A Less than Typical Nursing Career

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A reflective account of the nursing career of an aspiring Eurythmic-loving, PhD student, specialising in Safe Motherhood and international women’s health. Richards discusses her path to midwifery, starting in the Art Room at school. She highlights the relevance, and importance, of a pot pourri of transferable skills in health care and beyond in midwifery training.

“Can you draw a diagram to illustrate your life and career so far?” My diagram is always the most complex: a sketch here, a mountain there, a roller coaster and sometimes even doldrums. My journey to midwifery has continued to follow a less than typical path. You can picture the scene. Most are nervous to present their masterpieces. Well, mine is always a Vincent van Gogh! If I were a scientist, it might resemble a map, perhaps, or if I painted, a Jackson Pollock! Although my journey has been unconventional, each step has played an important role in making me the midwife I am today.

I started my career as an artist, like my Dad. I was hopeless in Sixth Form, except in the Art Room. I rocked my black eyeliner and Annie Lennox hair. I was the talk of the town. My first two commissions were to my O level design and A level history teachers – a life lesson in how it feels to now be earning money (£5 a piece!).

Next, in my quest as an aspiring Eurythmic, I tried a Customer Service Assistant role at the local water board; a job from which I quickly got sacked, ironically, having flooded the kitchen! It taught me about health and safety, food hygiene, cleanliness, and getting to work on time. Then a barmaid in town, great for mental arithmetic, dealing with the public, keeping cool under pressure, putting your best face and smile on, developing a cracking wit, and turfing out at last orders! All good experience, and character building for nursing!

I even did a spell on a fruit and vegetable stall in the market. Now every time I add up the controlled
drugs, I think of them as a five pounds of potatoes and a quarter pound of mushrooms. A much simpler, but equally effective and time-tested calculation method. At this point in my career, I think I learned to be a judge of character and the importance of honesty. As a waitress, I gained competency in silver service (not wholly unlike surgical instruments in my later nurse training). Moving and handling bakery crates, keeping fit on the move, managing a caseload (a table of 6), the ultimate customer care skills, marketing a menu, note taking and documentation. I met some of my best and lifelong friends at this time. Needless to say, the significance of effective team-working has left an indelible impression on me. I started one job as a secretary (good photocopying experience), and on the first day bumped the boss’ car arriving in the car park. I knew, all things considered, I needed a true vocation.

I think it was my best friend who suggested applying for nurse training. “You’re good with people”, she said, “I think you’d like it”. Well, I have had a good start. I’d been a newsagent, as well, so I was used to early rising! I’d been sacked so many times from so many minimum wage jobs that the Job Centre offered me a post transcribing CVs, so, I knew it was in the bag when the brown letter landed on the doormat! I also knew how to work a photocopier by then from my secretarial experience, all skills beneficial to a productive nursing role. But Rule 1: try not to break anything.

A positive work-life (AND leisure) balance, that is the secret. Work hard, play hard. And we did! It was usually to the amazement of the matron that we passed our coursework at all! Eventually, I was a student nurse at one of the most prestigious, city institutions. I polished my badge and shoes with pride. My niece asking – “What have you got that cake box on your head for?” (back in the day of cardboard hats!) will go down in family history. Gradually I progressed from one to three epaulettes. I loved my training, albeit not the early starts, and especially I loved surgery and felt a natural inclination towards ITU. I applied myself well to learning with enthusiasm. It wasn’t long before we were supervised running wards and organising our own workload – quite some responsibility. But the true inspiration for me was my maternity placement. It was the autonomy of the midwife’s role that appealed to me; a highly specialist field that complimented what I had already learnt and built on my achievements so far. I liked the fact that mostly we dealt with people of a similar age to me and I found the well woman initiative a worthwhile endeavour supporting those in need, aimed at providing the tools that allow women to take their health into their own hands. Empowerment to manage holistic health was a real win-win in my mind.

The first birth I witnessed was spine-tingling. A special, momentous moment. I applied immediately, and was shocked to receive an interview before even qualifying as a nurse. I do not regret my post-registration route into midwifery. Having been a nurse, I appreciated the adaptation to a specialist field, greater autonomy and more independence. I am indebted to the families I cared for; a privilege to be part of every special journey. The professionalism of the Sister and the department was first class. All on a par with Annie Lennox, for me! The researchers in the early IVF fertility clinic seemed so forward-thinking and inspired, and the Consultant was a true gentleman. I remember them all. Even 30 years later. I continually developed, but never forgot my roots and how applicable those transferable skills are.

As a midwife and PhD student looking back, throughout my tumultuous career, my art has sustained me. Like a calm, scented wax melt, the perfect tonic to a stressful but rewarding career. For me, painting is akin to taking a bath and soaking weary ward-trodden feet. Therapeutically, it refreshes the body, mind and soul. It is a good hobby and distraction. So, although it took me to 22 years of age to find my feet in theatre clogs, which may seem worlds apart from Van Gogh (or Annie Lennox!), I can still draw a mean diagram (and I still have ‘Sweet Dreams.’)

Unfortunately, my hopes to be the next member of the Eurythmics came to nothing. Nevertheless, I have never regretted my career choice. Midwifery and health care is a pot pourri profession whose practitioners originate from all manner of backgrounds, and whose life experiences are so varied and relevant in so many ways. “We’ve got doctors, lawyers, politicians too-oooo-oooh!”. All learning is useful, no opportunity ever wasted. As Camilla Eyring Kimball once said, “You don’t find a happy life. You make it.”

I hope in my endeavours to serve women and families I have touched lives in the same way as my NHS
colleagues did in the 1990s. It was a critical ‘Changing Childbirth’ time for maternity services, when the medicalisation of childbirth was being questioned like never before and the rights of women to choose, exert control over what was happening to them and demand continuity of care was being asserted in a cultural revolution within the public sector to challenge paternalism like never before. Baroness Cumberlege led the way with her ground-breaking report, reviewing policy and making recommendations to put women at the heart of all aspects of the service - a triangular view of teams comprising the disciplines of general practice, midwifery and obstetrics. Greater autonomy and shared decision-making were key buzzwords at this time - I was inspired!

For me personally, moving away and developing professional associations and friendships lasting a lifetime was a time when we felt that times were a’changing too. Though babies had been born in their millions in a million years, here I was amidst it all, an aspiring Eurythmic-loving student at the offset of a career. Since then, I’ve travelled, taught, tutored, studied and written about midwifery, as well as practised the art and science of it during changing times. The privilege of being ‘with woman’ has always kept me going. And in the words of Annie Lennox, whose tunes I hummed whilst learning about all kinds of things - cardiomegaly, renal transplants and intravenous infections, “sweet dreams are made of this.”

Yes, it has been hard work, but it has been fun getting here. And the best is yet to come.

References


Understanding Midwives in Indonesia

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Summary

Indonesia is still struggling to battle high maternal and child mortality rates and contributes to the global burden of maternal and child mortality. My PhD in New Zealand, which offers an acclaimed and world-class midwifery education service, gives me a unique take on midwifery in Indonesia. Having spent around 12 years as a midwifery lecturer in the country, I have witnessed changeable policy in midwifery there. This paper focuses on midwives’ role in Indonesia and how critical their position has become to improve maternal and child health outcomes.

Understanding Indonesia’s complex landscape
Known as a string of emeralds on the equator, Indonesia is in South-East Asia between the Indian and Pacific Oceans. Geographically, Indonesia is the world’s largest archipelago country. It has more than 17,000 islands, including Sumatra, Java, Kalimantan, Sulawesi and Papua. Java is the most populous and developed of these islands. With around 265 million inhabitants, Indonesia is a multicultural nation with more than 350 ethnicities scattered across 34 provinces, each with its local government and capital city. Indonesia is the fourth-most populous country in the world, after China, India, and the United States, and forms 3.46% of the world’s population. Although the country is classified as a middle-income country, 9.66% or around 25.67 million people live in poverty, and 49.51% of impoverished households have inappropriate access to food and 25.29% to housing. Birthrate is around 2.34 per 1,000 births, and life expectancy is projected to be 72.4 in 2035. Administratively, all provinces in Indonesia comprise 514 districts, 98 municipalities, 7,094 sub-districts, 8,412 administrative villages (kelurahan) and 74,093 villages (desa). People live in various settings within its borders, stretching from the densely populated urban areas and the glimmer of lights on the island of Java to the sparsely populated rural and remote islands of Papua. Evidence in Indonesia shows that socio-economic development, such as housing, industrial development, transportation and health facilities, is not equal throughout the country. East and West Indonesia lag considerably behind the Middle of the country. As the centre of the Indonesian government, Java dominates development, which creates discrepancies of human resources and facilities across the rest of Indonesia. The following statistics indicate the achievements and difficulties faced by the Indonesian government in its handling of healthcare, primarily in maternal and child health. Contraceptive prevalence was 64%, childbirth assistance by midwives was 62.7% and 83.53% of public health centres have an excessive number of midwives. However, current evidence from national reports reveal that the maternal mortality rate was 305 per 100,000 live births, which is three times higher than the Millennium Development Goals (MDGs) target in 2015. Sub-Saharan Africa and Southern Asia, accounted for around 86% of the maternal mortality rate worldwide. The prevalence of children under five years old with stunting was 30.8%. The neonatal mortality rate was 15 per 1,000 live births, the infant mortality rate was 24 per 1,000 live births,
and the children under five years old mortality rate was 32 per 1,000 live births.⁴ Therefore, reducing the maternal mortality rate to less than 70 per 100,000 live births, reducing neonatal mortality to less than 12 per 1,000 live births and reducing child mortality to less than 25 per 1,000 live births to achieve Sustainable Development Goals (SDGs) targets in 2030 could be challenging for Indonesia.⁸,⁹ The Indonesian government has made intensive efforts to reduce maternal and child mortality rates, rolling out many maternal and child health programmes, such as Safe Motherhood; the Midwife in the Village programme; the mother-friendly movement; the participation of husbands; empowering the community and empowering through birth preparedness and complication readiness; and a free-of-charge health service for low-income families; expanding maternal and neonatal survival; a special allocation fund for the health sector; and a healthy Indonesia programme focused on improving maternal and child healthcare. However, Indonesia is still struggling to battle high maternal and child mortality rates and contributes to the global burden of maternal and child mortality.⁴,¹⁰

