



Midwifery in the 21st Century: The Politics of Economies, Medicine, and Health

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Editor's Note

What follows is an edited excerpt of the ACNM Foundation Therese Dondero Lecture presented at the 2004 ACNM Annual Meeting in New Orleans, Louisiana. The author is Bridget Lynch, RM, Assistant Professor, McMaster University, Ontario, Chair of the Division of Midwifery, St. Michael's Hospital, Toronto, and Regional Representative for the Americas to the International Confederation of Midwives.

It was with great pleasure and a good dose of humility that I accepted the invitation from the ACNM Foundation to give the Dondero Lecture at this 49th Annual ACNM Conference. The pleasure is derived from being in the midst of such a dynamic group of women, and the humility is speaking as a part of the legacy of Therese Dondero. It is appropriate, however, that I invoke her spirit this morning, as we need the spirits of the innovative and courageous women who have come before us to guide us in these uncertain times.

My chosen topic is "Midwifery in the 21st Century: The Politics of Economies, Medicine and Health." I will attempt to braid these three strands: our relationship to medicine, to economies, and to women's health care, distinct areas that are infinitely intertwined.

THE RELATIONSHIPS BETWEEN MIDWIFERY, NURSING, AND MEDICINE

The United States

One hundred years ago was quite an exciting time in the United States. This was the Progressive Era, the era of suffragettes and the fight for contraception. It was the era of the development of a notion of public health and the firm establishment of medical science as the basis of medicine. The American Medical Association, which had been established in the early 19th century, was finally gaining control over health care and establishing normative standards for medical education and medical practice within the hospital setting.¹ There was active outreach by doctors who promised safety to women as medical obstetrics pathologized pregnancy and birth.²

Although midwives attended more than 40% of births in the United States in 1915, this number diminished to less than 11% by the 1930s.³ The reasons for this decline are multifaceted. But among them was that midwives were a disparate group lacking in unity and organization. Despite concerted efforts to eliminate midwifery, there were a small number of midwifery schools that were established and survived this time in the United States, but their total number of graduates was extremely small. However, as midwives dwindled in numbers, in both the United States and Canada, public health nurses were given the responsibility of providing prenatal and postpartum care to women under the direct supervision of doctors. In 1907, there were only 700 public health nurses in the United States, a number that grew to 11,500 by 1927.⁴

The point I am making here is about the powers that influenced public and political agendas. Medicine developed and built a strong profession by uniting and pushing their agenda. They took over maternity care by defining pregnancy and childbirth as a pathological process within a risk-based value system and, despite significant evidence to the contrary, promised women better outcomes under a physician's care in a hospital setting.^{1,2,5,6} We are living with this value system to this day: one that has directly led to the current malpractice crisis, where women sue when the promised good outcome does not occur.

It was not until the revitalization of midwifery programs as a nurse-midwifery specialty in the 1960s, 1970s, and 1980s that midwifery began to develop a legitimate national profile here in the United States. But it is interesting to look at the ways nurse-midwifery has continued to use the medical bias and gaze in order for midwifery to survive. A medically sanctioned form of midwifery has emerged by aligning itself within nursing. Nurse-midwifery distinguished itself from non-nurse midwives, thereby contributing to a notion of the "legitimate" midwife versus the "non-legitimate" or non-nurse midwife. This has resulted in nurse-midwifery being engaged in a tenuous relationship with nursing and medicine and midwifery. As midwives strive for increased autonomy in the United States, both nursing and medicine have undo influence on the education, regulation, scope of practice, independence, and financial stability of the profession.

This is not about having answers to this complex issue; it is about asking questions, reviewing the history of

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midwifery and the allegiances that have been formed in order for midwifery to survive, and then questioning the status quo. It is about finding the wherewithal to ensure the survival of a fully autonomous profession of midwifery by recognizing the colonial, political, and patriarchal forces that have shaped it.

Canada

In Canada, efforts by the national Canadian women's organization to recognize and educate midwives failed in the early 1900s, due to similar political and medical influences that were taking place in the United States at that time.^{7,8} During most of the 20th century, public health and obstetric nurses provided supportive care to pregnant and birthing women under the direct supervision of physicians. Small numbers of lay and indigenous midwives continued to practice midwifery, and nurses who had midwifery training (mostly from abroad) worked in remote northern communities. During the 1980s, there were increasingly active groups of lay midwives and consumers who wanted midwifery care recognized across the country. In the province of Ontario, the government responded by establishing a task force to study the issue.

