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Whether to read out of interest, or to provide support with your midwifery training, continued professional development or research studies, *MIDIRS Midwifery Digest* offers something to everyone.

The journal has a long history and was developed by a small group of dedicated individuals, comprising mainly midwives and advocates of normal childbirth in the early 1980s. They all shared the common goal of supporting midwives to provide women with the best care possible during the childbearing experience. The organisation has grown through the years and built upon the strong early foundations, retaining the belief in supporting women and families in making choices based upon unbiased evidenced information.

As the name suggests, *MIDIRS Midwifery Digest* is a combination of original papers plus reprints and abstracts from other sources. This enables you to gather evidence from a range of avenues which may not always be readily accessible elsewhere. This is an international journal and as such we include relevant articles and papers which give a much wider understanding of midwifery from around the world.

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Principal Editor, MIDIRS
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Midwifery in the sustainable development era

Toyin Saraki

Midwives have played an invaluable role in women’s health for over 2000 years, with references to midwives even included in the Bible. As support for the profession grew, and training became formalised over time, the medical skills of midwives have grown significantly. Skilled midwives now have the training, knowledge and potential to provide expert advice to pregnant women about their health and the health of their child — both during and after pregnancy. This year is one of great importance for the international community as we make the transition from the Millennium Development Goals (MDGs) to the Sustainable Development Goals (SDGs). This pivotal year for international development is also crucial for the direction of midwifery, as I firmly believe that midwives will play a key role in the achievement of SDG 3 — to ensure healthy lives and promote well-being for all at all ages.
As the Global Goodwill Ambassador for the International Confederation of Midwives (ICM), the journey of the midwifery profession and midwives around the world is exceptionally important to me. As ICM Global Goodwill Ambassador, I seek to ensure that the voice of midwives is heard on international stages, such as the United Nations General Assembly (UNGA). This September at the 70th UNGA in New York, I amplified the voice of midwives globally, speaking of the incomparable impact that midwives can have in overcoming social determinants of health, protecting pregnant migrants and refugees, and providing antenatal care that can transform health habits for generations. In this role, I seek to expand the visibility of midwives by shining a spotlight on the excellent work of local midwives through my global tour of national midwifery associations, which has already seen me visit Suriname, Lesotho, the United States of America and many other countries, for regional ICM conferences. I also seek to further the vision of the ICM, its member associations, and individual midwives, of a world where every childbearing woman has access to a midwife’s care for herself and her newborn. This role is one that I am passionate about because I know that by expanding the voice, visibility, and vision of midwives, we can make a drastic impact on the health of mothers, newborns, and children around the world in this new era of sustainable development. No mother, anywhere in the world, should have to risk her life and that of her baby by going through childbirth without expert care. Complications that kill hundreds of thousands of women and babies in developing countries are managed effectively in richer countries by a midwife or health worker with the right skills, the right equipment and the support of a health system.

Since 2000, when eight MDGs came into effect, the international development community has focused its efforts on fulfilling the targets by the end of 2015. On 1st January 2016, 17 SDGs will come into effect. The SDGs seek to set the world on the road to human dignity by 2030, encompassing far-reaching goals that include peaceful, inclusive societies, climate change, the reduction of inequality, and the strengthening of global partnerships.

I established the Wellbeing Foundation Africa (WBFA) in 2004 to accelerate progress on the MDGs in Nigeria and sub-Saharan Africa, with a particular emphasis on MDG 4, which sought to reduce child mortality, MDG 5, which is dedicated to improving maternal health and MDG 6, which sought to combat HIV, AIDS, malaria and other diseases like polio. The progress that has been made on the MDGs globally has been outstanding, with a 53% decrease in preventable deaths of children under the age of five between 1990 and 2013 (BBC News 2015) and a 45% reduction in global maternal mortality rates between 1990 and 2013 (World Health Organization (WHO) 2014a). And just over ten years after WBFA began its work in sub-Saharan Africa, child mortality has fallen by 48% in the region (Gladstone & Sengupta 2014). However, despite these achievements, maternal and infant mortality rates remain high in developing countries, with Nigeria having the second highest rate of maternal and child mortality across the world (Oyedele 2014, WHO et al 2014).