The role of the midwife in Indonesia

The midwife as professional, congruent with the International Confederation of Midwives (ICM), is a long profession in Indonesia.¹¹,¹² The health system’s hierarchy has the midwife as the centrepiece of Indonesia’s maternal and child system: the midwife is the backbone of midwifery care and plays critical roles in maternal and child health outcomes in Indonesia.⁴ Historically, the first course of midwives was held in 1850 by the Dutch government. The establishment of this training was intended to replaced traditional birth attendants called ‘dukun’ in Indonesia – a dukun was a specialised person who accompanied women in childbirth and was tasked with providing contraception, assisting with fertility and inducing abortion. The high maternal mortality rates attended by dukun had been a great concern by the Dutch government, who began to train Indonesian midwives. In the 1950s, after Indonesia proclaimed independence on 17 August 1945, the first school for Indonesian midwives was initially opened, and priority was given to the daughters of members of the families of dukun.¹³,¹⁴ Since 1996, midwifery education in Indonesia has had a direct-entry pathway. There are vocational (diploma, advanced diploma and applied master in midwifery); academic (bachelor and master of midwifery); and professional midwifery programmes. To date, 856 midwifery schools run by universities, institutes, polytechnics and academies have been approved to prepare new midwives.¹⁵,¹⁶
For many decades, the Indonesian government clearly stated that the philosophy behind the midwifery practice model in Indonesia is that midwives work in partnership with women and provide professional and comprehensive midwifery care. The partnership model means that the midwife and the woman are viewed as equal decision-makers regarding healthcare choices; that midwives provide continuity of care (CoC); and midwifery care is evidence based. The midwife’s scope of practice states that a midwife has to be responsible and accountable as a partner of women to offer support, care and counselling during pregnancy, the childbirth process, and the post-partum period. A midwife takes responsibility for conducting the labour process, including care for the newborn and infant. A midwife may practice in any midwifery service, including the home, community, hospital, clinic or other health units. Midwifery care includes prevention, detection of abnormal conditions and emergency cases. A midwife also provides health counselling and education for the woman, the family and the community. Midwifery care further includes antenatal education, parenthood, women’s health, sexual health, reproductive health and childcare. 

Evidence in Indonesia shows that socio-economic development, such as housing, industrial development, transportation and health facilities, is not equal throughout the country.

Current and future challenges for midwives

Over many decades, the Indonesian government has committed to supporting the midwives’ role and responsibility, advancing midwives to work autonomously within the health system. The 2019 Midwifery Act has demonstrated the government’s commitment to improve the quality of midwifery care. A robust professional association and an independent accreditation agency for midwifery are essential to achieving high-quality midwives, guided by ICM standards. However, there are challenges in producing new graduate midwives, as demonstrated by a study on strengthening Indonesia’s midwifery education. Translating the 2019 Midwifery Act into midwifery practice and workforce is still challenging. According to the act, a new midwife has to complete a professional programme to work autonomously, while the programme still has divergent views on implementation in Indonesia.

Conclusion

Highlighting Indonesia's complexity, the government, alongside professional associations, accreditation agencies and stakeholders across the country, is dedicated to improving maternal and child health outcomes. The Indonesian government did not reach the MDGs 2015 target, but midwives are still at the centre of health professionals offering maternal and child healthcare in Indonesia. There are still significant challenges to educate, regulate and integrate new midwives into the health system in order to reach the SDGs milestone by 2030. TPM

References

Qualifying as a Midwife in Argentina

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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
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).

**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 midwives 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

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**The Effect of Hatha Yoga on Low Back Pain and Sleep Quality in Nulliparous Pregnant Women: A Clinical Trial Study**

**Peyman Namdar - Associate Professor of Emergency Medicine, Department of Emergency Medicine, Emergency Medicine Specialist, Qazvin University of Medical Sciences, Qazvin, Iran**
Summary

This clinical trial study aimed to determine the effect of Hatha yoga on low back pain and sleep quality in nulliparous pregnant women. It was performed on 60 eligible nulliparous pregnant women. The samples were selected using convenience sampling and were assigned to intervention and control groups via random sampling without replacement. The intervention group attended Hatha yoga classes twice a week from week 26 to 37 of their pregnancy. A demographic information questionnaire, a visual pain scale and the Pittsburgh Sleep Quality Index were used to collect information. In addition, SPSS software (version 24) and descriptive and inferential statistics were used to analyse the data. Using Wilcoxon tests, the comparison of low back pain showed there was no significant difference between the pain scores in the intervention group before (p = 0.057) and after (p = 0.172). Moreover, using Sign test (p= 0.007) and Wilcoxon signed-rank test (p= 0.001), sleep quality scores in the intervention group before and after the study showed that there was a significant difference between sleep quality scores in the intervention group. The research shows that Hatha yoga did not have a significant effect on the low back pain scores in the intervention group, however, it had a significant effect on their sleep quality.

Introduction
Pregnancy and childbirth are important and frightening experiences for a woman throughout her life and may have many symptoms and problems. One of the most common of these problems is low back pain (LBP), which affects more than two-thirds of pregnant women. Physiological and musculoskeletal changes that occur during fetal development may play a role in causing it. However, the exact causes of LBP during pregnancy are not well known. Symptoms associated with it include stiffness and limited movement in the back and shin. Approximately one-third of pregnant women reported that the pain increases during the day, while another third reported that the pain worsens at night and often disrupts sleep. Another symptom that a pregnant woman may experience is poor sleep quality. Physical and hormonal changes during pregnancy cause these serious changes in sleep quality. As the study of Shariat et al has shown, about two-thirds of pregnant women in Tehran, Iran, complain of abnormal sleep patterns. A systematic review study by Yang et al, who measured sleep quality by the Pittsburgh Sleep Quality Index (PSQI), showed that 44.5% of pregnant women experienced poor sleep quality during the prenatal period.

On the other hand, LBP and sleep disorders during pregnancy have a major impact on pregnant women’s ability to do their daily activities, which worsens as pregnancy progresses. Unfortunately, despite the high prevalence of LBP and sleep disorders during pregnancy and their complications, there are limited treatments. In addition, these problems are often overlooked and not evaluated or treated by healthcare providers. So, healthcare providers should increase screening and recommend useful treatment options. In this regard, it is better to provide appropriate exercise equipment to pregnant women to reduce their risk of complications and to increase their chances of a healthy pregnancy.
Gurjeet et al showed in their study that one of the common reasons for women using the National Center for Complementary and Alternative Medicine (CAM) was having medical problems such as LBP and sleep disorder. Based on the criteria of the National Center for CAM for the category of mind and body-based practices, yoga is one of the most common sports, because of the safety and gentleness of its exercises. There are several types of yoga styles of which one of the most commonly used during pregnancy is Hatha yoga, which focuses on a relaxed impression in which animal-like movements are done and the whole body is stretched. It includes mental techniques, breathing exercises, mental concentration and the connection of body and mind. According to the National Health and Nutrition Examination Survey conducted between 1999 and 2006, approximately 7% of women reported doing stretching exercises and yoga during pregnancy. However, few studies have been conducted on yoga as an effective intervention during pregnancy and its relationship with LBP and sleep disorders in the population of pregnant women. In this regard, the research team in this study intended to investigate the effect of Hatha yoga on the LBP and sleep quality of pregnant women who referred to the women’s clinic of Kowsar Hospital in Qazvin.

**Methods**

The present study was a controlled clinical trial and was performed in the gynaecology clinic of Kowsar Hospital in Iran. For sampling, eligible nulliparous pregnant women entered the study using convenience sampling. Then, via random sampling without replacement, pregnant women entered the Hatha yoga or control groups according to the colour of the ball they took from a bag containing two balls (blue or red). Thirty-four women entered the Hatha yoga group (represented by the blue ball) and 32 women entered the control group (represented by the red ball). The inclusion criteria of the study were: conscious consent to participate in the study; age group of 18 to 35 years; normal pregnancy according to the written diagnosis of a gynaecologist; and first and singleton pregnancy. The exclusion criteria of the study were: a history of orthopaedic surgery; lumbar disc according to medical records; attending a Hatha yoga class or regular exercise; fetal problems during Hatha yoga exercises; selective caesarean delivery; leaving the Hatha yoga class due to unwillingness; and absence in more than two sessions of the Hatha yoga classes. To estimate the sample size, Cohen’s d table was used to consider the correlation of the main variables of the study, with an approximate average effect size (r=0.35), for a two-way test by selecting the first type of error as 0.05 (α =0.05) (with the confidence interval of 95%) and the probability of the second type of error as 0.30 (β=0.30 ) (the test power: 70%). Finally, using the following equation, the sample size was estimated to be 54 women. Considering a 10% drop, the sample size was increased to 60 women.