The task force examined midwifery in Holland, Denmark, Britain, and the United States. On the basis of the experiences and challenges they witnessed in the midwifery systems in these countries, the task force recommended that Ontario establish an independent direct-entry midwifery profession with the route of entry in the form of an undergraduate health sciences degree in midwifery.⁹ Midwifery would be self-regulated with an independent regulatory body.

The nurses' associations in Ontario fought hard to include midwifery within nursing education and regulations. Many physicians lobbied fiercely against independent midwifery. Together, they campaigned for nurse-midwifery, which would be practiced only in the hospital setting.⁹ But independent midwifery found support from many consumers, some physicians, and key politicians. The independent model was implemented under the Ontario Midwifery Act, which took effect December 31, 1993. During that time, other provinces were also engaged in recognizing midwives. Today, direct-entry self-regulated midwifery is the Canadian model of midwifery care in 5 provinces and 1 territory. Our regulations require us to attend birthing women at home, in birthing centers, and in the hospital setting. We have staff hospital privileges, and our provincial hospital regulations require that all on-call obstetricians provide midwives with backup care as needed. In 4 of the 5 provinces, midwives are publicly funded by the provincial Ministry of Health.

There are several points to make here. One is that we were in a privileged position in Canada in many ways because midwifery had never been regulated. We had the luxury of looking around the world and examining other

systems. We saw that the strongest most autonomous models of midwifery in the world were the independent direct-entry models. The only groups who disagreed with us were the physicians and nurses' associations who wanted to exert control over the profession.

The other important message here is that, through this process, we developed ongoing relationships with midwives from other countries. In Britain, where nurse-midwifery has long been the norm, more than 50% of midwifery students are now in direct-entry undergraduate midwifery health science programs, some of them similar to our education programs in Canada.

The point I am emphasizing is the importance of coming across our borders and learning from each other—weaving the threads of our work and experience back and forth and thereby creating a strong fabric of relationships and stronger professions of midwifery in our respective countries. These thoughts are intended to add to the vigorous discussion and reflection that are currently taking place among midwives here in the States. Who is currently representing midwifery in local hospitals, in state legislatures, and in educational settings—nurses, doctors, or midwives? If midwives maintain that we are independent practitioners, why are we ever being represented by anyone but ourselves? This issue is not unique to the United States. These questions are being asked in other areas of the world where nursing and midwifery share regulatory boards, educational settings, and funding. These questions are being asked wherever physicians are in control of a midwife's scope of practice.

There is a seismic shift that is currently taking place in obstetric care in the United States. The obstetric system is showing extreme signs of strain, mostly due to malpractice insurance. This is a time of opportunity and I urge you to seize it. You are developing a critical mass of midwives. You have successfully established midwifery on the public radar. You have a stunning history of women who have organized and made impressive advances in the profession. But questions must be asked. What is the agenda for midwifery here in the United States—what is the ultimate goal of the profession? How are midwives partnering with women and each other? Are there ways to unify your efforts and establish midwifery as the primary maternal health care discipline in the United States? It is important to midwifery not only in the United States, but in the rest of the world that midwifery in the United States be united and strong. The strength and autonomy of midwifery in each country directly translates into the work and voice of midwifery at the global level. If we have no direct autonomous voice in our workplace, in our educational setting, in our state or provincial legislative assembly, how can we be effectively recognized and involved in woman's health care globally?

AUTONOMOUS MIDWIFERY AND HEALTH POLICY DEVELOPMENT

The World Health Organization (WHO) has acknowledged midwives as central to reproductive health and urges Member States to involve midwives “in the framing, planning and implementation of health policy at all levels.”¹⁰ This statement begs the question: Are we recognized in our own countries at state/provincial and federal levels as independent professionals who hold that responsibility? It is vitally important to recognize that the WHO and the International Confederation of Midwives (ICM) expect midwives to step forward as an autonomous voice, central to issues of reproductive health at all policy-making levels. This is actually a question of the survival of the profession of midwifery globally. If we do not appear at those policy-making tables, we will simply be forgotten. We will be bypassed and lose the opportunity to be primary stakeholders in women’s reproductive health.

Midwives, I believe, should be claiming the role of the protector of women’s reproductive health globally. We should be taking the lead in this area. As midwives, we are positioned in our very philosophy of care to focus on the determinants of health. Our holistic notion of care includes psychological, social, as well as physical aspects of health. It includes primary prevention initiatives. It includes respecting cultures and traditions. If we truly believe this, then we must also include challenging the economic policies that threaten the psychological, social, and physical well-being of women and their families around the globe.