During the MDG process, it became abundantly clear to those of us working to improve reproductive, maternal, newborn, child and adolescent health (RMNCAH), that access to a skilled midwife can often be the difference between life and death for a mother and her newborn in the fragile 24 hours during and after birth. In fact, the WHO (2014a) identified skilled midwifery care as one of the most powerful weapons in our fight to prevent maternal and newborn mortality, and a recent Lancet Series report on Midwifery found that by increasing access to midwives by just 25%, we could halve maternal mortality rates (Renfrew et al 2014). This cemented my belief that midwives are the linchpins of an effective health care system and if given the right education, regulation, and support of midwifery associations, midwives will enable us to achieve SDG 3 targets to reduce the global maternal mortality ratio to less than 70 per 100,000 live births and end preventable deaths of newborns and children aged under five.

Following this year’s UNGA in September, I believe that for midwives to be able to immediately implement and accelerate progress on SDG 3, a global midwifery services framework (MSF) in line with the ICM’s recommendations should be adopted in all countries (ICM 2015). A global MSF will be crucial to scaling up, improving, and incorporating sexual, reproductive, maternal, and newborn health services by midwives within national health systems. This will offer a systematic approach and support for a midwife-led model of care, which provides effective and desirable services for women and their families. This will strengthen midwifery services by offering a step-by-step guide to improving quality of care, education, regulation, and effective management of health care professionals. By adopting this framework, nations can ensure an integrated and sustainable approach to health and well-being, which are key to achieving SDG 3 and its targets.

Midwives are uniquely placed to be able to provide integrated care that can detect, prevent, and treat illnesses or health challenges that can affect maternal and newborn survival. Starting from the onset of pregnancy, skilled midwives offer vital antenatal care that can ensure both mother and baby remain healthy by providing an invaluable health education, as well as screening tests that can identify risks to pregnancy or preventable illnesses. Identifying these risks or illnesses early helps women make informed choices about their pregnancy and enables midwives to rapidly treat the
illness before birth. Moreover, antenatal care enables women to work with their midwife to develop a birth plan that prepares mothers and ensures that their wishes are adhered to during childbirth, setting the course for respectful maternity care.

During childbirth, midwives provide crucial support at one of the most vulnerable junctures of a woman’s life, and are viewed as an integral part of a labour and delivery team due to this relationship. This relationship is maintained in the weeks following birth, with midwives providing insight on bonding with your baby, postnatal depression, family planning, and birth spacing. A midwife working at the heart of the community and within a functioning health service is able to visit women to give care, advice and support. The relationship between a midwife and a newborn is also invaluable. The first 24 hours following birth are the most critical for a newborn, with one million babies dying on their first and only day of life, each year (Wright et al 2014). The frustration is greater when considering how attainable the solutions are: they sit not with complicated technological advances but with good quality care provided during pregnancy, labour and the first 24 hours after birth. Without immediate skilled medical attention from a midwife, the life of a newborn could hang in the balance. Many countries have now invested in bicycles or motorbikes for midwives, enabling them to travel to remote communities more easily and to provide more frequent visits and support.

Following birth, a skilled midwife is also well positioned to deliver advice on nutrition. Undernutrition is a serious condition that accounts for 45% of all deaths of children aged five and under (Black et al 2013) and contributes to stunting — a serious condition that affects a child’s life well into adulthood. Stunting can trap children into a lifelong cycle of poor nutrition, illness, impaired learning skills and lower earning abilities. Breastfeeding can safeguard against this and prevent 800,000 child deaths from malnutrition each year (UNICEF 2013).

From the first hour of a baby’s life to age two, breastfeeding offers protection against infection, malnutrition, and stunting. Midwives can inform mothers about the benefits of breastfeeding and offer guidance, especially in line with timing the critical first feed. They provide counsel and comfort on any health issues that may arise, such as: the need for better nutrition in the pre-pregnancy and pregnancy phases; diminished milk supply or pain in the post-delivery phase; and helping mothers track their breastfeeding progress.

However, in order to provide effective integrated care and accelerate progress on SDG 3, midwives need the tools and resources that can track patient data and provide a continuum of care. Midwives in sub-Saharan Africa often point to a paucity of data as a major challenge in treating pregnant women effectively and providing integrated RMNCAH care. The African continent suffers from a lack of accurate record keeping and data collection, with only four out of 54 countries on the continent capturing 75% or more of their births and deaths (Oti 2015). For midwives, a lack of accurate record keeping means that they cannot effectively track patient progress or identify health risks in pregnancy. For patients, a lack of accurate records means that they cannot track their own progress during pregnancy, leaving them without vital life-saving information. Learning from this situation, WBFA introduced the client-held, integrated Maternal, Newborn, and Child Personal Health Record (PHR). The PHR has been designed to be in the custody of mothers so that they can bring them to health centres during their pregnancy and labour, and up until their child attains the age of five years.
Women have to face a myriad of choices on which to make informed decisions during the childbearing continuum. Planned place of birth is of particular importance to them and their families in providing a positive birthing experience. This experience will influence future planned pregnancies and have an impact on their beliefs in the normality of labour and birth and enhance outcomes in terms of breastfeeding uptake and continuity (Sandall 2008). A challenge to ethical practice is the proposed threat to midwifery supervision, an activity that safeguards women and midwives. This paper examines the ethical implications, such as autonomy, of choosing place of birth from available choices, specifically midwifery-led care, and how these decisions can impact women’s birth experience. The discussion draws on the four principles of biomedical ethics (Beauchamp & Childress 2013) and the new Nursing and Midwifery Council Code (NMC 2015).

