual influences in labour.

The focus on guidelines enables set parameters which is ideal for a maternity system that is based on risk-talk requiring numerical data. But risk-talk does not embrace the holistic paradigm, and neither does it empower midwives to use a non-biomedical model of care. Risk is likely to continue being the dominant discourse in maternity; consequently, it needs to be considered how midwives can be empowered to challenge unnecessary medicalisation of the latent phase within a risk-based system.

Have you ever worked ‘outside’ of your local hospital trust guidelines for latent phase care?

Construct midwifery knowledge
To reduce fear related to risk and to build trust, the roles and knowledge of the midwife and obstetrician must be embraced and valued,\textsuperscript{16} where traditionally there has been a physiology versus pathophysiology divide. Theoretically, by embracing each profession as suggested, the risk-based system cannot just rely on the encoded knowledge provided by guidelines.

Embodied knowledge (intuition and experience) also needs to be considered, but empowering midwives to use this in a risk-based system is not straightforward. Where embodied knowledge is not accepted, midwives may act covertly and inaccurately document labour findings, such as cervical dilatation.\textsuperscript{17} This potentially disempowers them further and challenges professional integrity. In addition, inaccurate documentation may negatively affect the strength of future research and understanding of labour.

Perhaps the increasing acceptance of midwifery researchers within maternity and academia will bring a wealth of maternity research challenging the biomedical model of care, which will subsequently empower midwives globally. It has been questioned whether feminist epistemology is beneficial in constructing midwifery knowledge: if building theories with other feminist theorists could potentially inform practice.\textsuperscript{18} Whilst knowledge with a feminist perspective could promote and empower midwives to use their embodied knowledge, it could be flawed by the assumption that women all think in the same way, with identical socially constructed notions of motherhood, rather than focusing on women’s individual needs. Thus where embodied knowledge is embraced, midwives need to be mindful of their own biases.

\textit{Can you reflect upon a time you have used embodied knowledge to guide your practice?}

\textit{Just listen}
Conversely, it could be suggested that midwives would be more empowered by the simple act of listening to women and truly being their advocates. However, listening is a skill that requires time and attentiveness,¹⁹ and is therefore potentially challenged by place of birth and resources. Reasons for intervention in the latent phase may not just be due to a biomedical model of care being dominant, but also due to the lack of physical and personnel resources in an organisation.²⁰ Thus, intervention may be due to a lack of space to care for women in latent phase who decide to attend hospital, but also a shortage in midwives. The solution to increasing staffing is not straightforward, but decreasing intervention will reduce healthcare costs,¹ theoretically increasing financial resources for further midwife-led care provision. Whilst staffing is a challenge, a continuity of care model that enables a trusting relationship to be built with women could empower midwives to find the time to listen to women and their wishes, and provide us with a reassuring certainty within the uncertainty of the latent phase of labour.

Conclusion
Overall, it is evident that the research and guidelines surrounding definitions of the latent phase of labour and what constitutes a prolonged latent phase have huge disparities, thus challenge the risk-based maternity system and expose how women may be subjected to unnecessary medicalisation. Midwives have historically been disempowered by their gender and profession, yet as the main caregivers in maternity care, we need to be empowered to prevent unnecessary medicalisation. The empowerment needs will be individual to the midwife, for example, one may need to contemplate the language they use with midwifery colleagues and how this impacts their lower- gendered hierarchical position. Whilst midwives individually claim empowerment, they may be supported in their journey through positive leadership and the risk discourse embracing embodied, as well as encoded knowledge. The maternity context is changing continually as new policies and reports are published; therefore, the empowerment needs of midwives will be on a continual timeline as it adapts to the current situations. Although this article has discussed how midwives can be empowered to prevent unnecessary medicalisation of the latent phase, the examples are not exhaustive. There has been no exploration of empowerment of women before they become midwives, the role of midwifery education, or in-depth discussion of political influences and the need for latent phase research focused on physiological birth. Further research and discussion regarding empowerment of midwives may enable a greater understanding and improve care for women. TPM

References


Matricentric or Medically Responsible: An Exploration of Midwives’ Attitudes Towards Caring for Women and Birthing People Who Choose to Birth Outside of Guidelines

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Summary

Matricentric care centres around the birthing woman/person and acknowledges the systems and structures that may impact upon them and their experience. Choice is embedded into modern maternity care, with multiple human rights legislations supporting an individual’s rights to accept or decline care. In practice, birthing people have reported incidences of facing opposition or feeling unsupported in their choices, which has the potential to lead them to pursue other options exposing them to more risk. Midwives play an integral role in supporting birth choices and providing respectful maternity care, and as such it is crucial to identify factors affecting this.

Introduction

Birth outside of guidelines can be defined as choices that fall out of line with national clinical guidelines and policies.
Women and birthing people value having opportunities to consider and plan for their birth, and support and choice from a midwife has been shown to be integral in this. Rayment et al also concluded that adequate information to make a choice was key, along with challenging the assumption that obstetric units are best for all women.

Matricentric care is focused on midwives fostering and protecting these essential human rights. A meta-ethnography, including five studies appraising midwives’ experiences of caring for those making unconventional birth choices, identified a spectrum of midwives’ views and the key role of the midwife in facilitating birth choices. This study aimed to explore the attitudes and feelings of midwives who care for those who choose to birth outside of guidelines, focusing on perceived barriers, previous positive experiences and how comfortable midwives feel providing care.