The data in this study were collected using a three-part questionnaire that included the following parts:

1. a) A researcher-made checklist including demographic information (age, level of education, job
status, history of LBP before pregnancy, the measures taken to reduce LBP and the related
diseases).

2. b) A visual pain scale, which was used to assess the severity of LBP in pregnant women and
consisted of a 10cm horizontal line numbered from zero (no pain) to 10 (the most severe pain the
participant has ever experienced). Based on the response of a pregnant woman to this 10-point
scale, her pain was measured so that a score below four indicated lack of pain up to mild pain, a
score of four to six showed moderate pain, a score of six to nine indicated severe pain, and a score
of 10 demonstrated the most severe pain.

3. c) The Pittsburgh Sleep Quality Questionnaire, which was first developed in 1989 by Buysse et al at
the Pittsburgh Psychiatric Institute. This questionnaire includes 18 statements that examine the
seven sub-scales of the mental quality of sleep, delay in falling asleep, sleep duration, sleep
efficiency, sleep disorders, use of sleeping medication and daily dysfunctions. Answering each
phrase in this questionnaire is based on a four-point Likert scale, ranging from zero to three (0:
nothing, one: weak, two: moderate, three: severe). Thus, the total score of the questionnaire is from
zero to 21. A higher score indicates poor sleep quality in such a way that obtaining a total score
above five in the whole questionnaire means poor sleep quality, having severe problems in at least
two sub-scales, or having moderate problems in more than three sub-scales. Using Cronbach’s
alpha, Buysse et al obtained the internal coherence of the questionnaire as 0.83. The validity and
reliability of the Iranian version of this questionnaire were obtained in the study of Shahrifar (cited
by Heidari et al) as 0.86 and 0.89, respectively. Moreover, in the study of Heidari et al, the reliability
of the questionnaire was obtained by Cronbach’s alpha method and the cleaning coefficient as 0.46
and 0.52.

First, all the eligible pregnant women entered the study voluntarily and signed the informed consent form
and agreed to participate in the study. All of them gave their addresses and telephone numbers for data
completion and becoming informed of the start of the Hatha yoga practice sessions. The pregnancy yoga
programme was Hatha yoga style including physical movements, and breathing and relaxation exercises.
The yoga programme included 24 sessions of 75 minutes each twice a week by a trained instructor.
Pregnant women started in their 26th to 28th weeks of gestation and ended in their 37th week of
gestation. The usual maternity care was provided to all pregnant women in the control group through the
gynaecology clinic of the hospital. First, the background information, pain scores, and sleep quality
questionnaire were examined and recorded in the two groups. Finally, after the end of the 37th week of
pregnancy, the sleep quality and pain questionnaires were reassessed in the intervention and control
groups. After collecting the data, they were entered into the SPSS 24 and the descriptive including mean
and standard deviation. Using the paired t-test and t-test, chi-square, Wilcoxon and Mann-Whitney tests
were performed.

Results

In this study, only 60 of participants were analysed in the final analysis of the trial (see Graph 1).

Graph 1: The complete selection and follow-up steps for the pregnant women
The Mann-Whitney and chi-square tests were performed on the demographic variables and the results showed that there was no significant difference between the nulliparous pregnant women of the two groups (P > 0.05) with respect to age, history of LBP, and treatment of LBP (Table 1).

Using the likelihood ratio test (LRT) before (P = 0.73) and after (P = 0.10) the intervention, showed that the LBP in the intervention and control groups was independent of each other (Table 2).

Using the Wilcoxon test, the comparison of LBP in the intervention group before (P = 0.05) and after (P = 0.17) the study showed that there was no significant difference between the pain scores. However, before the study, the prevalence of severe LBP was 11.7% in the pregnant women of the control group and 13% in the intervention group. After the study, the prevalence of severe LBP in the control group became 16%, whereas in the intervention group, it became 6%.

Table 1: The demographic characteristics of the nulliparous pregnant women who referred to the gynaecology clinic of Kowsar Hospital in Qazvin in 2019-2020
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<th>Variables</th>
<th>Yoga group</th>
<th>Control group</th>
<th>Results of the chi-square test</th>
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<td>Frequency (%)</td>
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<td>Employee</td>
<td>7 (23.3%)</td>
<td>1 (3.3%)</td>
<td></td>
</tr>
<tr>
<td>Self-employed</td>
<td>4 (13.3%)</td>
<td>0 (0.0%)</td>
<td>P &lt; 0.00*</td>
</tr>
<tr>
<td>Retired</td>
<td>1 (3.3%)</td>
<td>0 (0.0%)</td>
<td></td>
</tr>
<tr>
<td>Worker</td>
<td>6 (20.0%)</td>
<td>0 (0.0%)</td>
<td></td>
</tr>
<tr>
<td>Housekeeper</td>
<td>11 (36.7%)</td>
<td>28 (93.3%)</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>1 (3.3%)</td>
<td>1 (3.3%)</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illiterate</td>
<td>0 (0.0%)</td>
<td>1 (3.3%)</td>
<td>P &lt; 0.00*</td>
</tr>
<tr>
<td>Primary</td>
<td>1 (3.3%)</td>
<td>12 (40.0%)</td>
<td></td>
</tr>
<tr>
<td>Diploma</td>
<td>5 (16.7%)</td>
<td>12 (40.0%)</td>
<td></td>
</tr>
<tr>
<td>Undergraduate</td>
<td>19 (63.3%)</td>
<td>5 (16.7%)</td>
<td></td>
</tr>
<tr>
<td>Graduate</td>
<td>5 (16.7%)</td>
<td>0 (0.0%)</td>
<td></td>
</tr>
<tr>
<td>Low back pain history</td>
<td></td>
<td></td>
<td>P &lt; 0.754</td>
</tr>
<tr>
<td>No</td>
<td>23 (76.7%)</td>
<td>24 (80.0%)</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>7 (23.3%)</td>
<td>6 (20.0%)</td>
<td></td>
</tr>
<tr>
<td>Low back pain treatment</td>
<td></td>
<td></td>
<td>P &lt; 0.424</td>
</tr>
<tr>
<td>No</td>
<td>25 (83.3%)</td>
<td>28 (93.3%)</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>5 (16.7%)</td>
<td>2 (6.7%)</td>
<td></td>
</tr>
<tr>
<td>Yoga group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Control group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Test results</td>
<td>Mean ± standard deviation</td>
<td>Mean ± standard deviation</td>
<td>t-test</td>
</tr>
<tr>
<td>Age</td>
<td>29.37 ± 3.77</td>
<td>27.87 ± 5.20</td>
<td>P &lt; 0.207</td>
</tr>
</tbody>
</table>

Table 2: The comparison of low back pain in the two groups before and after the intervention

Table 2: The comparison of low back pain in the two groups before and after the intervention

<table>
<thead>
<tr>
<th>Variables</th>
<th>Pre-test</th>
<th>Post-test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yoga group</td>
<td>Control group</td>
</tr>
<tr>
<td></td>
<td>(%) Frequency</td>
<td>Likelihood ratio test</td>
</tr>
<tr>
<td>Low back pain intensity (visual analogue scale score)</td>
<td>Mild (0-4)</td>
<td>13 (43.3)</td>
</tr>
<tr>
<td></td>
<td>Moderate (4-6)</td>
<td>13 (43.3)</td>
</tr>
<tr>
<td></td>
<td>Severe (6-9)</td>
<td>4 (13.3)</td>
</tr>
<tr>
<td></td>
<td>Very severe (10)</td>
<td>0 (0)</td>
</tr>
</tbody>
</table>

Table 3: The evaluation of sleep quality changes, before and after the intervention, among all the nulliparous pregnant women
Table 3: The evaluation of sleep quality changes, before and after the intervention, among all the nulliparous pregnant women

<table>
<thead>
<tr>
<th>Sleep quality</th>
<th>Before intervention</th>
<th>After intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency (%)</td>
<td>Frequency (%)</td>
</tr>
<tr>
<td>Very good</td>
<td>11 (18.3)</td>
<td>19 (31.7)</td>
</tr>
<tr>
<td>Good</td>
<td>36 (60)</td>
<td>28 (46.7)</td>
</tr>
<tr>
<td>Relatively bad</td>
<td>9 (15)</td>
<td>9 (15)</td>
</tr>
<tr>
<td>Very bad</td>
<td>4 (6.7)</td>
<td>4 (6.7)</td>
</tr>
<tr>
<td>Total</td>
<td>60 (100)</td>
<td>60 (100)</td>
</tr>
</tbody>
</table>

Table 3 shows the evaluation of sleep quality before and after the study among all the pregnant women.

