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WOMAN AND MIDWIVES: POSITION, PROBLEMS AND POTENTIAL

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ABSTRACT

Summary

Objective: To describe and analyse birthing models in a number of countries, particularly Samoa and China, that have been the focus of my recent research and to discuss how cultural frameworks, colonisation and ideas of what is ‘modern’ influence the nature, place of birth and its attendant.

Implications for practice: Midwives need to reflect on their practice and consider broader health policy and how it impacts on health systems. They also need to understand the social, economic, historical and cultural context of practice including the influence of gender inequality and attitudes to women and themselves as midwives.
Introduction

In this paper I aim to encourage midwives, to think about the place of women in society, the position of midwives in supporting safe birthing and the potential for improvement. The goal is to help us consider how ‘femaleness’, cultural frameworks and history determine opportunity, status and problems and how all of these factors influence the nature, place of birth and its attendant.

Professional and local matters most often preoccupy us in our practice and professional development, and as midwives, we seldom raise our heads from the pressure of everyday work and personal responsibilities and think: Why do I practice like this? What has influenced this? How do other midwives practice and why is this different from my practice? Perhaps even rarer is the question; why do women around the world experience poor health care and limited attention to their emotional and practical support needs around birth?

As a midwife who has been privileged to visit, study and work in a number of different countries, I am aware that universal understandings are sought or claimed about what is best and appropriate for women. One of the few universals that holds is that in most cases, women attend and support other women at birth. How this occurs varies across time and cross-culturally (Barclay, 1986). Here I provide a bird’s eye view of issues for women in several countries with a particular focus on Samoa which is one of the smallest nations and China, one of the largest. I also describe the potential for improvements that can occur when women and midwives work together to meet women’s needs. I draw on my own personal journey and reflections and a range of Western and non-Western examples to develop this argument. My own recent research, and important work by others, confirms that it is necessary to understand institutions, organisations and political, social and economic structures to understand how health services work (De Vries et al., 2001, Institute of Medicine, 2001). Midwives need to consider broader health policy and how it impacts on their
place and role in society in order to understand and improve services and practices for the women in their care.

There is a complex set of interactions that demonstrate maternal death is not just a matter of health care but also an issue of social justice and human rights (Family Care International, 2000). In particular discrimination against women contributes to maternal mortality and morbidity (Ravindran and Berer, 1999). Despite more than a decade of focused global endeavours maternal death and morbidity remain unacceptably high worldwide with more than 500,000 women dying annually in pregnancy or childbirth around the world. These women are predominantly poor, young, uneducated and in developing countries (Ravindran and Berer, 1999). However, in Australia which is not classed as a developing country or publicly acknowledged as a discriminatory society, significantly worse outcomes occur for Aboriginal women (Slaytor et al., 2004). At the same time Australian women with private health insurance receive more obstetric care and also have increasing and unacceptable rates of operative birth and morbidity (Roberts et al., 2000). Globally, reform in maternity care has frequently been based on ‘modern’, mostly biomedically dominated assumptions (see for example Lukere & Jolly, 2002). These assumptions are often without an empirical base (Barclay, 1998, Cummins and Macintyre, 2002), and rely on technical analyses and opinion that do not consider social, behavioural and cultural knowledge or values.

