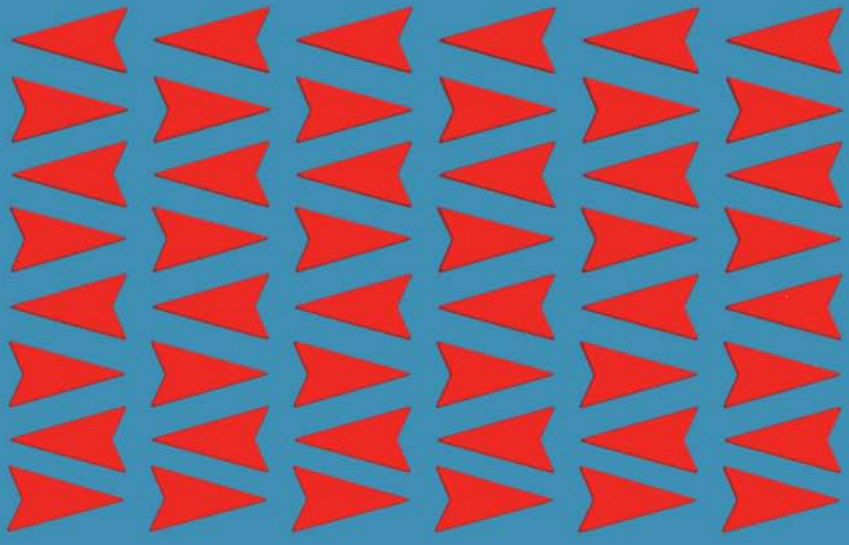
Helpers in Childbirth

MIDWIFERY TODAY



Ann Oakley
Susanne Houd

Helpers in Childbirth

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Midwifery Today

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Midwife . . . substantive, Middle English (probably formed from MID, preposition + WIFE in the sense 'woman' (so midwoman, thirteenth century), the notion being 'a woman who is *with* the mother at birth.'

Oxford English Dictionary

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Foreword

At the annual meeting of the thirty-two Member States of the European Region of the World Health Organization (WHO) in 1979, the Regional Office was asked to evaluate maternity services and make recommendations. In the process of evaluating these services, it became clear that midwifery services are an essential component of care that is being sorely neglected. Midwifery services are essential because the nature of the care provided by midwives is qualitatively quite different from the care given by obstetricians, although both professions contribute equally important components of care. Surveys suggest that when midwifery is subservient to obstetrics, or is altogether absent, the proper balance in maternity care is lost. This may lead to excessive use of technology and dehumanization of care.

Because the evaluation showed the importance of midwifery to quality maternity care, the WHO Regional Office for Europe decided to launch a research project to attempt to delineate further the nature of midwifery. Susanne Houd, a Danish midwife, and Ann Oakley, an English medical sociologist, had done an outstanding job on a WHO research project on alternative perinatal services, and we asked them to carry out this project. A practicing midwife with wide experience in many care settings together with a sociologist who had spent

many years researching and publishing on women's issues and birth issues proved to be an excellent combination for this type of research.

This book is the result of the research project on the nature of midwifery care. Research on midwives has been rare in the past. The information presented here can make a contribution to the important effort to strengthen midwifery and its central role in all maternity care.

J.E. Asvall
Regional Director
WHO Regional Office for Europe
Copenhagen, Denmark

Preface

This book began as a research project that changed its size and character during its gestation period. It is the product of collaborative work both within and outside the World Health Organization (WHO), which has spanned some six years. Ann Oakley is an English sociologist researching and writing in the field of health care and family life, and Susanne Houd is a Danish midwife practicing in both the community and the hospital and also involved in research. Both of us have worked as consultants for WHO, and we are both strongly committed to the idea of international and interdisciplinary work as the only reliable way of escaping from misleadingly narrow frameworks and cultural preoccupations. Midwifery is an international issue. Because childbirth both unites and divides cultures, the issues that preoccupy midwives working in one country will not be far from the heads and hands of others working elsewhere.

Over the past thirty years, a revolution has taken place in the care given to pregnant and birthing women in industrialized countries. Twenty years ago, most deliveries occurred at home, and in most places it was very difficult to obtain a delivery bed in a hospital. Care was mostly given by midwives, and there were few medical interventions in pregnancy or during delivery.

Beginning in the late 1960s, the centralization, medicalization, and techno-

logization of pregnancy and delivery have increased enormously. During the 1970s, the rate of home births dropped considerably in most European countries—even in the Netherlands, famous for its tradition of home-delivered babies. By the end of the 1970s, it had become as difficult to get a home birth as it had previously been to arrange a hospital birth. Through health personnel, the media, and—after a while—friends, relatives, and the community as a whole, the message given to the expectant mother took on a newly ominous tone: birth became an abnormal and therefore dangerous event.