The Kolmogorov-Smirnov test was used to evaluate the normality of the variables. Because of the abnormality of the sleep quality scores in both groups before and after the intervention, the Wilcoxon test was used for intragroup comparison and the Mann-Whitney test was used for intergroup comparison. The comparison of sleep quality scores in the intervention and control groups before the start of the study using the Mann-Whitney test showed that there was no significant difference between them (P < 0.049). After the intervention, there was a significant statistical difference between them (P < 0.001) (Table 4).

Moreover, using Sign test (P = 0.007) and Wilcoxon signed-rank test (P = 0.001), sleep quality scores in the intervention group, before and after the study, showed that there was a significant difference between sleep quality scores in the intervention group.

Discussion

In this study, 40% of the pregnant women reported moderate LBP and 11.7% reported severe LBP. This shows that due to the prevalence, severity, chronic side effects and little attention paid to the treatment of LBP, there is a need for a better understanding of this problem in the field of public health to provide more prevention and treatment interventions. In addition, healthcare providers should recommend useful treatment options to women with LBP. Research shows that a significant number of women seek complementary medicine such as Hatha yoga or other related physical activities to address their LBP. It should be noted that no studies have been reported so far on the side effects or negative effects of the yoga programmes on the body and soul of pregnant women. Therefore, studying the effects of physical activities including yoga-based activities is useful as a strategy to reduce LBP. Comparing LBP in the intervention group, before and after the study, showed that Hatha yoga did not have a significant effect on the pain score in both groups. The study of Holden et al also showed that yoga did not have a significant effect on the rate of LBP by expressing the LBP score on the visual analogue scale (VAS) in the second trimester of pregnancy. These results were consistent with the results of the current study.

Table 4: The comparison of the mean scores of sleep quality in the intervention and control groups before and after the intervention
However, according to the results of this research, after the start of the study, the prevalence of severe LBP decreased in the intervention group, while it increased in the control group. This decreasing trend in the prevalence of severe LBP in pregnant women is a promising result and further research may show that yoga could be an effective preventive strategy for LBP during pregnancy. Nonetheless, the study by Martinez et al showed that the severity of pain was reduced in the intervention group compared to the control group using the VAS. The results of another study by Sun et al, who used the Pregnancy Pain and Discomfort Questionnaire, indicated that the intervention group had significantly less pain during pregnancy than the control group. Field et al also showed that the intervention group had less LBP and leg pain compared to the control group. The reason for the inconsistency of the results of these studies with those of the present study can be due to the differences in the demographic characteristics of the samples, the type of yoga, the number and duration of yoga sessions, and cultural and climatic issues. The assessment of sleep quality in all the pregnant women showed that 21% of them reported their sleep quality as relatively bad and bad. In general, pregnant women suffer from problems such as shortened sleep time, frequent awakenings at night, difficulty in falling asleep, loss of deep stages of sleep (especially stages three and four on which sleep quality depends), drowsiness during the day, excessive and frequent snoring, and sleep disorders related to irregular breathing. The comparison of sleep quality scores in the intervention and control groups before the intervention showed that there was no significant difference between them.

However, after the end of the study, they were significantly different from each other (see graphs 2 and 3). Besides, the mean score of sleep quality in the control group was much higher than that of the intervention group, which means that after the end of the study, people in the intervention group experienced better sleep quality. Therefore, Hatha yoga had a significant effect on the sleep quality of the intervention group. This was consistent with the results of the studies by Shu et al and Li et al. Furthermore, the studies of Field et al and Beddoe et al demonstrated that the score of sleep disorders in the intervention group was lower than that of the control group. Moreover, the intervention group reported better sleep quality.

**Graph 2: The trend of changes in the mean score of sleep quality in the intervention group before and after the study**
Graph 3: The trend of changes in the sleep quality scores in the control group before and after the study

Acknowledgment
The ethical principles observed by the researchers included obtaining permission from the Ethics Committee of Qazvin University of Medical Sciences with the code: IR.QUMS.REC.1398.246. This study was registered in the Iranian Clinical Trial Registration Center under the number IRCT20190919044819N1. The researchers obtained written informed consent from all participants, granted participants the right to withdraw from the study at any time, applied the principles of anonymity and confidentiality and provided participants with the results upon their request. Consent for publication was not applicable.

Availability of data and materials
Data would be available by contacting the corresponding author.

Conflict of interest
None declared.

Conclusion
It was found that Hatha yoga under the supervision of an expert instructor can improve sleep quality for
pregnant women in the second trimester. However, one of the limitations of this study, which was not under the researchers’ control, was that some pregnant women believed that sleep disorders and LBP did not need treatment and were normal during pregnancy. Some women were also unwilling to do the exercises during pregnancy, which made sampling difficult for this study. Therefore, in order to remove these limitations and increase the awareness of pregnant women, it is recommended that more clinical trial studies with a larger number of samples and with appropriate tools be conducted to evaluate the effect of Hatha yoga on LBP and sleep quality. **TPM**

**References**

Inclusion Definitions, Priorities and Action in Reproductive and Maternal Health Practice

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Smita Bajpai - Project Director for CHETNA, a White Ribbon Alliance (WRA) member in India

Rose Syowia - Midwives Association of Kenya (MAK), a White Ribbon Alliance (WRA) member in Kenya

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Summary

Diversity, equity and inclusion (DEI) are three words that we hear and see in our practice and in all areas of workplace and media development, particularly in the Global North. While each of us will have our own context and definitions of these words and how they impact our practice, what do they mean when we shift our attention to the global agendas of maternal and reproductive health?

Diversity differs

Pause for a moment and consider the word ‘diversity’. Sound the word in your mind and notice where your thoughts lead; the concepts and ideologies that arise. Repeat this consideration with the words ‘equity’ and ‘inclusion’. Undoubtedly, you will have personal definitions of these words, contexts in which you apply your understanding of them and actions you prioritise in your initiatives towards achieving improved outcomes focused in these areas of your practice. Following the
onset of a global pandemic and the racialised and video-recorded murder of George Floyd by US police in 2020, the corporate and third sector rapidly confronted the need to prioritise workplace diversity, not just to fulfil diversity as a mere compliance requirement, but as an integral part of successful strategic business modelling. In the UK and US we know that disproportionate adverse outcomes exist in maternity for Black, Brown and minority ethnic women and birthing people. We know that there are barriers to inclusion of transgender and gender nonbinary people in sexual and reproductive healthcare and we are witnessing midwives and birth activists rapidly adjusting to the rightful colloquial embedding of language such as birthing people, people of colour, people from minority ethnic groups and the use of gender inclusive pronouns such as ‘they/their’ into their care language.

In discussing diversity and equity with our international colleagues, we realised that definitions of diversity vary substantially depending on country specific contexts. The United Nations Sustainable Development Goal (SDG) 10.2 outlines a global target for the broader spectrum of inclusion, proclaiming that ‘by 2030, we empower and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status’. The Global North is experiencing a wave of action and activism committed to including, respecting and hopefully alleviating oppression for our nonbinary and ethnically marginalised colleagues and people in our care. But what do equity, diversity and inclusion mean when we look at maternal and reproductive health from a global perspective? In our plight to take context-relevant action, are we applying the same concern and consideration for global inclusion as we are to our country-specific priorities and the ‘DEI’ classifications of the Global North? Arguably, some ideologies formed in the context of neoliberal politics harmfully frame and operationalise our activism in a way that leads to more divided social inequalities. In beginning to discuss the theme of this article with our international colleagues at White Ribbon Alliance (WRA) we agreed that this subject could fill a book – possibly several! In the last year, with the presentation of the dual harms of COVID-19 and the rise of the Black Lives Matter activism, the words diversity, equity and inclusion have become prolific concepts in the Global North. The rise in focus on anti-racism within our practice, the pertinent need for gender inclusion and the considerations of intersectionality when considering the needs of the people we care for is pressing and overdue. We are being called to unlearn our previous behaviour, consider our unconscious biases and act as allies to those facing marginalisation and oppression. And, yet, in discussing diversity and equity with our international colleagues, we soon realised that definitions of diversity vary substantially depending on country-specific contexts.

White Ribbon Alliance – what women want!
The WRA envisions a world where all girls and women realise their right to health and wellbeing. Our mission of activating a people-led movement for reproductive, maternal and newborn health and rights accelerates progress by putting citizens at the centre of global, national and local efforts. We pioneered the practice of amplifying women’s voices to guide global health and rights advancements. WRA’s ‘What Women Want’ campaign began with a simple idea: ask those who most use health services to tell us what they most need. Ask the clients, ask women. It led to responses from 1.2 million women and girls globally (see figure 1).

‘What’s your one request for quality maternal and reproductive healthcare services?’

Since the launch of the What Women Want Campaign on 11 April 2018, International Maternal Health and Rights Day, more than 350 groups – from small community-based organisations to giant corporations – in 114 countries picked up the campaign in large and small ways. While vastly different, all are united in the belief that women know best what they need and that they should be heard. When women asked for ‘respectful and dignified care’ – the top global demand – 10%/10,000 of those demands emphasised non-discriminatory care within the health system.

What does that mean?

Women want their experiences with health providers, health services and care WITHOUT discrimination.

Figure 1: What Women Want Campaign Results
They do not want providers to discriminate against them based on their: HIV status, caste, religion, gender or age.