International policy initiatives begun in 1987, led by the World Health Organisation (WHO) and others, have increased commitment and activity around maternal mortality and morbidity and The Safe Motherhood Program. The results have been disappointing and less successful than anticipated (Ravindran and Berer, 1999). Well-intentioned efforts have addressed technical
aspects of this problem. For example; identifying ‘risk’, increasing contraception to prevent unwanted pregnancy, training of traditional birth attendants (TBAs), antenatal care, and problems with the effective delivery of services (Ravindran and Berer, 1999). Even measuring rates of death and service improvements through maternal mortality (MMR) remains highly problematic in many countries. As an outcome measure MMR suffers from problems of reliability of data in rural and remote settings with underreporting or exaggerated over reporting, the relative rarity of maternal death, possible taboos about reporting, generalizing across regions and costs associated with measurement (Lukere, 2002). The quality of health services for childbirth is more likely to be measured through process outcomes, for example caesarean birth and direct and proxy evaluation of services (Abou Zahr and Wardlaw, 2001), morbidity rates, client ‘satisfaction’ and case audit of known and traceable deaths (Wardlaw and Maine, 1999). An example of this is how caesarean section (C/S) births are too seldom performed in areas with poor birthing services. Conversely, as described in the Australian case cited above C/S occurs too often in user pays services that are often over supplied with doctors.

**Background**

In the 1970s and 80s I began to study the profession of midwifery internationally and comparatively by reading as much as was possible and observing friends and colleagues overseas. This study alerted me to differences, way beyond those I expected. These were related not just to cultural differences and affluence, but also historical influences such as colonisation. Which nation was the colonising power, how and when they exercised that power made a substantial difference to the type of maternity service that evolved. The influence of medicine and technology, and perhaps most profoundly of all, though not always the most obvious, societal
gender values and attitudes to women, all influenced the care women received and the style of practice of their birth attendant.

My physical journeys began in the 1970s as I learned from a series of international visits to Canada, the United Kingdom, the Netherlands and France. This experience surprised and challenged me as I grappled for the first time with my own cultural idiosyncrasies and expectations. I learned an incredible amount, not only about other ways of doing midwifery but also more importantly, about my own views and why these were held. For example, I expected the Netherlands to exemplify an ‘idealised’ midwifery. In many ways this was so but the necessity of transferring a woman who was sick or needed medical care to the nurse and doctor challenged my sense of what was ‘best’ for women. In such cases, where women’s reproductive health was compromised and anxiety levels increased, I believed these women needed midwifery. In the United Kingdom the ‘hospital and obstetric era’ was dominant and in Canada I saw shackles on the sides of birthing beds. Over nearly four decades I have attended all but one of the International Confederation of Midwives conferences. These conferences have raised my awareness of a range of strongly held views on issues such as Direct Entry Education nurse midwifery; the east west and north south divides and the challenges of trying to make international organisations work for a range of members whose strongly held views are so different.

In the 1980s, I had a chance to visit India and following that, Papua New Guinea and Samoa. In these places I was able to observe and learn how women experienced traditional systems of birthing support, and how colonisation and lack of resources influenced the development of health systems and birthing services. I have written about this previously and I quote:
“In the highlands of Papua New Guinea (PNG)... The professional nurse-midwife told me, with some pride, how each woman having her first baby would be given an episiotomy and then she would undertake the suturing of the repair. I observed women, for whom modesty of the thighs and genital area is a vital part of culture, lying on their backs, without privacy and virtually naked... alongside other women similarly exposed. The labouring woman had no company ... and laboured alone. There were sporadic and mostly silent or scolding visits from the overworked midwife as she undertook physical assessments of the progress of labour and condition of mother and baby” (Barclay et al., 2005p 4-5).

In the late 1980s I worked for a time in India and visited the labour ward in the central hospital which was considered to be one of the best in the country with many of the medical staff having qualifications from the United Kingdom, North America or Australia. Again I learned a great deal and I quote:

“I saw women delivering without any social or family support, lying flat on their backs, undergoing routine episiotomy, being shaved of their pubic hair and having their bowels emptied with an enema.... In my naiveté I imagined that culture might have ameliorated some of these excesses of Western pseudo scientific practice. Or that the research, long earlier reported in the literature and that identified these rituals as valueless, would have begun to influence practice in one of the major medical and nursing [midwifery] education centres in the country (Barclay et al., 2005p 5).”
In India I also saw, in the lives of village women, a lack of opportunity that a Western woman would find unthinkable. For example, if a family were poor a boy might be treated but a sick girl child would not. The minority of women who went to hospital for birth had to pay an extra fee if they required treatment. Often they were not able to pay the extra, so any benefit the hospital may have offered was not available to them despite the financial sacrifice they made getting there. This was the first time I experienced, rather than just read about, females who were unimportant because they were women, and families who were not prepared or able to pay the cost to get them to medical care.