By this time, of course, deaths of mothers and babies had become much rarer than they had ever been. However, labels of normality or abnormality have little to do with the real risks of childbirth. Other factors are important in shaping how childbirth is seen and treated at any particular time. Over much of the industrialized world in the past twenty years, the dominant ideology has become that birth is normal only in retrospect: because of this, hospital birth with all its attendant "in case" technology is said to be the safest kind of birth to have. New rules for birth have been laid down: no birth more than eight hours, no second stage longer than one hour, all women to have episiotomies to prevent prolapse of the uterus in later life, and so on. As an integral part of all these developments, maternity care has come to be more and more under the control of obstetricians, and midwives have found themselves less and less able to care for childbearing women as independent practitioners skilled in the art (or science) of normal childbirth.

The experience of birth as normal has almost disappeared from industrialized society. Over the same period of time, the developed world has moved toward emphasizing the risks and hazards of life in other ways. The constant fear of nuclear war and the experiences of unemployment, crime, pollution, and stress are factors in our daily lives that color all our expectations of what life has to offer. We have lost the ability to look at life positively, concentrating instead on its dangers and risks.

However, social change has a tendency to generate its own counteractions. At the end of the 1960s, another set of attitudes began to emerge. These attitudes are based on a less materialistic lifestyle, on political movements for self-help and personal liberation, and on the idea that life is more likely to be a positive experience if regarded in a positive light. During the 1970s, the extension of this new political awareness into the health care movement spawned grass-roots groups that developed a new model of health care as something communities can and must do for themselves. And, finally, the women's movement and the grass-roots health movement got around to thinking about pregnancy and birth.

At first, the women's movement needed to go through a period of distancing itself from traditional female tasks. Only in the 1980s did it begin to accept that the power lying in the female ability to reproduce can be a source of energy, self-respect, and fulfillment for women. Other groups in the 1970s

worked for better birth conditions. These consisted mainly of parents who did not like the births they had had or expected to have and who began to ask awkward questions about the appropriateness, safety, and effectiveness of current birth procedures. Along with feminists and the protagonists of the new models of health care, these groups then began to work in parallel, attempting to retrieve our buried cultural knowledge of normal childbirth.

Increasingly, a confrontation has developed between two models and philosophies of childbearing. In one, pregnancy and birth are areas of life that belong to the medical profession: they are abnormal, disease-like conditions of the body, requiring expert management and control. According to the other model, pregnancy and birth are part of ordinary life experience, even—or especially—because they sometimes merge with death.

Who stands at the point of divergence between these two approaches to childbirth? The midwife. Her legs straddle the chasm between the two philosophies that describe childbirth as medical and social events. She is the expert, but also the practitioner of the normal; her expertise must be channeled into the preservation of the mother as the chief deliverer of her own child. These days, this has become a contradiction in terms, for there is no such thing as normal childbirth any more. The only "normal" childbirths are those that assertive and informed middle-class women fight for—and what can possibly be normal about that?

For these reasons, we have chosen to make midwives the central subject of this book.

In 1981–82, we worked together on a WHO project on alternative perinatal services in Europe and North America, and we prepared a report on this project in 1983. This study was concerned with the alternatives to the official services for pregnancy and birth that existed in ten sample countries (we discuss some of our findings in Chapter 5). Out of this work, ideas developed for further work: interviewing midwives and obstetricians about their definitions of risk in childbirth, and making observations and conducting interviews on the theme of midwifery work, both inside and outside the official services. We were interested in finding out whether midwives and obstetricians tended to differ in their perspectives on childbirth and the mother's role. We wanted to find out what midwives actually did and how their capacity to behave as independent practitioners might be affected by different work settings and ideologies. We do not claim that our research is systematic or representative; it can only offer clues and interpretive insights into the patterns of behavior and attitudes that are the subject of study. Systematic testing of the ideas we present in discussing these data (in Chapter 7) will require much larger samples.

The material collected in this extension of the alternative perinatal services project appears in this book, along with a wide range of other material. The book is a blend of research, secondary material, and "mere" ideas. Its aim is to highlight the role and position of midwives as a key issue in maternity care today.

Fictitious names have been used to protect the privacy of the midwives and pregnant women who were interviewed; portions of these interviews appear throughout the book. We believe that these first-hand accounts emphasize the relevance and immediacy of many of the issues raised in this book.

Aside from our professional qualifications for researching and writing a book of this kind, our own experiences as women and as mothers have given us a driving sense of the importance of birth and of the person who, most of all, is *with* women when they give birth: the midwife.