‘What’s your one request for quality maternal and reproductive healthcare services?’

‘Equality, no discrimination by the staff on basis of class, caste, religion (sometimes the providers discriminate us from other for delivery of healthcare services). This is mainly on the base caste, religion and colour. This should be banned.’ India, aged 33

‘Teenage mothers should not be discriminated and stigmatised when they seek maternal services.’ Kenya, aged 19

Equitable access: they want services and information available to them without discrimination in the points of access or points of care

‘You should not discriminate against rural women and illiterate women trying to explain properly about their treatment.’ India, aged 50

‘Government to ensure equitable services in all maternal healthcare care centres that all women delivering at a certain centre to be treated equally, despite of race, ethnicity or socio-economic status.’ Kenya, aged 23

They want to be able to make decisions about their body without facing the threat of jail

‘No more threats, to be able to abort in a safe way.’ Mexico, aged 37

‘That the hospitals support that we can abort and that it is not a crime.’ Mexico, aged 30
Nation-specific freedoms

Diversity and equity span entirely different priorities in Kenya, Malawi, Indonesia, India, China and, indeed, in each country context. There is not a homogenous way to frame diversity when we look at it from a global perspective. As highlighted by The Human Dignity Trust, LGBTQ+ rights differ substantially when considered in a global context.¹⁰

Figure 2: The Human Dignity Trust map of countries where LGBTQ+ identity and practice is criminalised

There are many parts of the world in which lesbian, gay, bisexual and transgender people are criminalised for their sexual orientation. In Iran, penetrative anal intercourse between men is punishable with the death penalty,¹¹ in Indonesia the ‘offences against decency’ Article 281 has been used to criminalise transgender people,¹² in Afghanistan Section 645 criminalises same-sex intimacy between women with imprisonment for up to one year.¹² We connected with the House of Rainbow fellowship in Nigeria, where in 2016 pioneering Reverend Jide Macaulay started House of Rainbow as a weekly gathering for LGBTIQ+ Christians in Lagos, which the media soon described as ‘Nigeria’s First Gay Church’. Members of his church share that they have been beaten up for their identity and feel that coming out in their communities placed them at significant risk of personal harm. These differences and risks need to be carefully considered when working as activists within global spaces. For example, we cannot rightfully talk to our Indonesian colleagues about adjusting towards the use of transgender-inclusive language in their maternity care settings – even the idea of such a conversation may present as high risk for them. Working together, globally, towards the ambitious achievements set out in the UN Sustainable Development Goals (SDG) requires that we challenge ourselves to consider a global target through localised experiences.

But what do equity, diversity and inclusion mean when we look at maternal and reproductive health from a global perspective?

Being ‘called in’ globally

The first step in extending our activism to include increased sensitivity for global diversity is to speak with our colleagues about what inequalities present as priorities for their communities. On anti-racism activism, our colleagues in Kenya, India and Nigeria expressed that anti-racism is a nuanced priority area for them in their country’s agenda on reproductive health. There are substantial differences to consider when exploring how discrimination presents in relation to nation-specific freedoms. In speaking with Smita
Bajpai, Project Director for CHETNA, a WRA member, she shared her country-specific priorities for equity in India. ‘In India, inequity in healthcare is a great concern. National surveys and reports have indicated significant differences in access to healthcare across rural and urban areas, across wealth quintiles, across social categories and education levels. This situation has continued since past several decades, despite policy and programme attention. Despite commitment to achieve gender equality, gender discrimination persists, given the patriarchal social structure.’

In Kenya, our colleague, Rose Syowia, of the Midwives Association of Kenya (MAK), a WRA member, shared her perspective on country-specific anti-discrimination priorities for reproductive and maternal health. ‘Women and birthing discrimination in relation to maternal and reproductive health is from sexual-based violence or gender-based violence. Also, women are not allowed to choose termination of unwanted pregnancy. In some instances, women use contraceptive methods secretly due to in-laws or husband denial or both. People experience discrimination based on sex, age, socio-economic status, class perceived by society and cultural stereotyping. To address dignity and justice, changes are being made by the government and civil society through legislation and advocacy, especially in female genital mutilation and gender-based violence. Racism is not a major problem in Kenya, but ethnicity is. The society is dealing with it through supporting intermarriages.’

We need to look beyond the lens of our singular country context, especially as we interact more and more in online spaces that bring together communities operating within differing freedoms. Challenging ourselves to consider how the priorities of our agenda for rightful change may impact and potentially alienate or harm our international colleagues should be part of our consideration for true inclusion and demonstrable respect for each other.

Our interactions with one another, given that we are building global audiences, require us to contextualise the work we are doing in our own freedoms and environments.

**Being a safe advocate in global spaces**

Social media has made it possible for maternity and reproductive activism to share a global platform. The ways in which we conduct ourselves in these spaces therefore need to assume global allyship with all citizens. ‘Democracy is in danger by social media. We presume that other citizens in a democracy will behave in certain ways. We assume people will be thoughtful about what information they will share. And why they believe the things they believe – we expect them to treat each other as equals. Our interactions on social media are introducing us to the idea that we don’t fulfil those presuppositions, that we don’t treat each other as equals because we are prone to vicious ways of treating each other. The longer that we go on seeing people treating people not as equal, we are on a slow course of thinking not as equal citizens.
but as opponents.  

Our interactions with one another, given that we are building global audiences, require us to contextualise the work we are doing in our own freedoms and environments. Diversity and equity cannot be achieved when we address inclusion through the lens of assumed access to the same rights and protections, therefore we must start out by increasing our knowledge and understanding of how discrimination presents in the lives of women, girls and people globally. Using the WRA’s interactive What Women Want dashboard – a literal global repository of women’s own voices – is one way to expand this knowledge and integrate global voices into our efforts to achieve equity.

**Conclusion**

Finding universal ways to define diversity, equity and inclusion is a big challenge. But perhaps merely defining these words is the wrong challenge. WRA is supported by a DEI committee that have debated this topic widely. One of the principal considerations underlying the search for definitions of these words is that we are really talking about a positive and adaptable vision of dignity and justice. What we always need to consider is that when dealing with discrimination, we must always examine who holds the power in any given situation. The power wielded in one context of discrimination may lie with a person who in another situation is themselves oppressed. We must also resist limiting diversity to representation but also to the diversity of ideas, of thought and of action, and ensure that we are moving towards activism and practice that allows for the possibility of respectful maternity care that compassionately considers global contexts.

TPM

**References**


Article of the month: Clasificación como partera en Argentina

Raquel Justiniano G - BS Partería, Estudiante de Maestría en Salud Pública

Instagram @midwife_kelly

Hablar de la partería en Argentina es reconocer – primero que nada – que es diversa, que existen modelos y enfoques diferentes, y que sin duda uno de los que más prevalece hoy es el modelo médico hegemónico. Poco después de graduarme como Licenciada en Obstetricia, comencé una búsqueda intensa de información y herramientas que complementaran mi preparación profesional para brindar cuidados integrales como obstétrica y, para ser honesta, porque me sentía insegura. Es habitual – aunque no tiene porqué ser así – que las obstétricas recién graduadas sintamos inseguridad, dudemos de nuestra capacidad y de la importancia del rol que ejercemos en el sistema de salud. Lamentablemente la formación que recibimos aún se basa en un enfoque médico-hegemonico, controlador e intervencionista, y tras décadas de inmersión en este modelo, surge también desconfianza en las propias mujeres gestantes de su capacidad de dar a luz, o incluso de cómo, dónde y con quién deben parir. Con el tiempo, entendí que este modelo que se impone controla nuestros procesos sexuales y reproductivos, e interfiere en la respuesta eficaz y la mitigación de las desigualdades en el acceso a la salud de las mujeres y familias. Trabajar en este modelo sin cuestionar sus acciones y repercusiones, resulta difícil ver otras formas – más humanas y dignas – de cuidar la salud, que van de la mano de la nueva evidencia científica que cada vez crece más. Es fundamental e indispensable tener apertura para reconocer horizontes que todavía no conocemos. Una lectura crítica del estado de la Salud Materna/Neonatal y de la Salud Sexual y Reproductiva en Argentina y en el mundo es vital para saber dónde estamos, y adonde queremos llegar como profesionales de la partería. Quizá esto nos sirva como motor para continuar investigando, descubriendo y aprendiendo de otros modelos de atención que nos ayuden a aplicarlos en nuestro contexto.
La Partería en Argentina

La partería en Argentina como en el resto del mundo es una práctica ancestral. Sin embargo, la profesionalización se desarrolló en un contexto histórico y sociocultural que tiene sus primeros registros a fines del siglo XVIII y principios del siglo XIX. A medida que se instalaba el proceso de medicalización del parto y el traslado de los nacimientos a la institución, comenzó a regularse el ejercicio de las osbtétricas/parteras, incluso antes que los proyectos de formación institucional.1,2,3 La partería comienza a atravesar grandes desafíos y obstáculos ligados al sistema patriarcal: la formación en partería era considerada una práctica del género femenino, y para poder acceder a esta educación formal, era requisito saber leer y escribir, algo que no era habitual – ya que muchas mujeres en aquel entonces no se les permitía asistir a la escuela–. Hubo altos y bajos en el acceso a la educación formal, muchas veces cerraron instituciones debido a que la formación médica era prioridad para un sector de la sociedad. Más adelante se debía obtener el permiso de un tutor legal o del marido para poder estudiar.4,5 Es así que la partería continua por algunas décadas ejerciéndose por fuera del sistema de salud, principalmente en las comunidades vulnerables.