**Methods**

**Design**

A 14-question online survey was designed using Qualtrics software to capture the thoughts and feelings of midwives regarding caring for those who birth outside of guidelines (TWBOG).

**Recruitment**

The survey link was shared solely via social media with relevant permissions.

**Questionnaire**

We collected both qualitative and quantitative data, with a variety of free text, multiple-choice and Likert scale questions. Open questions invited participants to share their feelings and comfort levels when caring for TWBOG, any barriers they perceive to be present, and their positive experiences. The time constraints of the MSc study precluded a pilot study.

**Sample**

Recruitment followed a non-probability convenience method, with participants volunteering to take part anonymously by following a link to the online survey. The survey invited participation from UK midwives. Data collection occurred over a period of 14 days in January 2020.

**Data analysis**

Quantitative data were analysed to determine the relationships between selected variables using Pearson’s Chi-Square tests. Quantitative tests were carried out by a statistics specialist at Swansea University using SPSS data analysis software.

Qualitative data from the free text answers were analysed using the Braun and Clarke method of thematic analysis, using NVivo12 for qualitative data analysis. The data were first read, then re-read and coded thematically by author A. Author B reviewed the codebook and nodes within NVivo to confirm themes.
Quantitative findings

In total, 707 midwives responded to the survey, equating to 1.9% of UK registered midwives. Midwives from all four countries responded: 62.07% of respondents were from England (n=437), 25% were from Wales (n=176), 6.96% were from Scotland (n=49), and 5.97% were from Northern Ireland (n=42).

Most roles within midwifery were well represented. Most respondents to the survey work within the NHS (92%, n=653). Independent midwives represented 3% (n=21), with the remainder of respondents working in education, the private sector, or not currently practising.

Respondents were questioned both about planning birth outside of guidelines and supporting TWBOG during labour. There was no significant difference overall between how respondents felt when planning birth and providing care in labour. Overall responses indicated that midwives agreed with feeling curious, uneasy and nervous, and disagreed with feeling afraid. That said, some midwives expressed extremely negative views. Community midwives felt more excited and less uneasy and nervous than hospital midwives. Perhaps this reflects the role of the community midwife in supporting women and birthing people to plan for labour and birth. When asked whether care provided is affected by the choice to birth outside of guidelines, 63.73% of respondents answered ‘no’ (n=448), 25.60% answered ‘maybe’ (n=180) and 10.67% answered ‘yes’ (n=75). Hospital midwives felt that the care they provided was more likely to be affected than community midwives. The responses of independent midwives reflected a more positive view of supporting TWBOG, with none of the independent respondents disagreeing with feeling excited, compared to 27.25% of NHS respondents.

Pearsons’ Chi-Square tests identified seven statistically significant relationships between variables:

1. Midwives who had been qualified for longer felt more comfortable caring for TWBOG. The highest levels of comfort for midwives qualified between 16 and 24 years.
2. Role affected level of comfort caring for TWBOG. The majority of community midwives reported some level of comfort. A greater number of hospital midwives showed some discomfort.
3. Midwives who felt supported by leaders felt more comfortable caring for TWBOG.
4. Midwives who felt less comfortable caring for TWBOG desired more training in this area.
5. Further training in caring for TWBOG was most desired by midwives who had been qualified for the least number of years.
6. Role affected whether midwives felt that if an individual declines any aspect of recommended care in labour, it may impact on the midwifery care that they would give her.
7. Midwives who wanted more training in caring for TWBOG felt more uneasy when reading birth plans of TWBOG.

Qualitative findings

We identified five key themes: ‘As long as’/fear of implications; challenging women and birthing people/negative relationships; coercion; organisational resources/time; person-centred care.

‘As long as’/fear of implications

The phrase ‘as long as’ was used by 162 respondents, indicating that clinical context and risk was important when considering TWBOG. Many referred to their professional registration/career, commenting they feared the professional implications of a negative outcome. Many midwives referred to repercussions, disciplinary action and lack of support. Some extreme views were expressed, with one midwife commenting that they ‘can usually persuade them to follow guidelines’.
Midwives felt confident in supporting women and birthing people only ‘as long as’ certain conditions were met, such as ‘a full and informed discussion prior to labour starting’ and ‘counselling properly and understands the risks fully, so that if a situation arose they are aware of what that could mean’. Some respondents also referred to the individual’s right to choose their care pathway:

‘More than happy if she has made a fully-informed decision. The risk is not ours to take’

This demonstrates a belief in women and birthing people’s right to exercise informed choice, but also suggests shifting accountability to the individual and an alignment with the language of medicalised practice.

Some midwives referred to the restrictive nature of guidelines, stating that they ‘prevent you from giving holistic care’ and that deviating from guidelines can be ‘really freeing’. Other respondents appeared more concerned with the implications for themselves rather than those under their care:

‘I think as long as the senior staff offer a good support system for the midwife to support the woman’s choice it would allay my fears’

The repeated use of the phrase ‘as long as’ could be seen as a protective, caring statement in line with the midwife’s role, which is to promote informed decision-making.

Conversely, for some midwives, TWBOG provided them with the chance to exercise their professional autonomy:

‘I find it exciting and interests me when women challenge the guidance, I think many are right to do so and I love supporting choice’

This theme also highlights midwives’ discomfort when women do not access the support and birth guardianship offered.

