LEADER OF THE MATERNITY CARE: DOCTORS OR MIDWIVES

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ABSTRACT

Technology of delivery of health care for developing countries is not a resolved issue. Moreover, maternity care differs from other areas of health care in many ways. Developing countries have to carefully adapt to what has been done in developed countries. Recent debate and data on maternity health care organisation have been in favour of midwifery-led maternity care. Midwifery-led maternity care is described as the best and necessary part of the sufficiently and thus inevitably health producing maternity health care organisation.

Key Words: Midwifery-led maternity care, maternity health care organisation, midwives, doctors.

INTRODUCTION

In relation to antenatal care it has been argued that the service of flawed methodology has been exported to developing countries and is being promoted by WHO and other agencies.¹ In a recent WHO trial, a basic regime of four antenatal care visits, with a specific emphasis on interventions of proven effectiveness, was as effective in preventing adverse events in low-risk women and their babies than the typical regime of upto 12 visits. It may also be less costly.² Moreover, full-fledged maternity care can only be conceived if it has all three components: antenatal, intranatal and post-natal.

DISCUSSION

Maternity care differs from other areas of health care in the following ways:

- a. Most users of maternity services are usually well. Maternity services need to avoid over-treating and over-medicalizing pregnancy and childbirth, otherwise this can lead to iatrogenic complications and waste of resources.
- b. Some users of maternity services will through the pregnancy develop conditions requiring a higher level of maternity care. Many of these conditions are unpredictable and some are life-threatening. Maternity services therefore

also need to be wary of under-treating some women.

- c. Maternity care is aimed at least two recipients, the mother and the baby. Outcomes for both are important, so advantages and disadvantages for each need to be counterbalanced.
- d. Maternity services deal with the culturally and emotionally sensitive area of child-birth. Non-biomedical outcomes may be more important for childbirth than for other areas of health care. Hence, recently quality of care in maternity services has been defined in a comprehensive way:

High quality of care in maternity services involves providing a minimum level of care to those who need it. This should be done while obtaining the best possible medical outcome, and while providing care that satisfies women and their families and their care providers. Such care should maintain sound managerial and financial performance and develop existing services in order to raise the standards of care provided to all women.³

The difficulties in measuring maternal mortality have led to a shift in emphasis from indicators of health to use of health care services.⁴ Furthermore, the recognition that some women need specialist obstetric care to prevent maternal death has led to the search for indicators measuring the met/unmet need

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for obstetric care. Although intuitively appealing, the conceptualisation and definition of the need for obstetric care is far from straightforward.⁵ Historical data suggest that the key factor enhancing the decline in mortality appears to have been the sharp rise in professional attendance by midwives at home births (from 40% to 78%).⁶

The various ways of delivering essential obstetric services were described for settings in which the maternal mortality ratio is relatively low in a review by Koblinsky, Campbell, and Heichelheim. The review yielded four basic models of care, which are best described by organizational characteristics relating to where women give birth and who performs deliveries. In model 1, deliveries are conducted at home by a community member who has received a brief training. In model 2, delivery takes place at home but is performed by a professional. In model 3, delivery is performed by a professional in a basic essential obstetric care facility, and in model 4 all women give birth in a comprehensive essential obstetric care facility with the help of professionals. It appears that not all countries are ready to adopt Model 4, and its affordability by many developing countries is doubtful. Although, there have been some successes with model 1, there is no evidence that it can provide a maternal mortality ratio under 100 per 100 000 live births. If strong referral mechanisms are in place the introduction of a professional attendant can lead to a marked reduction in the maternal mortality ratio.⁷ An increasing influence of the demise of linearity in managing health services has been speculated and a call for post normal health care has been made. Kernick writes that the emerging science of complex adaptive systems offers a complementary perspective on organisational analysis and is already finding an application within health care. The emphasis moves away from the features of normal science (analysis, prediction and control) to focus instead on the configuration of relationships among the system's components and an understanding of what creates patterns of order and behaviour among them. The important features are connectivity, recursive feedback, diversity and the existence of self-ordering rules that give systems the capacity to emerge to new patterns of order.⁸ This complexity theory perspective may suggest a key-word nurse-midwife to those involved in reforming health systems, conducting development work in third-world countries, and those responsible for creating sustainable and growing maternity health care system and organisations in these developing countries. In developing countries context the professional around which maternity care has to be organised might be the midwife. This was supported by evidence from an intervention study in Bangladesh.⁹ Later contribution on this subject by Maine and colleagues emphasised the fact that services of midwives had to be backed up by adequate referral services.¹⁰ This is natural and obvious, because even if hypothetically obstetricians were posted to the

villages instead of midwives, the services would need equally adequate referral backup. In Indonesia it was reported that after launching of a strategic programme of a mid-wife in every village, though specialized obstetric care could not be provided for all women needing it, skilled birth attendance increased dramatically.¹¹ This only indicates of the need of further strengthening of the midwifery-led services. After appropriate screening, intrapartum care for low risk deliveries is effectively provided by midwives.¹² If those arguing for homebirth in developed countries and those exploring the dire necessity of skilled attendance at birth in developing countries could speak with one voice the midwifery-led maternity care as the best option for organising maternity care could be made more evident, though it seems the proposal has generated immense response for now and is accepted by many working in this field. Role of the nurse-midwife for primary care of American women was reviewed and highly acknowledged.¹³

CONCLUSION

Building a midwifery-led community-based maternity program could achieve desired results not only in the sphere of primary care, but also in the sphere of comprehensive maternity health care.^{14,15,16} If one cannot go without "E" (evidence) in MCH as suggested by Miller et al, or fashionable reproductive health of today midwifery-led community-based program could be the target question or product to be evaluated.¹⁷ But at present one is compelled to ask rhetorically: if only the maternity health care which is sufficient and thus inevitably produces maternal health can be termed as appropriate, then isn't the midwifery-led maternity care as the best and necessary option while organising maternity health care, at least in the poor developing countries?

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