A medida que se instala un nuevo sistema de salud dependiente del Estado, es cuando la partería es considerada una profesión en condición asistente al médico, a veces remunerada, muchas otras no.6 En el año 1967, se sancionó la ley 17.132 – que permanece vigente – en la que se configura el ejercicio de las obstétricas como actividad de colaboración de la medicina.* Esta ley no hace sino limitar nuestra práctica como colaboradoras en la asistencia de embarazos, partos y pospartos. Y pone a los médicos como únicos responsables a cargo de la atención. Sin embargo, a pesar de que la ley limita la práctica profesional de las obstétricas, en las últimas décadas nuestras competencias se han ampliado mucho más allá de asistir partos. Hoy en día nuestra formación profesional nos capacita para brindar asistencia durante los ciclos sexuales y reproductivos desde la adolescencia hasta la menopausia, en planificación familiar, consejería, educación sexual con enfoque de derechos y de género, prevención de infecciones de transmisión sexual, asistencia pre-concepcional, control prenatal, asistencia al parto y post-parto, lactancia, puericultura, en la docencia, la investigación, el asesoramiento, y administración de servicios de salud, entre otros. Estas competencias –alineadas a los estándares de la Confederación Internacional de Matronas – configuran que somos los profesionales idóneos para cubrir el 87% de los servicios básicos en la Salud sexual y Reproductiva de la población.7

Investigación y liderazgo

Sin embargo, a pesar de que nuestro alcance es amplio, la Salud Sexual y Reproductiva y la Salud
Materno/Perinatal son áreas donde se evidencian enormes desigualdades de acceso a la atención y por ende los índices de morbi/mortalidad no han mejorado. Las obstétricas ejercen su pericia dentro como fuera del sistema de salud, debido a que existen normativas obsoletas y en muchas provincias del país restringen y limitan ejercer dentro de todas nuestras competencias obstétricas. Argentina es un país federal que se encuentra conformado por 24 provincias. Catorce de ellas aún permanecen ligadas a la antigua ley 17.132, la cual tiene limitaciones en el alcance profesional. Hoy gracias al enorme trabajo en abogacía y liderazgo de las obstétricas, diez provincias lograron actualizar su ley de manera que se contemple toda nuestra práctica profesional. Es por eso que desde diversos colectivos y asociaciones se trabaja para conseguir una nueva legislación nacional. Es una lucha con varios años de reclamo para que se reconozca la autonomía y el ejercicio pleno de la profesión. El año 2019, por unanimidad de votos, se logró la aprobación de una nueva legislación en la Cámara de Diputados. Se esperaba que durante 2020 pasara por la Cámara de Senadores, pero debido a la pandemia se pospuso. Desafortunadamente, el proyecto de ley perdió su estado parlamentario nuevamente en 2021.

Esta situación frena el crecimiento de la profesión en partería y exacerba las brechas en suplir las necesidades esenciales en términos de Salud Materna y Neonatal y Salud Sexual y Reproductiva. Con una ley de aplicación nacional que contemple nuestras incumbencias y alcance profesional, las/os obstétricas/os en todo el país podrían brindar servicio integral a las mujeres y sus familias, contribuyendo así a mejorar los resultados de salud que se han retrasado debido a la pandemia.

Nuestra labor de abogacía en los próximos años tendrá que redoblar esfuerzos. No podemos desanimarnos. Necesitamos fortalecer el liderazgo y la abogacía, brindar mayor apoyo en la investigación científica en partería que pueda influir en cambios en las políticas de salud pública y las prácticas obstétricas. Lo que hacemos y cómo nos organizamos será clave en los próximos años, por lo que necesitaremos todo el apoyo que podamos obtener para poder lograrlo. Desde mayo 2020, el Colegio de Obstéticas de la Provincia de Buenos Aires, conformó un comité de Investigación y Liderazgo para planificar acciones que fortalezcan estas dos áreas: la investigación y el liderazgo. El objetivo es que colegas argentinas así como de América Latina participen y coordinen acciones conjuntas para fortalecerlo. También se está trabajando para abrir una nueva sede de la carrera de obstetricia, ya que necesitamos con urgencia incrementar el recurso humano obstétrico en todos los rincones del país. Hoy en día existen trece instituciones, concentradas en un sector del país, y el acceso a la educación debe ser otra prioridad para lograr los objetivos del milenio.
Conclusión

Se han alcanzado logros importantes, pero todavía nos quedan muchas cosas para cambiar y promover el crecimiento de nuestra profesión. Creemos que la partería puede brindar más a la comunidad y contribuir en la mejora de la Salud y los Derechos Sexuales y Reproductivos de la población.  

TPM

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Midwifery Lecturers’ Reflections of Midwifery Education During Covid-19 in Ireland

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Summary

The COVID-19 pandemic has caused major disruption to midwifery education. Traditional approaches to teaching and assessment have been transformed. Creative thinking is required to ensure a positive and caring virtual learning environment is maintained. Collegiality and human kindness have never been so important. The long-term effects of COVID-19 for undergraduate midwifery education remains to be seen. The pandemic may represent a catalyst for the transformation of midwifery education in the future.

Introduction

Over a year ago, in March 2020, the COVID-19 pandemic caused major disruption to midwifery education, initiating a cycle of prompt and responsive actions from educators and students alike. These ongoing actions resulted in the transformation of many traditional approaches to teaching and learning. Midwifery students and midwifery educators found themselves rapidly adapting to all aspects of education provision, while also maintaining teaching and regulatory standards and requirements. We needed to think about things differently, quickly creating a positive and caring virtual learning environment while balancing our own and students’ anxieties in the midst of a global pandemic.

Post-COVID learning

In the pre-COVID world, our midwifery education was provided face to face in a classroom university setting. Now, we find ourselves at home, teaching online from a distance, using a virtual classroom (Blackboard Collaborate©), which is embedded in the university Virtual Learning Environment (VLE). A combination of pre-recorded and live lectures, tutorials and virtual workshops are timetabled. The virtual classroom enables lecturers and students to relate virtually and communicate effectively using audio, video, text chat and an interactive whiteboard. The ‘breakout room’ function is used to create small group activities. Student response systems, such as Socrative, are used to further enhance student engagement. This also facilitates students the opportunity to self-assess their own knowledge and evaluate their own learning. We also use podcasts allowing international midwifery experts to be accessible virtually and offer students a broader perspective.
Substantial planning and reconfiguration of these sessions is required to ensure that we keep students and faculty safe.

Midwifery is a practice-based profession; therefore, it is important to us and midwifery students to continue to provide clinical simulation skills within the university setting as far as public health restrictions can allow. We continue to host obstetric emergency simulation skills, breech, medication administration, neonatal resuscitation and first-year midwifery skills, such as abdominal palpation and postnatal examination skills. Some clinical skills are taught using online resources. Substantial planning and reconfiguration of these sessions is required to ensure that we keep students and faculty safe. Midwifery packs that contained a sphygmomanometer, stethoscope and fob watch were distributed to students to practice their vital signs at home on parents and siblings. In normal times, students usually have in-person examinations and assessments held in large examination halls. However, as this is not feasible many changes have occurred in how we assess students. Written assignments and terminal end-of-trimester exams have reduced significantly and are substituted with the use of E-posters and algorithms, video submission assignments, video OSCEs and virtual presentations. Along with traditional written feedback, we also use recorded oral feedback, offering students more opportunities to engage proactively in feedback mechanisms.

Acting on concerns

Listening and responding to student concerns and feedback is critical.

Many students express feeling ‘demotivated’ and we believe that this is accelerated by the absence of physical and social interaction. Several students are living with vulnerable family members and are concerned about the elevated risk of contracting COVID-19 especially when on clinical placements. In contrast to this, a substantial number of our students have taken up healthcare assistant employment and are therefore balancing work with their online studies and parenting from home. The presence of the COVID-19 virus in Ireland meant that students’ clinical placements were suspended from mid-March to September 2020 and again for three weeks in January 2021. All students continue to have genuine concerns over the potential lengthening of their programme. They are apprehensive about if and when all missed time during the suspension of placements will need to be rescheduled. For some it will affect their summer, a time when students often work to fund the next university academic year. Students are anxious about the implications of having reduced clinical exposure to gain core competencies and clinical midwifery experience and are conscious that this could impact on them completing European Union requirements for midwifery education. Listening and responding to student concerns and feedback is critical. We have adopted the motto ‘we are only an email away’ if a student requires support. We use Zoom and Google Meet to meet virtually with students. It is critical that we give students a space to voice their concerns, actively listen but also act on these concerns and advocate for them as we try to create solutions for the problems they have encountered during the pandemic.