Challenging women and birthing people/negative relationships

This theme (543 respondents) acknowledges difficulties that midwives might face when supporting people who may be challenging, obstructive or even combative in their relationships with care providers:

‘The women themselves often are defensive expecting negative communication’
However, some of the responses reflect the midwife’s authority and the institution of medicine, and the assumption that women and birthing people should defer to this authority:

‘The lack of respect from parents for evidence-based practice and safety for mother and unborn’

Furthermore, midwives appeared disturbed by situations where their knowledge, experience and professionalism are not accessed or respected by the birthing person.

‘Unable to provide the best or safest care I can because of choices’

This suggests that midwives maybe uncomfortable when the exercise of ‘informed choice’ is against recommendations. There may be degrees of deviation from guidelines, some of which are more tolerable than others. One respondent recognised that women often feel ‘passed from pillar to post’ and ‘radical’ when deciding to birth outside of guidelines, and can ‘take longer to let you build rapport or even communicate’. Some responses suggest the rigid adherence to guidelines and guideline-based practice works against midwives practising effectively and supporting informed choice and humanistic care.

That said, some responses reflected negative views of healthcare staff, which perhaps explains some of the barriers that midwives face:

‘Staffroom slandering, that ‘does she not love her baby?’ attitude. Doctors treat these women like naughty kids’

From this, we can infer a clash of cultures between a ‘truer’ midwifery ideology and the exercise of midwifery values, and a potentially deeply ingrained, inherited culture of patriarchal paternalism and reductionist medicalisation which fails to respect women and birthing people as experts in their own lives and bodily knowledge, and midwives as experts in providing person-centred care.

One midwife cites a ‘lack of trust’ and certainly this is unlikely to support a positive birthing environment or a positive workplace. Midwives also repeatedly cite issues with those in positions of greater power than their own:

‘External pressure from obstetric team, you’re then caught between two worlds and being stuck in the middle is difficult’

What is most telling in this theme is how vulnerable midwives feel to judgement, censure and professional criticism.

‘Fear of being labelled as a reckless midwife’

**Coercion**

Fifty-nine respondents referred to coercion in their responses. Although midwives in this study cite the fact that decision-making often involves ‘compromise’, they also state that varying degrees of psychological force bring women and birthing people into line with guidelines:

‘Obstetric concern which can sometimes manifest as bullying or coercive, sometimes resistance comes from other family members’

The use of ‘coercive’ and ‘coercion’ appear in several of the responses to the questionnaire, often linked to the behaviours of obstetricians, but not always so:

‘Some of the senior midwives also will come and speak to the woman to talk her into compliance’
‘Consultants putting on pressure for women to ‘conform’, doctors telling women they are being selfish and their baby will die’

This links back to the previous discussion on authority, knowledge, power and trust, and speaks to a lack of trust in midwives from other colleagues.

One respondent displayed extreme views, stating ‘They won’t listen to my advice. I know better than [them]’. Other midwives appeared to recognise that coercion was unacceptable, however seemed unable to advocate this amongst their colleagues:

‘I feel like I have to lie and tell them that I have tried to persuade the woman to agree to their guidelines etc’.

Organisational resources/time

This theme was referred to only 44 times by respondents. However, common statements emerged strongly and frequently, which suggests systemic issues affect the ability of midwives to practise effectively and women to exercise their rights and agency:

‘System not set up to support either the woman or the midwife in this circumstance’

The limitations of ‘guidelines’, ‘institutional’ factors, ‘local policies’ and ‘birth centre eligibility criteria means not accepting women who would otherwise choose to birth there’ all affect how midwives support women and birthing people. This absolutist attitude derives from a perception of guidelines as ‘rules’ and the false idea that the guidelines are completely right for everybody.

‘Stand-alone birth centre guidelines are not clear enough, for example some issues say ‘individual assessment’ – what does this actually mean?’

Further responses referred to resource-based issues such as ‘management have closed home birth services due to lack of staff’, which clearly impacted upon choice. Other respondents, however, cited smaller issues as barriers to supporting TWBOG:

‘Failure to have time to get to know the woman’

‘Extra paperwork, risk assessments’

Person-centred care

The final theme identified was person-centred care, referred to 161 times by respondents. Many of the respondents find that there are benefits to supporting women as individuals, and align supporting choice with their core values and practices:

‘Choice is absolutely central to the care I give’

Midwives appeared to experience positive benefits to supporting women in this process of self-determinism and agency:

‘Feedback from women about feeling empowered, listened to, proud of themselves etc’

This is a feature of professional satisfaction for midwives and relates to the relationships they build with birthing people. However, there is also evidence in this theme that midwives may place a limit on their provision of person-centred care:
'I support women’s informed choice but within the safe practice remit of my registration’

The sense of caution here aligns with earlier themes. Nevertheless, most midwives associated referred to supporting women to birth in autonomous ways and having positive experiences:

‘I feel it is important that women take charge of their own births, and often their choices will optimise their physiology and their spiritual experience of birth’

From this, it is possible to see that rather than being a professionally risky and maternally irresponsible issue, birthing outside guidelines is, in fact, a part of an empowered and powerful experience for both mother and midwife.

Discussion

There are some key issues that emerge from this study. The first is the evident fear of implications for midwives, meaning that they qualify their readiness and comfort in caring for TWBOG with conditions; ‘As long as’ the birthing person is informed, the midwife may feel safer. This raises questions about the meaning of ‘informed’ in this context. The responses within this theme infer consistently the idea that the authoritative knowledge lies with the professionals, which must be imparted for women and birthing people to make decisions. Midwives’ confidence might relate more to confidence in their accountability rather than their confidence in the individual making the decisions. Does this relate to the evolution of midwifery professionalism and increased medicalisation?