We thank our friends, our colleagues, our midwives, and our children for contributing in visible and invisible ways to the making of this book. We are particularly grateful to those health professionals providing care for mothers and babies who agreed to be interviewed for the research included in the book, and to all those using and providing such services who allowed us to photograph them or to use photographs taken for their own private use. We acknowledge the services of Johanne Maria Jensen, who graciously offered material from two of her slide shows on birth. Particular debts are owed to Jo Garcia and Marianne Scruggs, who patiently read and advised on the manuscript: but, of course, the final form of the book remains our responsibility.

Ann Oakley
Susanne Houd

Chapter One

What Is a Midwife?

In 1961, the International Confederation of Midwives, the International Federation of Gynecologists and Obstetricians, and the World Health Organization (WHO) jointly defined a midwife. They wrote:

> A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery. She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventive measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for the patients but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child

> care. She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service.

Behind this joint definition lie slightly different definitions of midwifery in different countries. The Swedish definition, for example, states:

> A midwife is a person who is qualified to practice midwifery. She is trained to give the necessary care and advice to women during pregnancy, labor, and the postnatal period, to conduct normal deliveries on her own responsibility, and to care for the newly born infant. At all times, she must be able to recognize the warning signs of abnormal conditions that necessitate referral to a doctor, and to carry out emergency measures in the absence of medical help. She may practice in hospitals, health units, or domiciliary services. In any one of these situations, she has an important task in health education within the family and the community, family planning and child care.

The definition in the Federal Republic of Germany specifies that "the practice of midwifery includes advice and assistance to pregnant women, supervision and assistance during delivery and miscarriage, as well as care of lying-in women and newly born infants." It is stressed that the midwife must deal only with normal situations. In Italy, the midwife is also responsible for "the surveillance of a mother and her child until the latter has attained the age of three years."

Although the wording and the specified period of care differ, the message is clear: the midwife gives independent care to women who have normal pregnancies and births. Beyond these official definitions of the midwife's role, there are other important ways of describing her significance to birthing women. For example, Professor G. J. Kloosterman, former director of the Midwifery School in Amsterdam, says, "Throughout the world, there exists a group of women who feel mightily drawn to giving care to women in childbirth. At the same time maternal and independent, responsive to a mother's needs, yet accepting full responsibility as her attendant, such women are natural midwives. Without the presence and acceptance of the midwife, obstetrics becomes aggressive, technological and inhumane."

Crucial to the definition of the midwife as the person responsible for giving care to normal childbearing women is the idea that this care consists of emotional support as well as technical skills. This central idea is developed in the book *Spiritual Midwifery* (1980) by the American lay midwife Ina May Gaskin, who says:

> We have found that there are laws as constant as the laws of physics, electricity or astronomy, whose influence on the progress of birth cannot be ignored. The midwife . . . attending births must be flexible enough to discover the way these laws work and learn how to work within them. Pregnant and birthing women are ele-

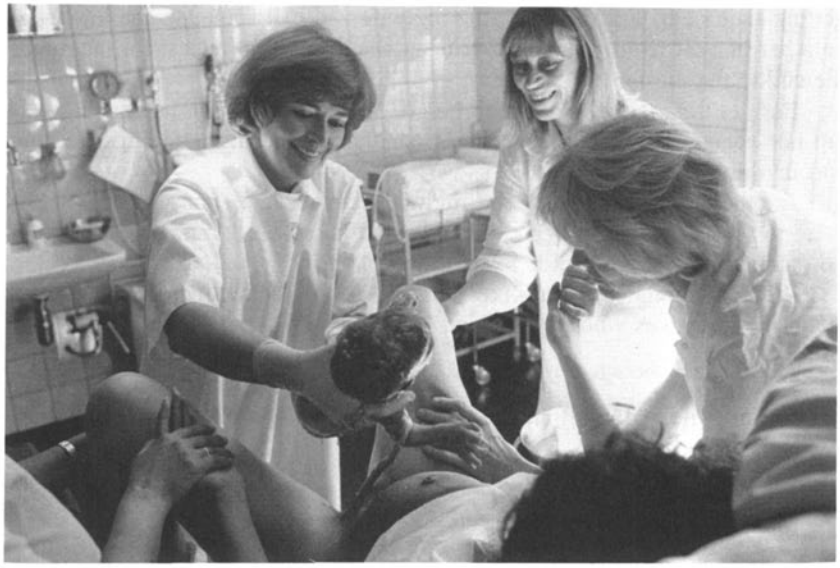

Figure 1 Danish midwife. (Photo by Jo Selsing.)

> mental forces, in the same sense that gravity, thunderstorms, earthquakes and hurricanes are elemental forces. A midwife . . . needs to understand about how the energy of childbirth flows—to not know is to be like the physicist who does not understand about gravity.