Embracing e-learning

The majority of students have readily embraced the shift to e-learning and have articulated that they value the flexibility of learning at their own pace, in their own time. Students express feeling ‘part of the team’. Quizzes ‘give me a chance to see what I understand’. Students also like the online clinical skills videos, stating that ‘the online videos were helpful to watch for skill practice’. Students’ online feedback suggests that they feel supported by faculty and like that a one-to-one meeting is available if required. As midwifery educators we too have learned the importance of collegiality and human kindness. We have supported each other throughout, pooling our digital knowledge and skills, holding regular Zoom virtual social catch-ups and meetings. We continue to attend webinars and university-held virtual events to upskill on virtual
learning technologies and assessment strategies. Preparation is key, and teaching from afar does work if you prepare well in advance.

Midwifery is a practice-based profession; therefore, it is important to us and midwifery students to continue to provide clinical simulation skills

Conclusion

Just over one year ago, we entered a global pandemic that altered our teaching and learning practice, but how is it going now? Well, some written assignments will not revert. We now know that some midwifery education can be successfully taught as an online resource, which will continue. Educators and students have coped with, adapted to and thrived in this deeply challenging situation. Times of crisis, however, also offer opportunity. The long-term effects of COVID-19 for undergraduate midwifery education remains to be seen, however, it represents a catalyst for the transformation of midwifery education and has the potential to change the landscape of teaching and learning in the future. TPM

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Maternity Voices - Partos en casa en España: comentario sobre la situación actual y el contexto histórico-cultural

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Los hechos

No es posible cuantificar el número de partos planificados que ocurren en el domicilio, puesto que el Instituto Nacional de Estadística (INE) no distingue el lugar de nacimiento en su registro. España cuenta actualmente con un total de 9.536 matronas,\(^1\) cifra que se sitúa muy por debajo de países como Reino Unido (RU) con 38.855 matronas colegiadas en el Nursing and Midwifery Council\(^2\) (NMC). Los puestos de trabajo son tan escasos que muchas de las matronas ejercen como enfermeras buscando mejores condiciones y estabilidad, deviniendo en un número de matronas menor al recomentado.\(^3\) La asistencia al
parto en España se clasifica dentro de un modelo intervencionista institucionalizado, en el que el parto es atendido en hospitales por profesionales de medicina y de enfermería especializados en obstetricia y ginecología. La mayoría de las mujeres, conocedoras del sistema, desean dar a luz en un hospital sin plantearse otra alternativa. La estrategia al parto normal de 2008, intentó mejorar la calidez, participación y protagonismo de las mujeres en el proceso. Esta estrategia no consideró la incorporación de casas de partos en los hospitales, ni menciona la opción al parto en casa. A pesar de los datos que aporta la comunidad científica del parto en casa, este es considerado altamente peligroso, siendo sus principales oponentes las sociedades médicas de ginecología y pediatría, los equivalentes a la Royal College of Obstetricians and Gynaecologists (RCOG) y la Royal College of Paediatrics and Child Health (RCPCH) en RU. He aquí por tanto que la escasez de profesionales dedicados al parto en casa junto con su mala reputación escenifica las oportunidades de las familias españolas.

**Analicemos la historia**

La historia nos ayuda a comprender los principios por los que se rige una sociedad. En el caso de las matronas españolas, su trayectoria a lo largo de los años contextualiza la situación precaria del parto en casa. Desde el siglo XVIII, en toda Europa y Norte América, la ampliación del discurso de la diferenciación sexual y la conocida revolución obstétrica, cambiaron la suerte de las matronas, ya que fueron desautorizadas de atender partos “difíciles” alegando como innato en las mujeres la ignorancia en temas obstétricos. A partir de 1790 comienza la formación de matronas en las escuelas, controladas por la facultad de medicina, donde sus competencias quedaban restringidas consiguiendo la subordinación a la figura médica. En contraposición con RU que formó únicamente a hombres hasta 1924. A principios del siglo XX, las matronas trabajaban a domicilio de forma privada y era en los dormitorios donde las familias veían nacer a sus hijo/as. En caso de complicaciones, la mujer era trasladada a los centros de beneficencia por la matrona, donde trabajaba en equipo con el tocólogo. Al igual que en RU, únicamente acudían a los centros públicos mujeres que deseaban ocultar su estado o cuya pobreza era extrema. Las familias costeaban los servicios hasta la llegada del seguro de maternidad, cuando los tocólogos exigieron al gobierno crear instituciones donde poder obtener control de los partos con matronas trabajando como auxiliares.

Poco a poco, los tocólogos consiguieron su propósito y, a pesar de la reticencia inicial de las mujeres de abandonar sus domicilios, tras la guerra civil española la asistencia a los partos se trasladó a las instituciones, al igual que ocurrió en otros países. La propuesta pretendía reducir muertes maternas y neonatales, sin tener certeza de que el hospital fuese más seguro que el domicilio o viceversa. Mucho antes que RU, en 1953, la formación de matronas se incluyó dentro de los estudios de Auxiliar Técnico Sanitario (ATS), que englobaba las carreras de matronas, practicantes y enfermeras en una. A partir de entonces, las matronas pasaron a ser enfermeras con una formación específica posterior de dieciocho meses en ginecología y obstetricia. Sin embargo, la falta de adecuación curricular de los estudios de las enfermeras obstétricas al nuevo plan europeo hizo que la Unión Europea (UE) parase la formación de las matronas en toda España. A raíz de este suceso, lejos de solucionar los fallos, el gobierno optó por ignorarlos y transcurrieron así diez largos años sin que se formasen matronas. Tras una larga lucha, en 1994, las recién graduadas matronas, llegaban tras muchos años de institucionalización del parto en los hospitales. Consecuentemente, los referentes de asistencia domiciliaria al parto estaban para aquel entonces a punto de jubilarse.

Como consecuencia de la hospitalización, las matronas perdieron su independencia y estatus social como expertas del parto normal. Las parturientas se convierten en pacientes y el parto en patología. Además, la propia estructuración del hospital despersonalizó la atención a las mujeres y aumentaron las intervenciones rutinarias hasta límites nocivos.

Aspecto que destacar es la formación que reciben las matronas, puesto que se cimentan en los principios generales y bioéticos de enfermería centrados en el paradigma de ayudar. Esto implica una atención matrona-gestante paternalista que, en última instancia, se impone sobre los deseos de las mujeres. El
paternalismo de los profesionales actúa en contra del derecho humano fundamental de las mujeres para tomar decisiones en el proceso de parto. Los movimientos para la humanización del parto comenzaron en los años 70, numerosos grupos de feministas denunciaron al sistema hospitalario pidiendo el retorno a la vivencia familiar, querían poder coger las riendas de la maternidad y tener una preparación al parto de manera activa y crítica. Autoras como Isabel Villena impulsaron en España proyectos de asistencia al parto domiciliario en respuesta a la violencia obstétrica sufrida por las mujeres en los hospitales. Con la participación de matronas españolas en conferencias internacionales, las ideas de Michel Odent, Frances Lamaze o Dick-Read fueron surgiendo efecto. Consuelo Ruiz fue pionera con el uso de la psicoprofilaxis del parto y gran luchadora por los derechos de las mujeres de decidir el lugar para parir. Consuelo fue una de las fundadoras de la aún vigente organización Nacer en casa. El crecimiento de organizaciones de mujeres como el Parto es Nuestro o de profesionales como ALPAC, el parto en casa en España vuelve a ser una opción segura.

Dentro de las competencias profesionales de las matronas se incluye el ejercicio en domicilios, áreas públicas y privadas. Sin embargo, no existe formación fuera del ámbito hospitalario y de atención primaria, por lo que las matronas que asisten partos en casa actúan de manera independiente al sistema, siendo las familias las que asumen el coste. No hay matronas independientes en todas las comunidades, con lo cual el acceso es limitado. Además, la ausencia de seguros profesionales de matronas o el vacío legal existente de prescripción enfermera en diferentes ciudades, hace complicado el acceso a medicamentos requeridos en emergencias obstétricas. Esto pone a las matronas en un aprieto legal que influye negativamente en su decisión de asistir partos en casa.

La actualidad

Recientemente se han publicado por primera vez en España dos estudios cuantitativos con datos de partos planificados en casa. Ambos muestran resultados similares a otros países donde la asistencia al parto en casa no está integrada en el sistema sanitario. Ambos estudios coinciden en que más del 90% de las mujeres con partos planificados en casa, tuvieron un parto vaginal de inicio espontáneo. Además, las cifras de traslado fueron menor del 15%.

Conclusión

En palabras de Consuelo Ruiz, hay cuatro enemigos principales del parto en casa: la ignorancia, el miedo, el dolor y la impaciencia. Presionar a las instituciones por un colegio de Matronas donde la educación esté basada en los conocimientos más actualizados y en las prácticas más seguras, conseguiría aunar a todas las profesionales, limar asperezas con la comunidad médica y proporcionar la calidad asistencial que nuestras familias se merecen. Incluir el parto en casa dentro del sistema sanitario no se trata de volver al pasado, sino de recuperar la confianza en las matronas para asistir partos eutócicos y en la autonomía y poder de las mujeres para parir. TPM

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Reducing the chances of women suffering from perineal trauma during birth is a hot topic in maternity care. Perineal trauma is assessed as a range of classifications relating to the severity of tearing (first to fourth degree).\(^1\) Third and fourth-degree tears pose the most significant concerns as women may suffer ongoing pain, incontinence and sexual dysfunction which has negative long-term impacts on their everyday life.\(^2\) It is estimated that up to 80% of women will experience some degree of laceration during birth, however, wide variations exist.\(^3\) Some researchers suggest variations relate to inconsistent classifications of perineal trauma or inconsistent reporting.\(^2\) However, it is also conceivable that perineal trauma is not inevitable and some can be prevented. Therefore, it is incumbent for midwives to understand the evidence for a range of techniques that may minimise perineal trauma. The focus of this skills summary is antenatal perineal massage (APM).