Wright et al. identify medico-legal issues as a source of professional stress for midwives. The idea that midwives’ care is conditional runs counter to the core principle of unconditional positive regard that should underpin all our activities. This is a critical point for institutions to consider, particularly as the role of the midwife should be and is matricentric, suggesting that the discourses and practices of midwives should be matrifocal. Yet the data suggest that midwives are greatly concerned with their own accountability.

Whilst some midwives find it liberating to facilitate informed choice, others are less than comfortable. This may reflect our cultural constructs of authority, power and control in birth. Madeley et al. in their qualitative study of midwives caring for with complex needs choosing home birth, identified the ‘radical midwife’ and relate this to a tension between ‘traditional beliefs and practices, physiological processes, midwife knowledge’. Our study reflects this, drawing on tension between midwifery ways of knowing and being; the matricentric midwife, and professional ways of knowing; the medically responsible midwife. The dichotomy between guidelines as a representative of medical control and midwives’ role in promoting autonomy relates to fears, which points to potential reasons why midwives might become less willing to support women and birthing people’s autonomous decision-making when it runs counter to the dominant will of the institution, as made manifest in the guidelines. The only real solution to this would be to change the nature of guidelines, and to instil in healthcare culture a new belief in the power of guidelines to inform practice, rather than defining or restricting it. This may then remove the pressure and coercion that has been identified in the qualitative themes.

Using threat to force a person to comply with recommended action is illegal. Deviance and conformity are socially derived constructs embedded in and shaped by social values of gender, behaviour and professional power. It is a concept that has emerged in other research and debate and speaks to the role of conformity within medical systems. In this case it is possible to see this made manifest in the microcosm of maternity care through the enacted power structures referred to in the data. Guidelines are not rules or laws, but a guide to support mutually respectful and individualised decision-making and care planning. They should be a pillar of person-centred care, something that the midwives in our study associated with their role and values. The study suggests that guidelines affect the autonomy and agency of both parties in the professional-person dyad and need a critical and radical rethinking.
Our study suggests that certain factors affect the comfort level and feelings of midwives. Length of time since qualification affected levels of comfort when caring for TWBOG, with those qualified for between 16 and 24 years feeling the most comfortable. This suggests that building midwives’ confidence in respecting and supporting choices might be needed in certain groups, particularly in those who have been qualified for fewer years. Bäck et al\textsuperscript{15} suggest that feelings of confidence and competence evolve over time, however Bedwell et al\textsuperscript{16} argue that it is the influence of colleagues that affects midwives’ confidence. Perhaps supporting informed choice in this regard comes with time and experience, but maybe more work with midwives with less experience would support them to develop more comfort with TWBOG.

Levels of comfort when supporting TWBOG may vary according to role. Most community midwives reported some level of comfort, whilst a greater number of hospital midwives showed some discomfort.

There was a statistically significant relationship between role and feeling that an individual declining care would impact upon care given. This may relate to a medicalised culture that persists in Western maternity care. Jenkinson et al\textsuperscript{17} discuss how a medicalised culture limits maternal autonomy, and enculturates women and birthing people into a limited maternal role holding them to account for their choices in restrictive ways.

Midwives wanting further training shows a potential desire to feel more prepared for caring for TWBOG. Bäck et al\textsuperscript{15} link competence to learning. Perhaps midwives need more training or learning opportunities to understand women and birthing people’s perspectives and knowledge about birth\textsuperscript{7} or indeed to unpick the impact of medicalisation and current birthing systems on autonomy. It might also be that midwives need clearer training and guidance on respectful maternity care\textsuperscript{18} and human rights.\textsuperscript{19}

**Limitations**

The study was designed to gather information identified through literature review and professional interest, but the questionnaire was not validated or piloted before use.

**Conclusion**

Our research shows that professional and cultural issues, organisational factors and leadership and management/issues all
impact on midwives’ ability to provide truly person-centred care. Yet it is vital that midwives can adhere to their philosophies of matricentrism as this supports them to create the conditions for positive birth experiences. Rather than viewing women and birthing people exercising choice and autonomy as ‘risky’, midwives view it as a sign of empowered mothers and empowered midwives. It is vital therefore that midwife leaders and managers, and midwives themselves, use this as a starting point to interrogate their own practice. Strong leadership is required from managers who also respect midwives and who push back against the systems that constrain them unnecessarily.

The power of this study lies in its ability to encourage us to interrogate midwives’ perspectives and the precarious position in which they find themselves, caught between the power of the system of medicine and the philosophy of midwifery. Guidelines should support autonomous decision-making and provide a framework to aid mutually respectful conversations between service provider and service user. A matricentric midwife is one who believes and practises person-centred care in which the birthing person’s power is celebrated, valued, respected and honoured. A medically responsible midwife combines matricentrism with care that empowers women and birthing people to feel fully informed and ensures that they are not alienated from or excluded from full access to all medical intervention and support should this be needed, regardless of their choices. It is time to rethink the ways that we view and use obstetric guidelines and consider reframing our practice to reflect humanised maternity care within a matricentrism and inclusive culture of respect for personal and professional autonomy. **TPM**

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**Ethical approval**

Granted by Swansea University College of Human and Health Sciences Research and Ethics Committee [180919a].

**Caveat**

Alys is now Editor-in-Chief of The Practising Midwife. This article was submitted prior to her appointment and independently peer reviewed.