A Danish midwife writes that "the midwife must know herself, so that she knows what is going on between the woman, the man and the child. It's easiest if she knows them from the beginning of the pregnancy. She needs to help the woman and the man, making sure that they have just as much help in the postpartum period as they did before and during the birth. They must have peace to get to know the baby and each other in the new situation. This situation is new with every new child that is born."

The key phrases are: to know oneself, know the family, give people space to know one another. A midwife can judge a couple's security with each other and their commitment to the child, both before and after it is born. During the labor, they do not need to be constantly told how far the birth has progressed; they are in the process, it belongs to them. They want the midwife and other helpers to join them in this. They want to receive help from them if problems develop, but they are fully aware that they themselves are closest to the child. The midwife has important work to do in the circle around the family. She can see for herself when she needs to go into this inner circle, when others should enter, and when to pull out of the circle again. She is the connection, the person

who can get help from outside when necessary. There are different ways of getting such help. For example, the midwife can call someone she knows will help her in a difficult situation. Whatever she does must be best for the mother, the child, and the father.

Besides this, the midwife must be good at her work. The best tools she has are her hands, then her senses (smell, sight, and hearing). Intelligence helps, and intuition is a must.

Another midwife says, "The midwife is a servant, not a goddess. She's there to serve you and to bring her skills and knowledge, but, beyond that, it's not her business. The birth belongs to the parents."

What do parents think of midwives? These are the feelings of some parents about the midwives who have helped them:

> A midwife is there to support you and help you.
>
> Our midwife told us all the time what she was doing, and that gives you such a feeling of safety.
>
> A midwife has no routines. . . . she is *in* the situation and responds to it individually, and that makes you feel secure.
>
> For me, the midwife was everything. . . . She was the one I gave birth together with, she was the one I listened to. In a way, I had nothing to say myself, because my body gave me the messages I needed; I followed the needs of my body. My midwife (whom I knew) gave answers and help according to my body's needs. I *was* my body, it was she who did the physical things. . . . To give birth with a midwife I did not know already—I could not imagine that.

Figure 2 Danish home birth.

Figure 3 Midwife's hands.

These individual reactions identify key elements in the role of midwives today and in the past: personal support, continuity of care, sensitivity to the mother's needs. These values are emphasized in more systematic surveys of patient satisfaction. Looking at the North American literature on nurse-midwifery in a study for the U.S. Office of Technology Assessment, Brooks found that mothers readily identify greater ease of communication, and more "patient" control over labor and delivery, as characteristics of midwife care. Women also say that midwives keep their clients waiting for much shorter times than physicians, on average. Women having babies share with all social groups a tendency to be satisfied with the status quo, so that this fact has to be remembered when making sense of the literature on patient satisfaction. Yet what stands out is that women are more likely to feel satisfied and confident about the care given by midwives than about that given by doctors. In North America, these differences in women's attitudes are reflected in the much lower incidence of malpractice suits for nurse-midwives. A national survey in the United States in 1982 found that 5 percent of certified nurse-midwives, compared with 31 percent of obstetricians, admitted having been sued at some time (20 percent of obstetricians had been sued at least three times).

MIDWIVES ON MIDWIFERY

Elisabeth Davis, a California midwife, writes, "Midwifery is a way of life, both grueling and transformative. The continual learning on high levels has definite effects; after a year or so of practice comes the discovery that midwifery is a whole lot more than the joy of catching babies. It makes us work on

all levels, either by disintegrating or integrating us." A West German midwife says, "My work means everything to me, and I hope that none of the women that I help gets the feeling she is just a number. I must help them to experience birth as the greatest, most natural experience that exists."

Midwifery can be an extremely exhausting occupation. In my (Susanne Houd) own work as a midwife during a time when I was constantly on call for home births, I wrote:

> When I work like this, I must have two kinds of readiness: one is a daily readiness; I have to be ready with everything practical. This reminds me of my own pregnancies, when everything had to be ready all the time. Now, arrangements for my children have to be 100% secure, because of my work as a midwife. When I'm home, I spend as much time together with them as possible. I can never promise anything in the future, only what I can do here and now. I feel it is very important that my children don't get allergic to births.
>
> I can't begin big projects. I have to be rested all the time. My love life suffers. It's difficult to get really involved in making love when you know the phone can ring any minute. But, interestingly, I'd thought beforehand that it would be worse. For slowly, this way of working has become a lifestyle.
>
> The other kind of readiness I experience during the births themselves is a feeling of being *there—right now*—at *that* birth *now:* time stops, and I get the feeling that my soul and my calmness is with me and we dive into timelessness together. But this doesn't always happen. Sometimes I'm impatient—I can't listen to the way the birth is going, and then I start to interfere.

I later experienced the same kind of dive into timelessness when I visited the midwives at The Farm in Tennessee, who consciously work with and around the energy of the woman giving birth.