In recent years I began working in Indonesia and again worked with and observed another mix of beliefs and colonised systems around birth. As the Dutch had been the colonising power, midwifery had always been strong, independent and separate from nursing. This held even through periods of nursing domination at government level, led by United States trained nurses. The professional midwifery organisation successfully resisted a hegemonic attempt to dominate and reduce the quality and status of midwifery and currently a professional resurgence of midwifery, educationally and in other ways, is evident in Indonesia. Nevertheless, hospital practice, as in many countries where this is promoted as ‘safer birth’, is heavily medically dominated and often unrelated to current evidence. Indonesia is a country that struggles to meet the needs of village women for safe birth because of costs of transport and quality of emergency care available. Even if a woman does manage to get to hospital in a crisis, blood transfusion, for example, might not be available and would cost money if it were. Poverty and chronic ill health are common, particularly in rural areas, with diseases such as malaria causing serious co morbidities.
Two contrasting case examples

In the last decade I have become increasingly interested in the complex relationships between government policy, health systems and birth outcomes. This has led to work in China where I am leading research with Australian and Chinese colleagues in two Chinese provinces. The contrast with Samoa is stark. China’s population of 1.2 billion is one fifth of the world’s population occupying the world’s third largest country after Russia and Canada. In China macroeconomic reforms have been accompanied by new evidence of stark and growing disparities in health (Grogan, 1995, Liu et al., 2001). In China, as well as elsewhere, decisions about resource allocation, education of health workers and the introduction of technologies around birth are made based on ‘modern’ assumptions, and policies are premised on ideas accepted as fact often without accompanying empirical information.

China has undergone a transition to a market economy since the late 1970s with a concurrent rise in household incomes and economic development contributing to a dramatic improvement in health (Yunguo and Bloom, 2002). One marker of this was infant mortality which declined from 179 per thousand to 44 per thousand (Iredale et al., 1999). Maternal mortality, however, was ten times higher in the poor interior of China compared to the prosperous coast and infant mortality actually increased by 25% in poorer counties during the 1980’s (Liu et al., 2001). Investigations show marked differences within poor and more affluent rural areas (Iredale et al., 1999, Qian et al., 2001). Poverty influences outcomes in ways that are complex and not only for obvious reasons such as lack of services, inability to pay and administrative exclusion (Iredale et al., 1999).
Poverty is not the only explanation for poorer outcomes around birth although women cannot get care if they cannot pay, as China has a ‘user pays’ health system.

Work with colleagues in Australia over recent years has sensitised me to the toxic effects that health funding and insurance systems can have on the experience of Australian women able to afford private health insurance. This work has demonstrated how unnecessary health system expenditure can result from medical interventions (Roberts et al., 2002, Tracy and Tracy, 2003), and how remoteness, race and racial attitudes influence birthing experiences (Kildea, 2001, Smith, 2004, Watson et al., 2002). Similarly, our research in China investigates the proposition that health funding models lead to both poor and more affluent women suffering from poorer quality maternity and birth services across cities and rural areas of China. Not unlike Australia, and other very different settings, there is paradoxically and simultaneously an absence and overuse of services in rural and urban settings respectively. Both contribute to unacceptable levels of morbidity and mortality. The unintended consequences of reform-associated changes to health sector funding, and polices around use of health workers, are now becoming apparent in outcomes for birthing women in China.

