Blog for International Day of the Midwife

On this International Day of the Midwife we ask: why has the midwifery model of care for healthy women in childbirth been outlawed by the National Maternity Strategy?

At the heart of midwifery is the mother–midwife partnership – the theme of today's International Day of the Midwife – based on a trusting relationship developed over time through continuity of care.

Instead of advocating freestanding birth centres managed and run by midwives as an option, the Strategy sets out a medicalised "model" of community care and hospital care that is a recipe for fragmentation (and medical fees). The woman will be seen by a multi-disciplinary team, getting her from a range of alternating providers, from midwives to GP to public health nurse, while under the care (i.e. supervision) of a consultant obstetrician which she will not need if she is healthy. This is 1950s style care, unchanged from the Mother and Child scheme, dressed up in today's language. Unlike freestanding birth centres, this approach offers no continuity of care or care, although research shows this is what women want.

Earlier this year, the UN Women's Committee, CEDAW, echoed by the Human Rights Commissioner of the Council of Europe, drew Ireland's attention to the need to bring maternity services into line with international human rights standards. Swiss human rights expert Ms Patricia Schultz told the government that its highly centralised system of maternity care "transformed the most important experience of a lifetime for women and their partners into a production-line process". The resources the government plans to put into maternity care should reflect the commitment, she said, to respect the rhythm of each individual birth.

The Strategy, regrettably, enshrines this centralisation and, by extension, the production line process it has given rise to. This is a system of care known as the "active management" of women in labour. It was designed in the 1960s at the National Maternity Hospital at a time when the hospital was severely overcrowded, just as it is today. Its effect was to maximise throughput in the labour ward. Active management involves the use of highly invasive procedures, such as rupturing the waters surrounding the baby in the womb to induce or accelerate labour. The effect of rupturing the waters is intensified by administering an intravenous infusion of oxytocin, a synthetic hormone. Oxytocin causes the womb to contract more frequently and severely than nature intended, heightening the woman's pain. No provision is made in the manual on active management for women to refuse these procedures: this is a system that is premised on involuntary medical intervention. Judged by internationally accepted human rights standards, it is not fit for purpose in 2017.

This is a perspective that turns the controversy about the €300 million new National Maternity Hospital (NMH) on its head. The claim made by the NMH master Rhona Mahony about the "unarguable" need for what is to be the biggest maternity hospital in Europe rests on the assumption that centralisation is best. But if centralisation leads to industrialisation and industrialisation leads to the denial of women's human rights in the labour ward, then the last thing women (and midwives) need is a shiny, new birth factory. There is an appropriate solution to

overcrowding that is consistent with scientific evidence and with the demands of women as service users, one that would cost a fraction of €300 million.

Birth centres are a half-way house between home and hospital that provide a relaxed informal atmosphere in a homely non-clinical environment. Run and managed by midwives who provide continuous care to healthy women from the outset of pregnancy through to 6 weeks postnatal, they are common in countries who, unlike the National Maternity Strategy, recognize the scientific evidence in their favour.

For low-risk healthy women, the evidence shows no difference in the perinatal outcomes for their babies, including those having their first baby, in birth centres compared to obstetric units. While the odds of having Caesarean or instrumental birth, or surgical incision of the birth canal (episiotomy) are significantly and substantially reduced for women in birth centres compared to obstetric units, increased levels of satisfaction for women and increased job satisfaction for midwives are also associated with birth centres. In comparison to midwifery-based care in the home and integrated midwifery-led units (MLUs), the probability of transfer to an obstetric unit during labour or immediately after birth is reduced in birth centres, a finding consistent for both first-time mothers and those having their second or subsequent baby. And in relation to costs, while planned births in all non-obstetric settings lead to significant cost savings, freestanding birth centres generate greater cost savings compared to integrated MLUs.[1]

As a solution to over-crowding, there can be no doubt that freestanding birth centres are the answer. Using the internationally recognised NICE guideline criteria for 'low risk' healthy women[2], a randomised controlled trial[3] involving the population of women registering for maternity care at Our Lady of Lourdes Hospital Drogheda and Cavan General Hospital, in 2005, found that 43 per cent were eligible for midwifery-led care. Of those, 54 per cent opted to join the study offering the chance of midwifery-led care in a unique, home-from-home, integrated MLU. Those findings were recently reflected in a survey of women's experiences of maternity care conducted in 2014 by AIMS Ireland.[4] Among 2,836 women, 58.5 per cent said they would opt for a freestanding birth centre if the service were available. This evidence shows that of the 9,186 women who gave birth in NMH in 2015, some 2,132 (23%) were eligible for, and would most likely have opted for, birth centre care had it been available.

This compelling evidence on safety and cost-effectiveness of birth centres under midwifery-based care begs the significant question as to how the National Maternity Strategy could come into effect without providing for this key option of care for which there is established demand by women. What it enshrines points to the politics of power and money over health benefits: in essence, a safe-guarding of medical incomes. The unfettered influence and control of consultant obstetricians on

---

[1] Hollowell J, Puddicombe D, Rowe R, et al (2011) '*The Birthplace national prospective cohort study: perinatal and maternal outcomes by planned place of birth'.* Birthplace in England research programme; Final report, Part 4. NIHR Service Delivery and Organisation programme

[2] National Institute for Health and Care Excellence (NICE) (2014) 'Intrapartum care for healthy women and babies'. CG 190: https://www.nice.org.uk/guidance/cg190/resources/intrapartum-care-for-healthy-women-and-babies-35109866447557

[3] https://nursing-midwifery.tcd.ie/assets/publications/pdf/midu-report.pdf

[4] The Association for Improvements in the Maternity Services in Ireland (AIMS Ireland) March 2014. What Matters To You Survey 2014: http://aimsireland.ie/what-matters-to-you-survey-2015/

maternity care policy in Ireland fundamentally obstructs the development of midwifery and choice in childbirth, and is a crystal clear strategy in safeguarding the obstetric monopoly of the lucrative Irish maternity care market.

We call on the Minister for Health to have regard to his obligations under international treaties to uphold the human rights of women and girls in maternity care in everything he does. The more maternity services are centralised into larger hospitals, the greater the need for uniformity and predictability in birth to avert a labour ward bottle-neck, and the more remote the possibility that women can give birth at their own pace. If women's rights to bodily integrity, self-determination and autonomy were respected in labour and birth, the centralised, medicalised production of babies would be unsustainable.

Investing €300 million in a huge new 10,000 births per annum maternity hospital providing extensive facilities for private medical practice in the absence of any investment in infrastructure at community level to develop midwifery-based care flies in the face of women's human rights in childbirth.