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**References**


Are We ‘Just’ Midwives or are We All Advanced Practitioners?

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Summary

Midwives in recent times have expanded their skill set beyond recognition. Where once it appeared novel to complete a newborn examination, now we are being trained in external cephalic version (ECV) and caesarean section checks on elective cases. All these additional roles come with advantages and disadvantages for both midwives and women. As midwives we may get job satisfaction, but are there not already enough pressures on our time? It feels like we are in the midst of creating a somewhat ‘super midwife’. Someone who can perform the most detailed checks on women and babies, prescribe everything and be a one stop shop.
Introduction

The rise of the profile of advanced practitioners within nursing has been well documented. These are nurses who have decided to expand their skill set and specialise in certain areas, often performing tasks that are synonymous with a junior doctor role. Advanced practice itself has its own set of values and ‘pillars’ to be adhered to, encompassing an extended degree of autonomy and advanced decision making, clinical practice and competence, leadership and education and research. These pillars and values should sound familiar. As midwives, we are very familiar with being autonomous practitioners, being advocates for the women in our care and keeping them and their babies safe. This often involves problem solving and the ability to ‘think on your feet’ when faced with often very serious scenarios which develop our clinical practice. We take responsibility for our own learning, attending not just the usual mandatory study days but also extra sessions that take our interest to enhance our care capabilities and ensure we meet the recommended standard for revalidation. This benefits our practice in a number of ways; it informs us of new evidence that is emerging in different fields; and it allows us to use evidence-based practice to inform the women and families in our care of the options available to them. This ensures they make choices appropriate to their needs. Midwives are leaders when it comes to practice improvement through the promotion of new best practice.

The difference between an advanced midwifery practitioner and a consultant midwife

All advanced practitioners within nursing, the allied health professions and midwifery should have a master’s degree in a relevant subject in order to fulfil requirements often set by employers. It is worth mentioning that there is actually no regulation for advanced practitioners. Nurses and midwives are still regulated by the Nursing and Midwifery Council (NMC), but consideration should be given to the Code, and more specifically, recognising limitations and practising within the remit of the practitioner.

Following qualification within midwifery, most additional skills, for example, the Newborn Infant Physical Examination (NIPE) course, are taught by way of postgraduate modules. However, with changes brought in by the NMC, universities are modifying and developing new curricula to ensure the future midwife is well equipped to deal with whatever practice may throw at them. This may mean that in future, only those wishing to pursue specialist roles, such as lecturers, uptake places on master’s programmes. The consultant midwife role is another one of these specialist roles that requires a certain level of education alongside experience. Consultant midwives provide support to women and their families, as well as a level of expertise to the unit they are employed by. They are often pioneers in the promotion of normality and link with other
professionals across the National Health Service (NHS) and the wider community, both nationally and internationally.

An advanced midwifery practitioner (AMP) is a much more ‘hands-on’ role and although highly skilled in their specialism, they are often used to fill the void left by an understaffed obstetric rota. They can be qualified to perform a range of tasks, from ECV to ventouse deliveries. This is particularly useful for a number of reasons; firstly it helps keep a maternity unit safe by providing an extra person of expertise where there previously would not be; secondly they provide a different viewpoint rather than a solely medicalised one that an obstetrician would bring. Thirdly, there is an aspect of continuity for the women. Even with these benefits, AMPs are still in a minority, with positions across the country few and far between. At the time of writing, a search for NHS jobs highlighted that there were no positions available for an advanced midwifery practitioner across the country.

The development of the midwife role

The traditional role of the midwife was to be a birth attendant for the labouring person. This was usually fulfilled by a lay woman who held no qualifications but was highly experienced in providing care. Gradually, this role has expanded as time has moved on. The Midwives Act, 1902 paved the way for regulation and since then, women’s health and the care they receive has massively improved. The end of the twentieth century changed midwifery – pregnancy and birth gradually became more medicalised, and midwives became lost in a sea of obstetricians and nurses. Thankfully, we seem to be finding our way back with midwives holding positions on panels at the NMC and in positions of authority to drive the profession forward.

From a trust perspective, the role of the midwife has been expanded at different rates, possibly due to a number of factors such as demographics, funding and management within each trust. Demographics and populations differ across the country; therefore, it may be difficult to implement an addition to the role when it is not warranted or there is not a need for a particular service. There may not be any funding for additional training courses, or simply management teams do not feel that extra duties are appropriate.

With extra skills come advantages and disadvantages, as one would expect. An immense feeling of pride and job satisfaction, and a clear career pathway within clinical practice are important for retaining experienced, competent midwives. These midwives are role models for newly qualified midwives who are building their skills and consolidating their knowledge. An up-skilled midwifery workforce contributes positively to the women and families in our care, alongside the wider government agenda, strengthening a continuity of carer model. The ability to build a strong relationship with the women and families, and continue this through the childbirth continuum, gives better outcomes and increased satisfaction than when care is fragmented. Unfortunately, as these additional skills are not often remunerated, midwives can also feel taken advantage of, despondent and eventually burnt out. Under the new agenda for pay, a newly qualified midwife
commences at a band 5 level, progressing to band 6 following successful completion of a time of preceptorship. Following
this, her career progression goes awry as opportunities are often limited in midwifery to ward management (including labour
ward coordinator/manager), other management roles such as risk management, or education-focused roles, for example
lecturing. There are very few opportunities for the clinical midwife to remain in a clinical role and develop herself.

