There are increasingly rare occasions when the spontaneity of physiology opens up to the delight of our profession as midwives. This event, childbirth, so human and primitive, natural and wild, becomes something which is unprecedented and infrequent in the hospital environment where the pressure of care and the safety of the women who are considered as patients are paramount.\(^1\)\(^2\)

Midwives base our raison d’être on the professional bond with women, accompanying their processes, helping them to be protagonists at the moment a family is born, always from a professional perspective that defends the right to respect their time, their desires and expectations, their preferences in reproduction, the birth process and breastfeeding.

However, in the course of learning and practising the profession, we are subject to the hierarchical model pre-dominant in the healthcare organisation, and we have also been incorporating, in our knowledge base, the advances that accompany the contemporary development of knowledge in the health and care sciences.\(^3\) Even so, traditionally, learning has focused on risk detection and has been based on the diagnosis of pathology and its treatment. This fact distorts the view of the whole picture and makes it very difficult to accompany physiological processes from a perspective of normality.

This premise decrees that the global concept of health be developed from this perspective, defining how women’s specific processes have been pathologised and subjected to excessive interventionism.

Safety in care has taken precedence, based on a defensive practice that has resulted in excessive manipulation of women’s health processes. Moreover, it is worth noting that the approach to women’s health has a marked absence of a gender perspective. The lack of incorporation of gender training content in university curricula also influences the health organisation, so that professionals are trained with experience, knowledge and ways of acting that are totally gender biased, which limits the incorporation of the gender perspective in health organizations.\(^4\)
These misconceptions to which this paradigm has led are probably one of the causes of what we call obstetric violence, or in a more light-hearted tone, malpractice, and have been integrated into the learning process during university and specialty training. The current model of care for women during health processes such as pregnancy and childbirth means that care is provided in highly technical or even surgical settings, with high rates of interventionism, unsuitable for fostering a warm environment and, consequently, not centred on the needs of women and their families. It could therefore be said that the concept of obstetric violence emerges from the need for a change of model that is oriented towards a more respectful treatment of physiological processes and the needs that women have been expressing in recent years.

Against this backdrop, it is perfectly understandable that different organisations such as the World Health Organisation (WHO), the United Nations (UN) and women’s defence associations denounce the appropriation of women’s bodies and reproductive processes by health agents, which is sometimes carried out from a hierarchical model that is not very humanised, resulting in the loss of autonomy and decision-making capacity of women themselves, a fact that has a direct impact on their health and quality of life. These organisations are calling for a policy of patient-centred medicine, especially bearing in mind that pregnant women are, for the most part, healthy users of the health system; rather than patients, their care should be as close as possible to physiology.

Some of the measures that the associations urge health authorities at regional and state level are: to promote continuous training of professionals in practices backed by scientific evidence, to guarantee the requirement of informed consent for any intervention, mandatory updating of hospital protocols on a regular basis and regional health plans that include measures to improve sexual and reproductive health, transparency in data and information related to the care of women, as well as allocating sufficient resources to improve care at birth in accordance with the existing evidence.

These claims are supported by the data that determine that Spain is the first country in Europe, together with Ireland, to have a higher percentage of instrumental deliveries, inductions and episiotomies, all of which are well above the WHO recommendations. This information is published in the evaluation reports on the implementation of the Strategy for Childbirth and Childbirth Care in the National Health System and in the document Perinatal Care in Spain: Analysis of physical and human resources, activity and quality of hospital services.

Acknowledging the existence of this problem is an obligatory step in the process of implementing a strategy for improvement; it is essential that all professional groups linked to women’s health rethink and evaluate our actions from a critical and constructive approach. This analysis must have institutional backing in order to establish meeting points between all those involved, valuing the contributions of patients’ associations and scientific societies involved in the care of women and newborns.

This objective has been set by the Women’s Health Observatory, which is currently working on the revision of the Strategy for Normal Childbirth Care in the National Health System. For this, evaluation and updating is necessary through an exhaustive analysis of the effectiveness and implementation of interventions in different contexts, avoiding the entrenched and inherited care practices that are routinely practised and which, according to current evidence, have been found to have a negative impact on the wellbeing of women and newborns and on the economic costs to public health agents. However, we must also consider the fact that in order to provide better care focused on women users and families, and from a more physiological perspective, as demanded by different organisations that watch over women’s rights, it is essential to review the organisational structures of maternity services in Spain, since as they are currently set out, they have a direct influence on the perpetuation of certain obstetric interventions and on perinatal outcomes.

The majority of women in Spain continue to give birth in conventional obstetric units attended by teams of midwives and obstetricians in deep hospital and quasi-surgical settings, and alternatives to this model of care are rarely presented in the National Health System. However, despite this context, midwifery care in obstetric units is associated with lower rates of operative deliveries and severe perineal damage, among others.

To change our model of care, a clear classification of the level of obstetric risk is a priority. This requires the correct definition of a portfolio of services that establishes the professional profiles that must assume, according to their competencies, the care of women during pregnancy, childbirth and the postpartum period, and in the same way, generate a new model of care, centred on the woman and her family and in line with the preferences expressed by women. In this sense, it is also worth highlighting the importance of the legal document Birth Plan; which has served to favour communication between women and professionals during the care process.

There is solid evidence that supports the importance of proposing a change in the model of care in Spanish maternity wards, in such a way as to promote a greater presence of these services led by midwives to attend women with normal and low- and/or medium-risk pregnancies. This new model must be based on the empowerment of women, on information to help them make shared decisions and put the social and health needs of women and their families at the centre, not only in the care of the birth process, but in all spheres of women’s sexual and reproductive health. In other words, care from the bio-psycho-social model during sexual and reproductive health care. If we focus on the birth process care, there are already experiences in the implementation of Birth Centres led by midwives at an international level and in Spain, obtaining very good obstetric and satisfaction outcomes and these outcomes may be inconvenienced if midwives propose another safer, more satisfactory and less costly way of caring for low/medium risk obstetric births.

The value of midwives in the National Health System is undeniable, especially when efforts are being made to improve women’s health during their sexual and reproductive lives. They are the key professionals in whom it is important to invest in order to provide solutions to the problems that exist in Spain’s maternity wards. Adequate training
and preparation of future midwives must be ensured, integrating the gender perspective, promoting quality care services for the female population and their families, and of course, guaranteeing a generational turnover that ensures a decent ratio of midwives to women, as is the case in other countries around us in Europe.

However, little has been done to invest efforts and resources in alleviating the shortage of midwives in Spain. From 2010 to 2018 there was an increase of 17.7% in the number of midwives, but there an estimated decrease of 16.6% in the number of places available for the training of Internal Nurse Residents (EIR for its initials in Spanish) for the speciality of midwifery. When this is added to the period in which the creation of places in the national territory was interrupted, an uncertain future presents itself, in which either the number of places in training is increased, or we face a period of shortage of these professionals at a national level. What is certain is that there is a serious problem in the way women are cared for during the birthing process in Spain, but the cornerstone of the solution has been abandoned: we need more midwives, with a greater presence in decision-making and taking leadership in the sexual and reproductive health strategy. 19 This is the best way to increase the sexual and reproductive health of the population, to give women back autonomy over their bodies and their decisions and, in short, to favour a positive experience of all the processes in which women receive sexual and reproductive health care.

References