Prior to the economic reforms in China, rural areas had a crude but apparently effective system of part time barefoot doctors and village midwives (Yunguo and Bloom, 2002). Now midwifery seems conceptually linked to ‘feudalism’ with village midwives grouped together with barefoot doctors and equated with inadequate standards of health care. This ‘premodern’ health system is incompatible with contemporary China’s social categorising of reproductive health, which incorporates family planning, to include child quality and quality ‘births’ (Greenhalgh, 1994, Greenhalgh, 1999). As Li Fuchun, a Chinese sociologist, claimed recently, in an English language
publication (it is not possible to know in English whether he was referring to a village or hospital midwife but one suspects the former) the phasing out of the ancient midwifery profession is a big step forward for Chinese society’ (Peoples Daily, 30 September 2002). As the numbers of health workers overall has declined, the overall quality of nurses and doctors has improved through increased training and certification (Iredale et al., 1999). Rural governments did not have the same capacity as more wealthy urban centres to support local services and better-trained workers relocated to urban settings. There has also been, alongside the privatisation of health services, an abandonment of local rural collective insurance schemes and the demise of the local midwife and the barefoot doctor (Iredale et al., 1999).

Training of midwives commenced in China with the establishment of a midwifery school in the 1930s. After the Cultural Revolution prestigious medical schools began enrolling nurses but excluded midwives from enrolling (Lucas, 1982). Our early research confirms that midwifery education, albeit at times at a less than professional level and of lower status than nursing education, persists in at least the two provinces in which we work. Obstetricians, comparable to Western post graduate specialists in medicine, are not common except in major cities. However, four year educated medical graduates called obstetricians are more numerous, at least in township health services, than midwives. Our research also shows that the ‘Outpatient and Emergency model’ of universal hospitalisation for birth is the preferred design for delivery of care even in poor rural areas. In this model women are referred to hospitals by doctors where they commence a patient journey through large outpatient departments, often being seen by numerous midwives and doctors, before giving birth in high technology delivery suites and being sent home 2 to 3 days later with rudimentary postnatal care.
common to general acute hospitals in the West, is the

The differences in access and quality of services between rural and urban populations are increasing (Knight and Song, 1999, Yunguo and Bloom, 2002). All health facilities, both rural and urban, have become at least partly self-funding with hospitals across the country reliant on charges levied for tests, curative services and dispensing medications. This has reduced preventive services and encouraged exploitation of services for which fees can be charged (Iredale et al., 1999). It has also had a profound effect on the style of maternity care provided. The capacity of rural facilities to charge fees is limited by the capacity of their population to pay. Measures of mortality and morbidity are disturbing across the rural-urban spectrum with maternal mortality highest in rural areas. The maternal mortality ratio was 62 per 100,000 in rural areas compared with 33 per 100,000 in urban in 2004 (UNDP China, 2005). Avoidable morbidity attached to operative birth is evident in cities in China and figures from our own unpublished audits as well as published data indicate that C/S is now very common, increasing from 1 to 2 per cent in the 1950s to 40 per cent in the 1990s in some hospitals. Even higher rates between 70 and 80 per cent are recorded in recent years for some hospitals at the district or town hospital level (Huang, 2000, Qian et al., 2001).

Excessive operative birth rates in major cities appear to have become a site of economic exploitation in similar ways to some Western or South American countries with hospitals or doctors benefiting from increased fees attached to C/S birth (Hopkins, 2000, Huang, 2000, Perkins, 2004).

Research in China presents additional interest. China has at least nominally had a ‘one-child policy’ since the late 1970s. This policy and both the successes and problems in regulation of
population help identify how health and social systems interact. For example, homebirth in association with an effective system of referral and emergency care, may be a safe economical option for most women around the world. It may also be seen to reduce opportunity for surveillance and could be seen as antithetical to China’s policy of accelerated modernisation and encouragement of delayed marriage and child bearing with higher quality births (Greenhalgh, 1999). In China, as elsewhere, government policies may have major unintended impacts on birth outcomes. Government policies that change the economic base and health funding system, that cease or retain low status midwifery education in comparison to that provided to nurses and doctors and policies promoting population control will create a particular style of maternity service, skillmix and associated costs.