APM is a technique women carry out themselves (or with their partner’s help) during pregnancy from 34 weeks onward to help the perineal muscle and skin stretch more easily during birth.\(^2,4\) Massage improves the blood flow to the perineum, increases its elasticity and is associated with less perineal trauma that requires suturing as well as less chance of an episiotomy.\(^2\) In the 2013 Cochrane review\(^2\) the positive effects are most profound for primiparous women, however, more studies have since been carried out, so we can look forward to an updated review. Midwives are best placed to raise the topic of antenatal perineal massage and should create the space and time to discuss the information and to ensure women understand an effective technique. For those of you less familiar with APM, I have collated some top tips, I hope they help!

- Vaginal or urinary infections and herpes are generally said to be contraindicated, advise women accordingly.
- Familiarise yourself with the technique of APM, what it is, what it isn’t. Use the online resources I have added below to fully understand how to perform effective APM and look up instructional videos.
- Consider carrying out on your own perineum, that way you will have experiential knowledge of what it feels like to share your knowledge with women.
- Consider sourcing a model pelvis that has the perineal structures so to demonstrate the technique to women and their partners.
- Understand the basic preparations to share with women before carrying out APM; a warm shower or bath can be beneficial as the blood vessels are dilated and can be more comfortable for women; emptying the bladder; clean hands; finding a private, undisturbed comfortable space; using cushions as needed to support legs.
- Advise that lubrication is recommended for greater comfort.\(^4\) Ideally, plant-based oils so to avoid potential irritation.
- Most recommendations suggest women work up to 10 minutes of APM just once or twice a week; research has found an inverse relationship with the number of times a week women perform APM.\(^2,5\) In this case, more frequent APM is associated with a decline in benefit.
- APM should not be painful, while some sensation should be experienced to indicate an effective technique, pain should be avoided. Discuss this point with women and suggest if pain or extreme discomfort occurs to stop and try again another time. Offering to observe their technique may be helpful. TPM
Further resources


References


Homebirths in Spain: A Comment on the Current Situation and the Historical-Cultural Context

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Summary

Every year in Spain, a small number of families decide to see their future child born at home, an option that is generally rejected by Spanish society and the medical community. The national health system does not include out-of-hospital labour care in its services, making it a privileged resource from which not all families can benefit, in addition to limiting the Spanish midwife’s autonomy.
Homebirth in Spain

It is not possible to quantify the number of planned births that occur at home, since the National Institute of Statistics (INE) does not distinguish the place of birth in its registry. Spain has a total of 9,536 midwives,¹ a figure that is well below countries like the UK, which has 38,855 registered midwives in the Nursing and Midwifery Council² (NMC). Jobs are so scarce that many of the midwives work as nurses for better conditions and stability, resulting in fewer midwives than what is recommended.³ Childbirth care in Spain follows an institutionalised-interventionist model, in which women give birth in hospitals and are cared for by doctors and nurses specialising in obstetrics and gynecology.³ Most women, who are familiar with the Spanish system, therefore want to give birth in a hospital and don’t consider the alternatives. The normalisation of labour strategy⁴ launched in 2008 was an attempt to improve the warmth, participation and leadership of women in the process. Although it tried to bring evidence-based knowledge to the healthcare system, this strategy did not consider the incorporation of midwifery-led units, nor did it mention the option of homebirth. Despite the data provided by the scientific community on homebirth, it is still considered highly dangerous. Its main opponents are the medical societies of gynecology⁵ and pediatrics,⁶ the equivalent of the Royal College of Obstetricians and Gynaecologists (RCOG) and Royal College of Paediatrics and Child Health (RCPCH) in the UK. This leads to a shortage of professionals who are dedicated to homebirths, along with a poor opinion about homebirths, which impacts on homebirth as a valid option for most Spanish families.

Let’s look at the history

History helps us to understand the principles by which a society is organised. In the case of Spanish midwives, their trajectory over the years contextualises the precarious situation around homebirths. Since the 18th century, throughout Europe and North America, the broadening of the discourse of sexual differentiation⁷ and the known obstetric revolution⁸ changed the fate of midwives, as they were disallowed from attending ‘difficult’ births, by medics who alleged that women were innately ignorant of obstetric issues. From 1790 onwards, midwives began to be trained in schools,
ruled by the faculty of medicine, where their competencies were revised and restricted, thus achieving subordination to the medical profession. In the UK, female midwives did not have access to schools until 1924. At the beginning of the 20th century, Spanish midwives worked privately assisting births at home, in the calm environment of the family. In the event of complications, the woman was transferred to the public maternity hospital by the midwife, where she would work with an obstetrician in the team. In the UK, only women who wanted to hide their condition or whose poverty was extreme went to public centres.

Families paid for the services until the arrival of maternity insurance, when obstetricians demanded that the government should create institutions where women gave birth under their direct supervision, working with midwives as healthcare assistants. These institutions allowed for obstetricians to get their way and, despite the initial reluctance of women to leave their homes, after the Spanish civil war, labour care was transferred to institutions, like in other countries. The shift from home to hospitals was mainly to try and reduce maternal and neonatal deaths, although there was no certainty that hospitals were safer than women’s houses or the other way round. Long before the UK, in 1953, midwifery training was included within the studies of Health Technical Assistant (ATS), which encompassed three mainly female careers: midwives, practitioners and nurses. From then, midwives became nurses with a subsequent 18 months’ specific training in gynecology and obstetrics.

However, the lack of curricular adaptation of the studies of obstetric nurses in the new European plan in 1987 forced the European Union (EU) to close the midwife schools throughout Spain. As a result of this, far from solving the failures, the government chose to ignore them, and 10 years went by without midwives being trained. After a long struggle, the new cohort of midwives arrived in 1994, when the institutionalisation of childbirth in hospitals was perfectly integrated. Consequently, midwives were by then on the verge of retiring their calls for homebirths in Spain. As part of the institutionalisation process, midwives lost their autonomy and their social status as experts in low-risk care. Women then became patients and labour was even considered pathological. In addition, the very structure of the hospital led to the standardisation of care with a subsequent increase in routine interventions, to the point that they were harmful.
Another aspect to highlight is that the training that the midwives received was based on nursing bioethical principles, developed in hospitals (under the influence of the technocratic model\textsuperscript{12}), and centred on the paradigm of helping.\textsuperscript{13} This implies a paternalistic midwife-woman relationship that, ultimately, hinders women’s choices to be heard. With the humanisation of the birth campaign in 1970, Spanish groups of feminists condemned the medicalisation women suffered from the institutions and claimed a return to the family experience. They wanted to be in control of their bodies and their motherhood experiences by participating actively during pregnancy and childbirth. Authors such as Isabel Villena promoted homebirth assistance projects in Spain in response to the obstetric violence women suffered in hospitals.\textsuperscript{7} With the participation of Spanish midwives during international conferences, the ideas of Michel Odent, Frances Lamaze or Grantly Dick-Read were taking effect. Consuelo Ruiz was a pioneer, promoting the use of psychoprophylaxis of childbirth, and a great fighter for the rights women have to decide their intended place of birth.\textsuperscript{14} Consuelo was one of the founders of the still active organisation Nacer en Casa (Be Born at Home). The growth of women’s organisations such as el Parto es Nuestro or professionals ones for homebirths like the Catalonia Association of Homebirth Midwives (ALPAC) in Catalonia, means that homebirths in Spain are once again a safe option.

As part of the Spanish midwives’ competencies, they can practice at home, in public and private hospitals. However, this midwifery training does not include homebirths, and is based on hospital and primary care settings. Midwives who attend homebirths act independently of the system, and families bear the cost. Independent midwives are not available in every region, limiting access. Furthermore, the existing legal vacuum around non-medical prescribing practices,\textsuperscript{15} which makes obstetric emergency drugs difficult to
access in some parts of Spain, added to the lack of official bodies that protect midwifery practices with insurance, puts midwives in a legal bind that negatively influences their decision to attend homebirths.

And now... what do we know?

Two quantitative studies with data on planned homebirths have recently been published for the first time in Spain. Both show similar results to other countries where homebirth assistance is not integrated into the healthcare system. Both studies share similar conclusions: that more than 90% of women with planned homebirths had a spontaneous onset vaginal delivery and the transfer figures were less than 15%.

Conclusion

In the words of Consuelo Ruiz, there are four main enemies in the support for homebirths: ignorance, fear, pain and impatience. Pressuring institutions for a midwifery school where education is based on the most up-to-date knowledge and the safest practices would bring together all professionals, create harmony with the medical community and provide the quality of care that our families deserve. Including homebirths in the healthcare system agenda does not mean stepping back to the past but regaining confidence in midwives as the advocates for low-risk births and in the autonomy and power of women to give birth as well as make decisions. TPM

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