**The future midwife**

As we are all aware, the NMC developed the new future midwife standards in 2019 in response to The Lancet’s series in
midwifery and from listening to key stakeholder groups. The six domains of the future midwife were developed to ‘future-
proof’ midwifery – our role is changing constantly on a local, national and international level. Even though the fundamentals
of the job description are essentially similar to that of ten years ago, there is now a need to update. Documents such as
Better Births, the triennial MBRRACE-UK reports and even independent reports on malpractice show how the profession
demands more of its members - and rightly so where lives are at stake. Universities now have the massive task of rewriting
their curricula to encompass these new standards and their perception of what the future midwife will look like. As
educators, we are trying to prepare students for being a midwife, an educator, a scholar, an expert. We are trying to prepare
them for the challenges of being a midwife on a daily basis, building resilience and arming them with the emotional
intelligence in order to support each other through the highs and the lows, and of course, the women they are advocates for.
We are at an exciting crossroads in education, with universities each forging their own path to enable their students to reach
the end goal, giving students the choice and opportunity to decide what they want out of the courses on offer; which one
best fits their needs. And as these student midwives qualify and become the experienced midwives of tomorrow, the
profession will assess how successfully we as educators have implemented the standards and what developments have
been made.

With regards to the advanced midwifery practitioner role, it is difficult to predict if more of these positions will become available. It would be a natural progression using the additional skills midwives will already have from qualification. However, to fulfil the definition of an advanced practitioner, a midwife requires experience and education. With this in mind, it seems unlikely that the AMP role will be developed any time soon, with postgraduate courses becoming absorbed into an undergraduate curriculum. The role of the midwife is in danger of becoming skill- and task-saturated, and those who want to develop clinically will have to embark on the usual career pathway and risk losing the skills they have worked hard for. There is also the additional hurdle of the justification for AMPs, with an ever-stretched NHS combined with a reluctance to embrace change as present in most organisations.

**Conclusion**

With the future midwife standards and refreshing new curricula, it would be a disservice to the profession not to harness
those skills and those who wish to progress further in a clinical capacity. The AMP role provides an opportunity for multi-disciplinary working as seen in other professions, job satisfaction, and ultimately benefits the women and families we provide care for. TPM

**References**

An Actionable Framework for Midwives and Healthcare Professionals to Help Reduce Sedentary Behaviour in Women in their Perinatal Period

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Summary

Being physically active during the perinatal period has many benefits for both the birthing parent and baby. Current Department of Health guidelines of 150 minutes a week can be abstract and broad for a lot of women. There are no clear pathways within the antenatal and postnatal care system to improve provision and support for women who may find enough exercise challenging to achieve. This article argues the need for a dedicated perinatal exercise science specialist within the care team for all women. The author also presents a simple framework modified from the World Health Organization (WHO) smoking cessation model to incorporate during routine appointments.

Introduction

As much as pregnancy and new motherhood is a time for positive health changes, most women find it hard to implement lifestyle changes that they may recognise as beneficial to them and their babies. Current Department of Health guidelines of 150 minutes of moderate intensity activity a week can be abstract, broad and inapplicable to a lot of women. Data suggests that even in normal circumstances, people are seven times more likely to go to an exercise class and 12 times more likely to become more physically active when the suggestion comes from professional quarters. At a time when we are all recognising the importance of physical, mental and emotional health in our chances of getting pregnant, having a
fulfilling pregnancy and reducing risks at birth, healthcare providers have a golden opportunity to engage perinatal women in a more active lifestyle. Yet 72% of GPs do not pregnant and new mothers). Key barriers seem to be lack of knowledge, confidence and resources.³

Why do we not talk about exercise?

In a recent study,⁴ midwives who were interviewed identified a lack of specific knowledge and training on giving exercise advice and guidance. They also said that physical activity was a ‘tick box’ for the booking appointment and there are no recurring prompts to discuss exercise throughout antenatal care. Antenatal care teams have specialist dietitians who can advise on food intake for women who need extra support. But we do not have qualified exercise specialists who know the nuances of pregnancy and postnatal exercise requirements. This omission has caused many care providers to shoulder the responsibility of promoting physical activity when they do not feel appropriately qualified to do so. Unfortunately, this leads to advice that can be generic, laden with personal bias and preferences, and that can cause a sense of anxiety in professionals who are not trained in exercise prescription. Considering the burden of sedentary lifestyles on the health of women and their families, we have an urgent need for specially trained physical activity promotion champions within the antenatal and postnatal care pathways. Now is the time to invest in more than posters and prompts. We are beginning to recognise the importance of the role of a trained mental health midwife; we need to see the benefits of the confluence of physical and mental health promotion holistically.

A supportive framework

As a starting point, we can at least begin to have meaningful conversations with women on increasing their activity levels during their perinatal period. The 5As model was developed by the WHO,⁵ and has since been used successfully in many fields, such as smoking cessation and obesity management, where GP contact is high but there are short appointment times. Based on my work in this area, I think this framework can also be successfully used in encouraging pregnant women and new mothers to be more active.

The 5As: ask, assess, advise, agree and assist

Ask

It is important to start by asking permission to talk about PA and its impact on pregnancy, birth and the baby’s future health. Approach this phase with non-judgemental curiosity and refrain from giving advice or talking about the benefits of PA. Not all women feel comfortable answering questions on their exercise regimes as many come from a legacy of trial and failure in a world of diets and exercise fads. We need to frame our questions to retain the sense of normality about PA. Vocabulary is key. Using terms such as ‘active’, ‘mobile’ and keeping things informal will allow for the conversation to open up.