Samoa

Samoa is a small south Pacific island nation north east of Australia and New Zealand and about 3,500 kilometres west of Hawaii. The population was around 176,848 in the 2001 census (Samoan Health Department, 2002). Influenced by British missionaries from the 1830s, it was colonised by Germany and Great Britain and later by New Zealand following World War 1 becoming an independent constitutional monarchy in 1962. In Samoa in 2002 there were 3,264 births recorded in health service facilities which include hospitals and smaller clinic services (Samoan Community Health, 2002). Research conducted by our team and reported in Lees (2004), showed many women were continuing to give birth at home with the support of the social midwife (more commonly described as Traditional Birth Attendants or TBAs). There are only 31 registered nurse midwives, all of whom are professionally qualified nurses, active in practice in Samoa (Health Department Annual Report, unpublished, 2002). Within the Government health system there is
one qualified obstetrician, one senior registrar, one house surgeon and one overseas qualified
doctor working in obstetrics (Samoan Health Department, 2002). There is also one private
hospital in Apia where about 100 births occur annually. One of the owners of this hospital is a
specialist obstetrician.

With Samoan colleagues and another Australian midwife I explored a clash of birthing cultures
common in countries introducing Western health care into traditional or socially managed
processes of health, healing and birth. We studied the experiences of social and professional nurse
midwives in Samoa by collecting their stories. Many previously colonised non-Western countries
are now responsible for the development and maintenance of their own health care and health
systems. However, colonisation has left them with Western aspirations, attitudes and education
systems but with non-Western budgets and cultural beliefs that remain their own despite many
years of Western influence and domination. Traditional birthing systems may have disappeared or
have been hidden. Samoa is different since not only has a ‘social birth culture’ remained, albeit
mostly underground until recently, but this is now being incorporated into the current health
system.

There are at least 89 active ‘high status’ TBAs or social midwives in Samoa (Barclay et al., 2005).
Originally chosen for this role because of their leadership potential or because they are married to
a Chief they contrast with low status midwives found in some other countries, for example in
Bangladesh where midwives may be low caste because of their link to rituals of pollution
(Rozario, 1998). The nurses and midwives of Samoa fought for high quality education in the 1980s
(Barclay et al., 1998). The professions of nursing and midwifery are closely aligned and their joint
efforts have produced university standard degree level entry to practice for the registered nurse
with a postgraduate diploma for education in midwifery. Courses studied include sociology and Samoan culture, with a specific focus on Samoan birthing and the role of TBAs. All these courses, and other professional developments such as standards and protocol development) are set within a Samoan professional philosophy developed from their own cultural beliefs.

Within the health system, evidence based guidelines and protocols for management of antenatal, birth and postnatal care have been developed and tested locally. I undertook this work over several years with colleague Caroline Homer. It was funded by the WHO under the auspices of a national Safe Motherhood Committee. A national Safe Motherhood policy has been accepted which enshrines the place of the TBA. In part this describes respect for traditional beliefs and practices around childbirth provided in the community through the Traditional Birth Attendants (TBAs) that has been retained alongside modern medicine and contemporary professional midwifery.

As part of this Safe Motherhood project, and based on our own research, a directory of TBAs has been established. This has resulted in over 80 known, active TBAs being linked to the health system though partnerships with local nurses and midwives (Barclay et al., 2005). Since 2002 these TBAs have completed a ‘Birth Book’ record for every birth they support which provides details of the birth and outcomes for mother and infant. The Birth Book was introduced through training provided for combined groups of midwives, both social (TBAs) and professional. This was to ensure that mutual responsibilities of both were known and understood and also that the professional midwives did not impose the book onto a group of ‘non-professionals’. The important data produced is only just beginning to be analysed. Anecdotal reports demonstrate the books are providing not only data but also an opportunity for better partnerships between both groups of midwives as they work together to collect statistics and review cases at regular. Data on
330 TBA attended births in 2002-2003 was collected and analysed by Kaisarina Tooloa Papua for the Safe Motherhood Committee (Samoan Community Health, 2002) and was reported in our recent book (Barclay et al., 2005). Only minor complications were recorded at these births and appropriate referral was made in all cases. There were no complications reported that suggest inappropriate practices occurring. For example there were no reported intrauterine infections, minimal post partum haemorrhages, no tears requiring suturing or traumatised babies from these 330 births although the reliability of the reporting system remains to be validated over a longer term.