All the midwives quoted so far work independently and mainly with home births. They work like this despite reactions from other professionals, which are often hostile, and despite the fact that their work usually means long, hard hours and little money. What about the other kinds of midwife—the ones who work within the system, in hospitals and clinics, who have scheduled time off, and get a salary every month, no matter how much or how little they do?

Anna Maxen is a midwife in a small hospital maternity unit in Denmark. The hospital is the only one on its island. There are about a hundred births a year. Three midwives handle all the antenatal visits and births. Anna lives five minutes from the hospital and has worked there for several years. She says, "I like my job very much. Because there are only the three of us midwives, we know each other very well, and the women know all of us. We also meet them in other situations, like your kids go to the same school or you meet them in the supermarket. I like that. We've pushed ourselves into the hospital clinic as well, so now the doctors think that it can't work without us. When there were fewer

births, we had to find other work areas, and we had so many complaints about the doctors in the clinic, the women didn't want to go there."

Midwife Beatrice Dana works at a university hospital in Denmark, where she has no chance of getting to know the women she delivers. This concerns her very much, and she tries to get as much out of each birth as possible, even though she says it is difficult to find the right balance. She says that she wants to be sensitive to each woman's needs, but "I don't know who she is or how she feels: she knows best herself. When she comes in to hospital, whether it's during the pregnancy or during the birth, I try to help her to decide how she wants the rest of the pregnancy or the birth to happen. She has to make up her own mind."

A midwife in the Netherlands, mainly working with home births but within the official system of care, talks about her way of working: "When I work, I use my instinct. On the whole, I treat every pregnancy individually. Categories of risk are a nuisance because, in fact, you might miss somebody who is not in one of your categories. I hate all these rules of thumb. I think midwives and other people have used them far too much anyway instead of using their clinical judgment."[1]

Sensitivity to the individual may be even more important for a midwife when she has no early opportunity of getting to know the women for whom she is providing care. One such midwife explained, "I look very hard at the woman, I think I can tell a lot about how she will deliver just by the way she looks." This midwife is tired of her job; she misses the opportunity for continuity of care. She has too much to do. She feels that she is not able to be sufficiently caring for the women, "but one has to survive . . . you can't give your soul every time." The need to work in shifts and countless deliveries of unknown women can exhaust midwives, so that their loyalty to their colleagues becomes greater than their loyalty to the women. This shows especially when a woman wants something different from the usual routine. For example, one midwife recounted this experience: "She told me that she wanted to stand up during the birth. But I thought to myself, oh no, I'm so tired, and what is everybody else going to say? I told her I thought it would be all right, and I went outside the room and told the others I was going to deal with this birth myself, as the woman didn't want anybody else in the room during her labor and birth. It was, of course, I who didn't want anybody there. It was difficult enough with myself, so I put a spiritual chair in front of the door, so to speak."

The practice of midwifery produces daily—and nightly—dilemmas of this kind. Writing about "The Night Shift" in the *Association of Radical Midwives Magazine,* Ishbel Kargar, a British midwife, describes how the tasks she is allocated on the antenatal ward provoke her to think not only about what midwifery *is,* but what it *ought* to be:

[1]The issue of risk categories is discussed in Chapter 6.

I walk upstairs, hoping that some of the women have gone home, as the night before we had a completely full ward, and as more than half of the 17 beds were occupied by postnatal mothers (a common occurrence). . . . We had been kept very busy all night. I find it rather frustrating to know that I am only able to give a fraction of the assistance most of these women need. . . .

My hopes have been realized, and of the 17 women I had left on the ward that morning there are now only half remaining. Some of the first-time mothers have gone home, too, and I feel that they are probably going to have a more restful night in their own beds, with only their own babies to disturb their sleep. It seems amazing to me that we don't hear more complaints from postnatal women about the noise of other babies. . . . The antenatal women are the ones who suffer from a mixed ward, and as they are usually admitted for "rest," it rather makes a mockery of the admission policy. . . .

Next is the medicine round, and the inevitable requests for painkillers begin. I am in constant conflict with myself, wondering how I, as a lone midwife, can reverse this mass acceptance of drug-taking as a way of life and wishing I could see more progress in the avoidance of episiotomy. There have been great reductions in these operations over the past few years, but the numbers being done are still far higher than in some units . . . and I feel that we should be looking at alternative ways of conducting labour and comparing results more than we do. . . .

Tonight I am unable to take my meal break away from the ward, as there are no midwives free to relieve me, so I make a cup of tea and sit down in the office with my sandwiches, hoping that I will be able to put my feet up for a short while, at least. Fat chance! The drip counter alarm sounds, and I spend the next ten minutes arguing with a piece of modern technology which seems to have a mind of its own. . . .