THE ROLE OF GLOBAL ECONOMIES

By understanding what conditions cause ill health, we can begin to get involved in participating to change them. The largest inequity in health care between rich nations and poor nations is in reproductive health. We all know the statistics. Ten years ago, 500,000 women a year were dying in childbirth in developing countries. Today, the numbers are almost 600,000 a year, despite more than a decade of efforts to reduce maternal mortality. In addition, 5 million women a year are disabled due to pregnancy-related conditions.¹¹ As we all know, maternity is not a disease. Then why is it killing and maiming women in ever-increasing numbers?

A recent World Bank study has shown that a typical developing country is poorer today than it was before global economic restructuring began 20 years ago.¹² Poverty negatively impacts biological health, access to care, and social status. Poverty puts women at risk of dying in childbirth. In the infamous words of Kofi Annan, “The face of poverty is a woman’s face.” And I would add that the face of wealth is the face of a man. To take it a step further, the color of that poor woman’s face is usually not white, and the color of that rich man’s face usually is. As midwives, we must ask how is global restructuring affect-

ing patterns of economic, gender, and race relations and what are the effects on women’s reproductive health?

To understand this better, please bear with me. I am going to talk about economies. It is crucial that we understand this and look back once again to get the context and some history. Sixty years ago in 1944, as part of reconstruction after World War II and in view of global financial needs, a triumvirate of international lending and trade organizations was established during a conference in Bretton Woods, New Hampshire. An international fund was established to provide short-term loans to countries in financial need, an international trade body was established to develop mechanisms for trade between countries, and an international bank was established to give development loans to underdeveloped countries. The fund was named the International Monetary Fund or the IMF. The trade body was named the General Agreement on Tariffs and Trade or GATT, which in 1995, became the World Trade Organization or the WTO. The bank is commonly known as the World Bank. The World Bank and IMF headquarters are located in Washington, DC, where the IMF has close ties with the U.S. Treasury Board.^{13–15}

In the ensuing years, these three bodies quietly provided loans for development aid and established international trade law. All the quiet activity changed in the late 1970s and 1980s. At that time of fiscal conservatism under Margaret Thatcher and Ronald Reagan, the World Bank and International Monetary Fund launched a crusade to remake the world in the image of the free market—not to be mistaken for democracy! What does the free market mean? In this instance, it means that those countries receiving IMF or World Bank loans must negotiate agreements that include opening their borders to trade, removing import duties on incoming products, removing internal subsidies on goods, and privatizing resources and services.

Let me give an example. Jamaica gained independence from Britain in the early 1960s. The country maintained a relatively solvent economy until a disastrous hurricane destroyed roads and other infrastructures in the late 1970s. The government could not cover the cost of repairs. The Prime Minister at the time, John Manley, reluctantly went to the IMF to take out a loan for his country. The IMF was willing to loan money to Jamaica, but there was a list of conditions attached. Jamaica had to remove its import taxes on vegetables, meat, and milk. They also had to pay interest at market rate. The interest on IMF loans is always at market rates. In today’s terms, that means a borrower will pay 13 cents in interest for every 1 cent borrowed.¹⁶

Another condition of the IMF loans is that the interest payments must be paid on time and as a priority, that is, prior to spending on education, health, or other services in the country. An IMF loan lasts for 3 years, at which point it is up for renegotiation. Of course, most of these loans cannot be paid off in 3 years. Each time the loan is renegotiated, new conditions on trade or internal spending are added. The consequence in Jamaica was that when the

import duty was removed, American and Canadian produce flooded into the country. This produce was subsidized produce from Canadian and American farmers. The Jamaican potato now cost more than a Canadian potato in the local marketplace. The Jamaican farmers stopped farming because they could no longer afford it. Jamaican milk was poured into the gutter when cheap powdered milk flooded the markets from the United States and milking cows were slaughtered. The result? A country caught in spiraling debts and the people of the country poorer today than they were in 1975.¹⁶

Women's Health and Trade Agreements

At the same time that the IMF is controlling loans, the World Trade Organization is pushing forward international trade agreements. These agreements determine the movement of goods as well as services, including midwives. The agreements often require the privatization of public services, including health care, education, and water.

During a trip to Bolivia last year I witnessed a huge demonstration by rural peasants in the streets of La Paz to protest against North Americans and the Free Trade Act of the Americas (FTAA). It was a powerful and unnerving protest. I learned that I had a responsibility as a white northern woman with my retirement funds and middle-class lifestyle to begin to understand the impact of trade agreements and IMF policies on the poor. As much as we in the Northern Hemisphere are unaware of the trade issues of the IMF and the WTO, the average illiterate peasant in Latin America is fully aware of their existence and methods of operation. Why? Because they are dying from them.