I recently revisited the questions that stimulated our research with my Samoan colleagues as we explored the research and other activities undertaken around Safe Motherhood in Samoa. I wanted to know why this small country was so successful in its adaptation to the problems it faced of insufficient resources and professional personnel and how it been able to incorporate Samoan customs and beliefs into birthing practices. We believe one of the reasons is their ‘nursing philosophy’ that incorporates Samoan beliefs and supervenes the very Western and unsuitable curriculum frameworks imposed previously by palangi (foreigners) and resented by Samoan nurses and midwives (Barclay et al., 1998). Being proudly Samoan appears to give confidence to highly professional leaders so they are discriminating in their adoption of international practices and the advice taken from consultants or professional colleagues.

There is a strong spiritual basis to Samoan birth. While many Samoans are Christian, older beliefs which existed long before Christian missionaries arrived in the 1880s also play an important part in birthing rituals. The power of God remains very real and tangible to the women who participated in our research. To me this seems analogous to the faith a Western woman appears to
put in the ‘doctor’ or medical science. Professional and social midwives alike put their trust and faith in God. There are a number of our participants, again both socially and professionally educated, who chose to birth alone and these women preferred to be with ‘God’ rather than anyone else at this time (Barclay et al., 2005). In Samoa, faith in Western medicine is balanced with other strong cultural beliefs about birth, illness, life and death.

The absence of a cash economy remains an important consideration in Samoa as some families have little or no money to pay even the minimal fees charged by hospitals or doctors. These families can provide food, cloth or ‘fine mats’ and therefore ‘gift’ rather than pay cash for the service of the TBA. The TBA also usually lives close by and comes to the woman’s own home while health service care requires transport and money for a bus if there is no vehicle in the village. There are also relatively few medical practitioners in Samoa and therefore no competition for economic rewards from births. There are also too few obstetricians and professional midwives working in over stretched hospitals and the Government encourages and supports safe alternative birthing services which are available in the community outside the hospital system.

Samoan midwives and nurses have worked hard at their own formal and informal professional education. Of the educators and clinical leaders in this small country, fourteen have completed overseas bachelors degrees and five masters degrees, despite the challenges that this has involved. Others are still studying despite limited sponsorship and low salaries (Barclay et al., 1998). Thirty-six have completed an accelerated, locally administered upgrading program at the National University that recognises prior learning and produces a Bachelor degree in nursing after eighteen months of study for suitable candidates. Local leadership has been stable, is very well informed and internationally well positioned. Local leaders have made the most of travel opportunities and
international participation on projects. Two professional nurse midwives have provided a substantial contribution to WHO projects internationally and to work in the South Pacific. The head of the nursing service, Associate Professor Pelenatete Stowers, is an experienced midwife and has been in her position for over twenty years with a high quality stable leadership group supporting her over this time.

At a global level it is unlikely that there will ever be enough professionals to attend every birth. This Samoan model shows how a highly valued and complementary system of social birth support can be being maintained alongside a modern health service where women and infants can be referred where necessary. The closely linked service is able to provide safe and economical care for women in their own homes. Samoan professional midwives no longer believe that women have to fit into the Western hospital-preferred mode of birth. They have personally collected evidence showing that when deaths occur they are likely to occur inside as well as outside the hospital (Barclay et al., 2005).