A call bell rings, and I am called to a woman who had been admitted for observation the day before, as she is a few days overdue and her blood pressure had risen slightly. Mrs B tells me she has been having contractions for about an hour, and they are now about five minutes apart. It is her third baby, and she recognizes the signs of true labour. I suggest she let me examine her; then we can decide whether she needs to go round to the labour ward yet. . . . She agrees, and we are pleasantly surprised to find that her cervix is 6 cm dilated. Her blood pressure is normal, and she doesn't want any analgesia, but opts to go to the labour ward, since her husband can then come in and be with her in labour, and she can walk around without disturbing her sleeping companions. This is when I wish we had a "Know Your Midwife"[2] scheme running, as it would have been so good to take her round to the labour ward, look after her in labour, help her to deliver her baby and then bring her back to the ward and carry on looking after them both. (p. 16)

Dissatisfaction with such conditions of practice sometimes leads to a midwife breaking away altogether. An independent midwife, Melody Weig, working in England, explains what led to her decision to do work on her own:

[2]See page 56.

I was always interested in independent midwifery, even as a pupil, and my experience in NHS [National Health Service] hospitals was enough to convince me. I met women in labor, helped them give birth and often never saw them again. . . .

Then there was the frustration of working with doctors at SHO[3] level, who, for the most part, had little experience and few specialist skills but who distrusted midwives and were taking over more and more of midwifery care. Why did all laboring women have to be clerked and periodically seen by doctors? Could a midwife not ascertain that a woman was in normal labor and call for help if necessary? Having trained with the belief that no labor is normal except in hindsight, the doctors' anxiety was soon transmitted to all around, and their willingness to interfere in what should have been normal midwifery cases led to many unnecessary interventions.

I was equally frustrated by some of my midwife colleagues, who seemed as stuck in their ways as the doctors. Why so many episiotomies, routine admission procedures of shaves and enemas, and routine observations in labor? No labor is routine; why try to make it so? . . . My attempts to change even small things seemed to fall on deaf ears.

I left because numerous incidents, procedures, and policies served only to undermine my midwifery skills and confidence, mystify the women they were meant to help, and turn the birth experience into a medically controlled "procedure."

I am all for modern obstetrics, but in the true meaning of the word: that it be practiced scientifically, that all interventions be of proven value, that the value outweigh the risks in each case, and that we wait and work with the process in a supportive and trusting rather than an interfering and worrying way.

Melody Weig's point about the desirability of practicing scientific obstetrics is an extremely important one for midwives today; we come back to it later.

All these midwives work in the developed part of Europe, but the constraints on the midwife's autonomy can be similar in other countries. A midwife from a less developed country describes her working history: "I've worked in a state hospital with many deliveries every day. In a way, I liked it because nobody, I mean no doctors, came and took over—I could do as I wanted. But in another way it was awful; sometimes you deliver six or seven babies in eight hours. It's impossible to get any kind of personal contact with the women. Mind you, most of them just want to get it over and done with."

A midwife in Morocco, working in a "birth house," says she has been here for twenty-five years. She has nothing to do with the women in pregnancy, meeting them for the first time when they're in labor, but she feels this is all right because "I'm here most of the time; I like being a midwife here; everybody in the neighborhood knows me."

Midwives have rarely revealed to others what it is like to be a midwife. In

[3]Senior house officer, below consultant and registrar level.

the past, they have seldom talked to each other about it. Being a midwife can be a very lonely business. In part, this is because of the importance of birth—the fact that it is a human event of tremendous importance to the individual, the family, and the community. In part, it is because of the way birth has been divided up among different professional groups, put in institutions, and rendered increasingly a medical and technological process. Wherever they work in the developed world, midwives have to find their way around complex bureaucratic and professional rules, and they must negotiate their own authentic space in the midst of confusing professional antagonisms and with continual regard for the needs of the women and families with whom they are working.

HOW MANY MIDWIVES?

It is surprisingly difficult to get correct and up-to-date information on midwives in Europe. Women who have trained as midwives may not be active in midwifery, or they may be working as nurses and thus registered in the statistics as nurses rather than as midwives. In some countries where midwives are also nurses, another cause of statistical invisibility is that it may be cheaper to belong to nursing associations than midwifery associations. In some places, midwifery is actually defined as a specialty of nursing, which makes the correct figure for the number of active midwives impossible to come by. One way of looking at the numbers of midwives in practice is in relation to the population of the country. There is significant variation here, as Table 1 shows. The figures in this table range from 129.5 midwives per 100,000 population in the Soviet Union to only 11.4 per 100,000 in Ireland. Changes over time move in both directions, with some countries increasing and some decreasing their midwife-to-population ratio. In general, however, despite these variations, it is true to say that for two decades the number and density of midwives have been declining all over Europe.