Argentina is a case in point. Argentina dutifully followed all IMF and World Bank policies, and everyone knows the story of the bank closures and the horrific recession that followed in this formerly thriving middle-class country. Today, more than 50% of Argentines live below poverty level. When I was attending a conference there recently, one of the young midwives told me with tears in her eyes that people are still starving to death in her country and no one is talking about it.

Last year in Bolivia, an international company, Bechtel, was attempting to privatize the water in the city of Cochabamba, as part of a trade agreement the Bolivian government had signed. Bechtel was privatizing all water, including groundwater, private wells, and rainwater. Mothers were faced with having to pay for water or pay to send their children to school.¹³ There was a rebellion by the indigenous peasant population, which resulted in the overthrow of the government who had signed the deal. But Bechtel is now suing the new Bolivian government for breach of contract on the water deal. Where is this conflict being mediated? In a tribunal at the World Bank.¹⁵

As we sit within the comfort of our bustling economies and lifestyles, we can no longer believe that poverty is just the luck of the draw. It has actually been perpetrated on the

most vulnerable of people by the IMF, the World Bank, and the WTO. These organizations are controlled by the most powerful nations and have no democratic accountability to citizens of any country in the world. The decisions bearing on trade, finance, and investment are made by senior government bureaucrats and politicians in agreements with corporate managers. It is also important to understand that foreign aid that flows not only from the World Bank but also from individual countries to the developing world requires that those countries receiving aid abide by their agreements with the IMF.¹⁵ Joseph Stiglitz, a Nobel Prize-winning British economist and former economist with the World Bank, observed that the IMF works in the interest of Western capital.¹⁴ It is an independent institution that has remained impervious to outside influence or self-questioning.

Twenty years into these IMF and World Bank restructuring policies, irrefutable evidence is exposing the damage they have done to millions of people. In almost every country in the world, there is an ever-increasing disparity between the rich and the poor.^{12,14}

Privatization, Women's Health, and Midwifery

As we talk about saving the lives of 600,000 women a year, we must address the root causes of their deaths. Yes, we should be working with Safe Motherhood and negotiating with governments to give more money to women's education and health care. But it is a waste of time if these same governments are signing agreements with the IMF and WTO that require the privatization of health care and well water. In the April 2004 *Interim Report of Taskforce 4 on Child Health and Maternal Health*, the authors suggest that the issue of trade and bank loans must be addressed in the struggle for Safe Motherhood.¹⁷ It is time that midwives in the United States, Canada, Europe, and Japan join coalitions that will put women's health on the IMF and WTO agendas, because we are the midwives closest to the industries and bureaucrats that forge and implement those agendas.

As privatization of health care is increasing worldwide under these trade and loan agreements, private clinics owned by groups of physicians or foreign investors are popping up everywhere in countries that formerly provided public health care to the majority of their citizens. In countries where professional midwives have traditionally provided maternity care, physicians are now the main obstetric care provider within these private clinics. This model represents the proliferation of an exclusive physician controlled, for-profit type of obstetric care, with the attendant overuse of technology and increase of interventions such as caesarean deliveries. As midwives, do we believe that this is the best export we can provide to resource-poor nations? Are we a distinct enough discipline to challenge this process and be heard?

CONCLUSION

It is important that midwives critically examine our histories, our interprofessional relationships, and our commitment to women's reproductive health. This examination is fundamental to imagining and preparing for our future. That future must include building partnerships with midwives and women globally.

To commit ourselves to the women of the world is a challenge, but it is nothing compared with the millions of women who truly struggle from 1 day to the next to feed their families. Here in the United States and Canada we are sitting in the land of privilege. How in the names and lives of the majority of women in the world do we justify our privilege? We must engage in a collective effort to educate each other in politics and economics, in issues of gender, race, and human rights. We must create coalitions with each other, with women's groups, and other health care providers. We must strengthen midwifery as a powerful, autonomous, and unified voice, working across borders to put midwifery at the center of caring for women everywhere.

Midwives are a distinct group of people. We have chosen to situate ourselves at the threshold of life, where mystery, mechanics, and poetics collide. Where we take risks because we believe in something we don't fully understand. Where we recognize the individual woman as unique and we support the unknowable of life. We did not choose the mechanical and surgical manipulations of medicine. We did not choose the supportive role of nursing. We chose to stand at this threshold and support life unfolding. That requires strength and resilience and ridiculous amounts of hope. It requires a trust in both ourselves and each other. It is antithetical to much of the way of the world. This is our strength.

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