Example: Are you keeping active?

Key points:

- ask questions and minimise statements
- use non-judgemental curiosity
• do not insist on talking about the benefits of PA at this stage.

Assess

There are no standard PA levels for pregnant or postnatal people and they should be developed. However, at this point a simple low/moderate/high assessment will suffice to ascertain the starting point.

This is also a good time to explore barriers to PA – both intrinsic and extrinsic – and perhaps explore drivers and motivations. It might seem daunting to assess barriers and motivations, but simple open-ended questions will enable you to identify key concerns.

Example: Is there anything that concerns you regarding doing exercise in pregnancy?

Key points:
• assess the root causes of sedentary behaviour – beliefs (intrinsic) and barriers (both intrinsic and extrinsic)
• assess any points that may motivate them – such as their own desire to be healthier or their baby’s health.
  Let them tell you.

The Ask and Assess stages create a collaborative relationship, demonstrating empathy and creating an environment where PA advice would be receptive and personal. Generic guidelines or posters can be ignored, or worse, can increase confusion, lack of connection and vagueness.

Advise

Ask permission to give advice but make sure your advice is clear and authoritative for meaningful impact. This is a great time to present the key benefits of PA for pregnancy/birth/baby. If you can suggest benefits that may be personally motivating to each individual woman based on your conversations, then your advice is likely to be more powerful and less like the generic posters in the media.

It might be beneficial to highlight the difference between ‘exercise’ and staying active through lifestyle choices, allowing the woman to look at her activities holistically as part of her day rather than yet another chore. This in turn reduces guilt and increases adherence to a plan.

Example: Now that I have a better understanding of your situation, can I recommend a plan of action to create more opportunities to be active in your day?

Key points:
• the advice needs to be clear and authoritative for it to have meaningful impact on a woman’s choices
• reduce guilt by suggesting active lifestyle choices rather than setting exercise regimes.
Agree

It is important to get agreement on an action plan. The woman herself needs to set PA as a priority in her life. If it’s not, she will disengage from the process. It is also important to get her to buy into the advice you give with the confidence that the advice is given with her particular situation in mind. She should not feel that her care provider themselves has any biases or barriers when they give the advice. Both of you need to agree on a plan that will bring realistic changes to improve PA levels. Target clear levels of PA that can be followed up on, and put in place behavioural changes that may need to be addressed in order to meet the PA levels agreed upon. Sometimes it takes more than one appointment to gain agreement – it should come through a trusting relationship that is based on the welfare of the woman.

Example: Walking your older children to school and back at least three days each week instead of driving is a great idea. As you say, you will be able to encourage your kids to walk a bit more too and your whole family will benefit.

Key points:
- the woman needs to identify PA as a priority in her life before agreeing on any plan of action
- you need to make sure your conversation does not bring in your personal preferences and biases of PA to ensure a high level of trust.

Assist

Assistance can be provided in the form of authoritative resources that have credibility. You can thus validate any recommendations you make based on the evidence. This is key, as most women will have heard many different things about exercise and don’t know what to trust. The source of your recommendation will reassure them, and also help educate her in seeking good quality information for herself, further enabling her to make her own choices.

Point to appropriate professional support if needed and arrange for regular follow-ups for accountability. This can be delegated within the community setting and reported back on a regular basis, creating a 360° setting of accountability reporting. This will ensure the woman feels supported in her decisions and when things get hard, she has the level of support needed to reconnect with her plan without feeling dejected or defeated.

Example: There is no data or good scientific evidence that suggest that moderate levels of PA can harm your pregnancy or cause miscarriage.

Key points:
- assistance should be evidence-driven, minimal but consistent
- create a 360° accountability setting of support via community and GP buy-in if possible

Midwives who were interviewed identified a lack of specific knowledge and training on giving exercise advice and
Conclusion

Knowing the benefits of PA across our lifespan, the impact of incorporating a PA pathway in all pregnancy and postnatal care packages, not just high-risk categories, is hugely important. I hope that with this simple, yet effective framework, we can start the conversation about more active lifestyle choices for women at antenatal and postnatal clinics. However, it is not enough to just start the conversation - it is important to keep the momentum going. Without a commitment to support women becoming and staying active throughout their lives, it will inevitably fall by the wayside.

In the UK we have amazing exercise science expertise. However, we need to focus this expertise on the perinatal period, as it is not just about serving women, but also getting it right for our future generations. The health impact, the long-term financial benefit to our health services and a collective culture of being active across all age groups starts with mothers and the babies in their wombs. TPM

References

Summary

It is common for newly qualified midwives to begin our professional practice with insecurity, doubting our capacity and the importance of the role we play in the health system. This often remains the same throughout our careers. Unfortunately, the training we receive is still based on a hegemonic-medical, controlling and interventionist approach. After decades of immersion in this model, there is also distrust in pregnant people themselves of their ability to give birth, or even how, where and with whom. In this article, Raquel Justiniano Gonzalez looks at Argentina’s current midwifery situation and what steps are being taken to achieve progress.