The reasons behind changes in the midwifery labor force are as complex as those behind the rise and fall of any occupational group. Shifting birth rates and other changes in the position of women, tightened legislation, the move toward institutional birth, increased use of technology—these are some factors. Statistics themselves are influenced by social forces. For example, in England between the late 1970s and the mid-1980s, there was an apparently large increase in the numbers of nursing and midwifery staff, but about half of this "increase" was due to a changed definition of the working week, which inflated the statistics, while the number of people working remained the same.

In a few countries, special efforts have been made to find out how many midwives actually work as midwives. In Norway, for example, it was found that only 700 out of 1700 trained midwives actually worked as midwives. The rest either were not using their training or were working as nurses. In a survey reported by Josephine Golden in the United Kingdom, recently qualified mid-

Table 1 Midwives per 100,000 Population in Selected European Countries

Country	Number per 100,000 population[a]	Annual percentage change since early 1970s
Belgium	18.3	−4.9
Czechoslovakia	44.9	+0.6
Denmark	14.0	+6.2
Finland	17.1	−3.4
France	16.8	+1.1
Greece	34.5	+7.3
Hungary	25.7	+3.5
Ireland	11.4	−9.8
Italy	29.1	−1.5
Switzerland	22.4	−1.9
Turkey	31.2	−1.2
U.S.S.R.	129.5	+1.1
United Kingdom	36.9	−0.4
Yugoslavia	35.2	+3.3

[a]Varies by country from 1980–84. In France and Greece, 1977.
Source: WHO (1986, unpublished data).

wives were asked their career intentions. More than two thirds did not intend to make a career in midwifery; one in ten, even so short a time (a matter of months) after qualifying, did not intend to practice at all. A number of studies conducted in this century have shown that fewer than 40 percent of qualifying midwives in the United Kingdom train because they want to practice: more than half use midwifery to further their nursing careers. Dissatisfaction with conditions of service and job prospects in midwifery are another reason for a lack of intention to use a midwifery training. One in four of a group of midwives qualifying in England in 1983 gave these as reasons why they did not intend to work as midwives.

WHERE DO MIDWIVES WORK?

Midwives work in hospitals, homes, and clinics. They are employed by the government, either centrally or locally. They work independently, either supported by the government or totally outside the system. However, to map out exactly where midwives work from existing data obtainable from international sources is difficult.

In the Netherlands in 1984, the number of practicing midwives was 860; of these, 16 percent were employed by hospitals and 69 percent worked independently, two thirds of these in solo practices. Forty-two percent of all deliveries

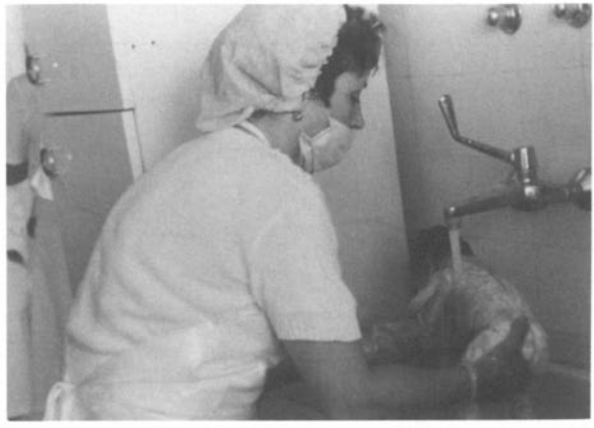

Figure 4 Midwife and baby in hospital.

that year were attended by midwives. Figure 6 gives an idea of the changes in the numbers of Dutch midwives since 1970 in relation to the two other main professional groups concerned with childbirth: general practitioners and obstetrician-gynecologists. The latter group is clearly profiting in terms of rapidly increased numbers.

In Italy, about six hundred new midwives are now licensed every year. In 1982, 69 percent of practicing midwives worked in the national health care system—half in hospitals, where they attended almost all the births, and the other half in the community, either supervised by local health authorities and

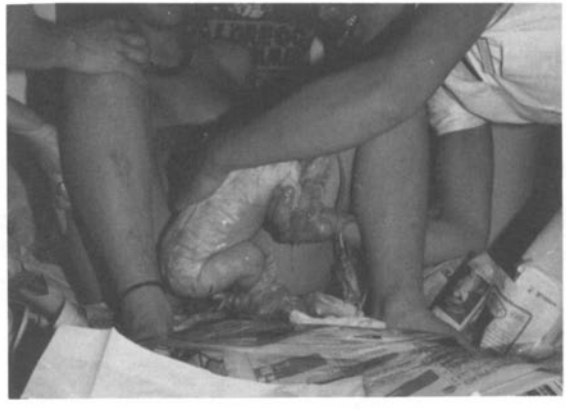

Figure 5 Midwife and baby at home.