**Background**

Supervision of midwives has to date been lodged in statute ensuring good midwifery practice through clinical supervision, mentorship and preceptorship support (Baird et al 2015). The NMC has recently accepted recommendations that statutory supervision should no longer be part of its legal framework. In the future the role of the Local Supervisory Authority will be abolished and the Department of Health will now have to consider how best to ensure ongoing supervision and support for midwives. As a result of the Parliamentary and Health Service Ombudsman’s investigation (Parliamentary and Health Service Ombudsman 2013) it is suggested that combining professional regulation and supervision presents a conflict of interest to the public. Consequently, contextual factors and statutory changes in the supervisory aspects of midwifery will have an impact on midwives’ autonomy as they must consider the consequences of their decisions without support of the supervisory process (Baird et al 2015). This places midwives in what is perceived to be a vulnerable position (MacLellan 2014) and therefore they must seek alternative approaches to the care they provide. One useful approach would be the value of relational autonomy, which is discussed in the next section.

A number of studies indicate that women’s perception of midwifery-led care provides a better childbirth experience (Coyle et al 2001, Walsh & Downe 2004, Morano et al 2007, Begley et al 2011). In addition, in contrast to previous studies, Rogers et al (2011) found that 87% of women perceived that birth in a stand-alone birth centre provided a safe alternative to either home birth or a hospital birth. This is one aspect of maternity service provision both in the UK and in other parts of the world.

Hatem et al (2008:2) points out that:

‘The underpinning philosophy of midwife-led care is normality, continuity of care and being cared for by a known and trusted midwife during labour. There is an emphasis on the natural ability of women to experience birth with minimum intervention’.
The impact of clinical research on developing an alternative way to provide antenatal and postnatal education to Black and Minority Ethnic mothers, using the internet as a means of mass communication

Gergana Nikolova

Introduction

Maternity services in the UK are among the best in the world, however as more studies define the internet and social media as factors reshaping the way maternity care can be provided (Lagan et al 2011, Lima-Pereira et al 2011, Dugas et al 2012), opportunities for development should not be squandered. Research Councils UK defines research impact as ‘the demonstrable contribution that excellent research makes to society and the economy, of benefit to individuals, organisations and nations’ (RCUK 2014), therefore the findings from a literature review published by the author last year (Nikolova & Lynch 2015), which looked at women’s use of the internet during pregnancy, were implemented in the design of a new model of early antenatal education for Black and Minority Ethnic (BME) mothers and families.
Is water birth natural?
Eileen Cunningham

Background: Women’s confidence in their innate ability to give birth risks being lost under the threat of a medical culture focused on risk. ‘Normal birth’ is becoming more difficult to define and the philosophical underpinning of midwifery may be becoming compromised. Water immersion is currently being promoted as a means of empowering women and women are choosing water birth in order to reclaim control over their birth experience.

Objective: This paper aims to provide a new awareness of water birth, one that goes beyond the safety and conventional assumptions of water birth, phrasing new questions regarding hominid evolution and capturing the significance of water to childbearing women.

Design: Systematic literature review drawing upon qualitative, quantitative and grey literature.

Search strategy: Electronic databases that were deemed relevant to midwifery were systematically searched: Cinahl, Scopus, BNI, ScienceDirect, MIDIRS Reference Database and the Cochrane Library. Further strategies including back chaining, snowball sampling and author searching were used in order to identify additional literature. Secondary data such as text books, opinion papers, commentaries and theories were considered in a narrative summary.

Findings: The findings enhance our understanding of the significance of water for women. Literature suggests evidence of a genetic bond to an aquatic past from both a maternal and neonatal viewpoint. Water birth is exceeding women’s expectations of birth and is keeping both mothers and infants safe.
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