Introduction

To speak about midwifery in Argentina is to recognise its diversity. There are different models and approaches and one of the most prevalent is the hegemonic-medical model. Shortly after graduating as a Bachelor of Midwifery, I began an intense search for information and tools that would complement my professional training to provide comprehensive care as a midwife because – to be honest – I felt insecure. Although it does not have to be this way, it is common for newly qualified midwives to begin our professional practice with insecurity, doubting our capacity and the importance of the role we play in the health system, which often remains the same throughout our careers. Unfortunately, the training we receive is still based on a medical-hegemonic, controlling and interventionist approach and, after decades of immersion in this model, there is also distrust in pregnant people themselves of their ability to give birth, or even how, where and with whom.
Over time, I understood that this model controls our sexual and reproductive processes and interferes in the effective response and mitigation of inequalities in access to healthcare for women and families. Following this model without questioning its actions and repercussions, it is difficult to see more humane and dignified ways of caring for health, which go hand in hand with a growing new scientific evidence. The openness to recognise horizons that we do not yet know is fundamental. A critical analysis of the state of maternal/neonatal health and of sexual and reproductive health and rights in Argentina and globally is vital in order to understand where we are and where we want to go as midwifery professionals. Perhaps this will serve as a motor to continue investigating, discovering and learning from other models of care that could help us apply them within our context.

Midwifery in Argentina

Midwifery in Argentina, as in the rest of the world, is an ancient practice. However, the professionalisation that was developed in a historical and socio-cultural context has its first records in the late 18th and early 19th centuries. As the process of medicalisation of childbirth and the transfer of births to the institutions was installed, the practice of midwives began to be regulated, even before institutional training projects. Midwifery went through great challenges and obstacles linked to the patriarchal system. Midwifery training was considered a practice of the female gender and, in order to access this formal education, it was a requirement to know how to read and write – an unusual skill to have, given that many women back then weren’t allowed to go to school. There were ups and downs in access to formal education. Institutions were often closed to women because medical training was a priority for a specific sector of society. Later, the permission of a legal guardian or husband had to be obtained in order to study. Thus, midwifery continued for some decades to be practised outside the health system, mainly in vulnerable communities. As a new state-dependent health system was put in place, midwifery became considered as a role to assist the doctor: sometimes paid, many other times unpaid. In 1967, Law 17.132 was enacted – and which remains in force – in which the practice of midwifery is configured as a collaborative activity of medicine. This law limits our practice as collaborators in the care of pregnancies, births and postpartum, and puts doctors responsible in charge of care.

Despite the fact that the law limits the professional practice of midwives, in recent decades our competencies have
expanded far beyond attending births. Today, our professional training enables us to provide assistance in: sexual and reproductive cycles from adolescence to menopause; family planning; counselling; sexual education with a focus on rights and gender; prevention of sexually transmitted infections; prenatal and postnatal care; breastfeeding and childcare; research; and administration of health services, among others. These competencies, aligned with the standards of the International Confederation of Midwives (ICM), make us the ideal professionals to cover 87% of the basic sexual and reproductive health services of the population, according to the United Nations Population Fund (UNFPA).\(^7\)

**Advocacy, research and leadership**

Although our scope of practice is broad, sexual and reproductive health and maternal/perinatal health are areas in which enormous inequalities in access to care are evident, so morbidity and mortality rates have not improved. Professional midwives exercise their expertise within and outside the health system, because of outdated regulations and restrictions in most provinces of the country that limit practice within all our midwifery competencies. Argentina is a federal country that is made up of 24 jurisdictions. Fourteen of them still remain linked to Law 17.132, which has limitations in the professional scope. Thanks to the strong work of midwives on advocacy and leadership, 10 jurisdictions managed to update the law, so that all our scope of practice is contemplated. Various groups and associations are working hard to achieve new national legislation. It is a struggle, following several years of demand for autonomy, for full exercise of the profession to be recognised. In 2019, by unanimous votes, the approval of new legislation was achieved in the Chamber of Deputies. It was expected to pass through the Senate in 2020, but due to the pandemic it was postponed. Unfortunately, the draft legislation lost parliamentary status again in 2021.

This situation slows growth in the midwifery profession and exacerbates the gaps in meeting essential needs in terms of maternal and neonatal health and sexual and reproductive health. With a
national enforcement law that contemplates our full scope of practice, midwives throughout the country would have been able to provide comprehensive service to women and families, and thus contribute to improve health outcomes that have been set back due to the pandemic. Our advocacy work in the coming years will have to double efforts. We cannot be discouraged. We need to strengthen leadership and advocacy, and give more support to scientific research in midwifery that can influence changes in public health policies and midwifery practices. What we do and how we organise ourselves will be key in the following years, so we need all the support we can get to be able to achieve this. In May 2020, the College of Midwifery of the Province of Buenos Aires formed a Research and Leadership Committee to plan actions that strengthen these two areas: research and leadership. The objective is that Argentine colleagues as well as those from Latin America participate and coordinate joint actions to strengthen research and leadership. Work is also being carried out to open a new midwifery careers headquarters, since we urgently need to increase the number of midwifes throughout the country. Today there are 13 institutions concentrated in just one sector of the country, so access to education should be a priority.

Midwifery continued for some decades to be practised outside the health system, mainly in vulnerable communities

Conclusion

We believe midwifery can provide more to the community and contribute to the improvement of the sexual and reproductive health and rights of the population. Important milestones have been achieved, but there are still many goals to help change and promote the growth in our profession. **TPM**

References

Further reading

*To learn more about the state of midwifery education and scope of practice in Argentina, please refer to the following documents:


https://global-midwives-hub-directrelief.hub.arcgis.com/pages/ffe9d8f120594e95a14bdf435c2e1d8d