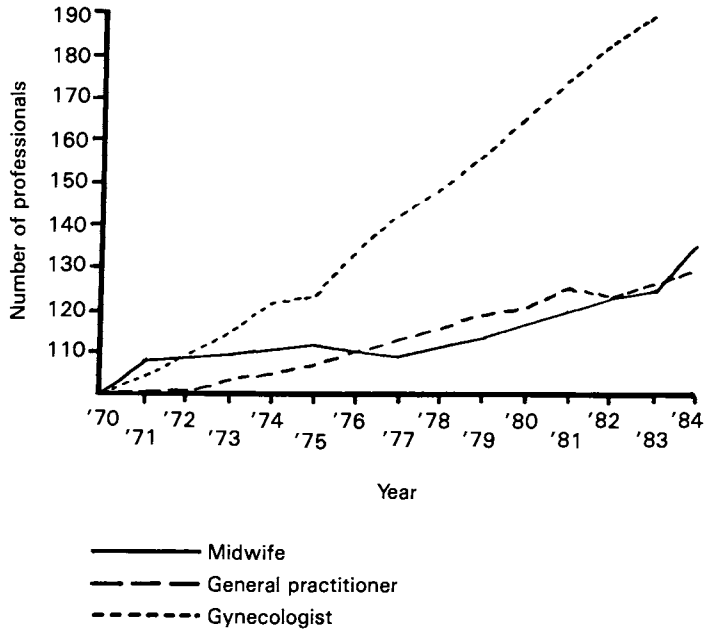

Figure 6 Development of numbers of obstetric professionals in the Netherlands since 1970. (From van Daalen, 1988, with data from Hessing-Wagner, 1985.)

working fairly independently or in family health practices (a recent development in Italy). Private hospitals employed 4 percent of all midwives, and 27 percent either worked in private practice or were retired (it is impossible to tell from the statistics whether a midwife is retired or not, since there is no age limit for a midwife in Italy).

As will be seen in the rest of this book, the theme of the midwife's competition with the obstetrician-gynecologist for the care and control of childbearing women is absolutely central to the situation of midwives in Europe today. The 1985 WHO report, *Having a Baby in Europe,* had this to say:

> Over the last 50 years, there has been a gradual decrease in the role of the midwife in providing care to pregnant women in the official services. Today, in most countries of the European Region, the visits to official services by women during pregnancy are divided between midwives and physicians. The midwife is the sole provider during pregnancy only in those areas where there are shortages of physicians. There are, however, other countries or areas where no midwives provide care during pregnancy, only physicians.
>
> There are also changes in the role of physicians in the officially sanctioned services for pregnant women. The most prevalent trend is an increasing role for

Figure 7 Styles of care-giving: the midwife at home.

obstetricians, even with uncomplicated pregnancies, with a decreased use of general practitioners. . . .

The way in which health personnel assist women during birth is at present changing considerably. In most countries, obstetricians are now in charge of most or all births. In some countries, midwives remain in charge of uncomplicated births, referring any complications to the physician, while in a few countries, midwives are in charge of all births, uncomplicated and complicated, relinquishing

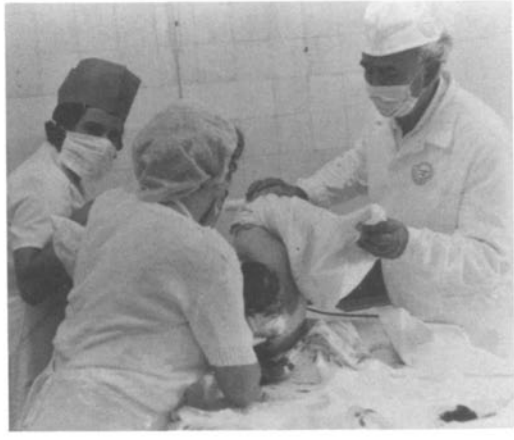

Figure 8 Part of the "team."

> responsibility only for Caesarean section. . . . As births move into big hospitals, physicians in training participate more in births. The overall trend, therefore, is for physicians more and more to take responsibility for all births. As a result, midwives find themselves more and more becoming physicians' assistants. This is a significant trend, since midwives (at least in the past) and physicians have had, in general, quite different styles of care during birth.

In other words, midwives and obstetricians are not interchangeable as providers of care for childbearing women. They have different histories, which help to account for their different styles of care. Thus, before looking at what midwives actually do in caring for childbearing women today, it is necessary to look at the emergence of the profession from its beginnings in the informal care given by women to one another during this both ordinary and extraordinary event called "having a baby."

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