Conclusion

It is curious to imagine that Western style heath systems are appropriate or achievable in countries where human and monetary resources are limited. Many countries, not just China, assume that hospital births performed by doctors are indicators of ‘modern’, good quality maternity services. However, global research shows that some hospitals, particularly in poor countries, may be ill equipped, unhygienic, understaffed and actually contribute to mortality (Byford, 1999, Loudon, 2000). Theses I supervised from Papua New Guinea in the 1990s and India in the 2000s showed high risks of hospital acquired infection and the challenges of minimizing this in a country without
running water and taps or soap in many facilities. This risk is now exacerbated by reports of HIV AIDS rates in both countries.

Recent technically dominant ‘modern’ assumptions about birth have proved to be problematic as evidence demonstrates that community orientated midwife led birth is often safer with lower C/S rates and fewer admissions to neonatal nurseries (Homer et al., 2001). Research has also shown that the continuous presence of a support person reduces the likelihood of medication for pain relief, operative vaginal delivery and reduces the risk of low Apgar scores (Hodnett, 2002). One of the most significant and measurable interventions is ‘continuity of care’ (Waldenstrom and Turnbull, 1998), the supportive relationship that is established between the midwife and the woman and her family during pregnancy and childbirth. Women who are cared for by professional midwives also experience greater satisfaction with care and are more likely to breastfeed (MacDorman and Singh, 1998). Recent reviews demonstrate that professional midwifery care is as safe as routine hospital care (Hodnett, 2002), and is less costly than interventionist obstetric care (Tracy and Tracy, 2003). Despite this, women all over the world increasingly believe that obstetric birth is an optimal model that gives them more control over the event (Bewley and Cockburn, 2002a, 2002b, 2002c). In affluent areas of China and Australia, as in other affluent countries, government funding polices result in over servicing through increased operative birth and consequent increases in morbidity (Roberts et al., 2000). I would argue that in China and Australia as well as elsewhere neither women’s own informed preference nor research evidence is the basis of services provided (Qian et al., 2001).

There are some powerful recent successes emerging in Western health care as some countries are changing birthing services to meet women’s needs; rather than the market place, biotechnology or
to satisfy the income or status needs of medical practitioners. Evidence of effectiveness and midwifery led research has often assisted with these decisions, but this is not enough. Socio-political change and increasing influence of women who receive the services is necessary before profound change that affects the culture of medically dominated, women ‘unfriendly’ health services can occur. Through these means in New Zealand, for example, midwives gained access to the same funding model as medicine for provision of care for childbearing women. Midwives worked with women to establish new models over a decade ago with a high level of political astuteness to influence context and systems so women have choice (Hendry, 2003).

While I cannot see an end to poverty or gender discrimination that creates differential opportunities for women, or cultural differences that disadvantage women or the female child, birthing women do not have to be wealthy or well educated to have a good birth experience and to be well supported by midwives. Understandings about birth sit within understandings of social context and influences beyond, as well as within, the health sector and disparities in health status and economic capacity across nations. As I have shown above it is necessary to try to bring these multiple understandings together to explain, make sense of and improve birthing care for women globally as well as understand why women receive the health services they do.

Most of us are women who also empathise and understand what childbirth can be like when the women’s experience and personal growth is valued. We have the luxury of fighting to achieve this in our own health systems. Few of us have had opportunities to understand the powerlessness of women or midwives in other countries when women can bleed to death without anyone seeking help. Even if help was sought there may be no safe blood transfusion and if there were, it may not be provided to them unless they could first pay.
I hope this paper introduces you to some of the range of experience of women around birth worldwide, their position as mothers and the problems they face in relation to birthing. Pregnant, labouring and post partum women often get little attention from society, receive poor health services and limited or no attention to their emotional and practical support needs. Midwives have potential to make a difference to the care that women receive but they must understand and work within or change the context that governs this.

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