

Call Us Midwives: Critical Comparison of What Is a Midwife and What Is Midwifery

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Research has identified midwifery as key to improving maternal and child health globally. Consequently, increasing the numbers, access, and quality of midwives is paramount as attention, funding, education, and support increases. Yet what a midwife and midwifery are is often misunderstood. The terms midwife and midwifery are often used interchangeably. Other cadres such as nurses, doulas, Skilled Birth Attendant, traditional birth attendant, and nurses with obstetric/perinatal experience are often referred to as midwives or providers of midwifery care. As health systems work to integrate midwives and midwifery, global clarity and understanding must exist on what midwives are and what they are not, and what midwifery is and is not. As the first step to establishing clarity; we undertook a critical comparison of existing different countries, 'not for profit and professional organizations' definitions and interpretation of a midwife and midwifery philosophy. The International Confederation of Midwives' definition of a midwife and midwifery philosophy, and their Global Standards for Midwifery Education acted as the baseline. A global consensus and commitment to educational systems and culture that teaches the midwifery model and the philosophy behind that care can positively impact and improve outcomes for women and babies.

KEYWORDS: midwifery; midwife; philosophy; education; regulation

WHAT IS A MIDWIFE AND MIDWIFERY?

Midwives developed the International Confederation of Midwives (ICM) definition of a midwife and midwifery for midwives around the world (ICM, 2017). The ICM has provided clarity in relation to the "noun" midwife and the "verb" midwifery. Despite many languages, not having the strict noun and verb construct of English, its 132 Midwives Associations, recognize these documents across 113 Countries, which represent approximately 500,000 midwives. The term "midwife" generally refers to the individual and the training and skills required to use the title of midwife. The term "midwifery" speaks more to how a midwife does what she/he does, as well as the philosophy behind the profession. A midwife offers care across the childbearing continuum, which begins with reproductive and sexual health education through to the postpartum period

(ICM, 2017). Using the theoretical and experiential knowledge from their formal education, the midwife draws on their formal education (ICM, 2018). Such skills and knowledge are enacted via the midwifery philosophy of a partnership relationship between the midwife and woman where there is mutual respect and shared decision-making (ICM, 2018; Miller & Bear, 2019). Consequently, the ICM provides direction that if a person is educated to the ICM Global Standards for Midwifery Education (ICM, 2018) and practices to the ICM definition of a midwife (ICM, 2017). Regardless of their local title, this person is entitled to practice the art and science of midwifery and use the title of midwife.

Despite this, some countries, not for profit and professional organizations, and other groups have published their own definition or interpretation of what a midwife's scope of practice is; what a midwifery philosophy should entail; and what a model of midwifery care is

(American College of Nurse Midwives [ACNM], 2018; Australian College of Midwives [ACM], 2018; Renfrew et al., 2014; United National Population Fund [UNFPA], 2018; World Health Organization [WHO], 2018). Individual countries, global organizations, and international non-governmental organizations (INGOs) also misuse the terms. For example, in some locations skills taught are basic while in other places, such as Nepal, complex skills such as a vacuum extraction (operative vaginal birth) are taught (Puri, Tamang, Shrestha, & Joshi, 2014). This “add on” training for nurses or new emergency obstetric care training for non-midwife providers or health workers may be as short as 3 months. Yet upon completion, the person is often called a midwife and they take on the role of working with childbearing women. This results in what could be termed “boundary slippage” of what a midwife is according to the ICM definition (ICM, 2017). The lines become blurred with those of a nurse, Skilled Birth Attendant Traditional Midwife, community health worker (CHW), and doula throughout the maternal child health care context. (SBA; WHO, ICM, & Federation of International Gynecologist and Obstetricians [FIGO], 2004). All of these cadres have unique educational pathways, some more clearly defined than others, but none of them meet the requirements of a midwife as defined by the ICM (2018).

WHO, in a joint statement with the United Nations Population Fund (UNFPA), United Nations International Children’s Emergency Fund (UNICEF), ICM, International Council of Nurses (ICN), FIGO, and International Pediatric Association (IPA), has attempted to clear this confusion with their recently published definition of “skilled health personnel providing care during childbirth” (WHO, UNFPA et al., 2018). The critical attention these global agencies place on women and their newborns is well founded. Their quest is to reduce maternal and neonatal mortality globally by providing women with access to some form of obstetric emergency care (WHO, UNFPA, UNICEF, 2009). It is, therefore, imperative to keep the needs of women and their newborns as well as those of midwives central to this discussion. What appears to be lacking, however, are fundamental elements such as the level of education, philosophy of training, and how these cadres are regulated (while still often given the label midwife). Having a distinct definition of what a midwife is, a midwifery model of care and philosophy is important for a profession, as these impact the unique education required to promote the profession. Further, it offers a framework for monitoring and evaluating quality midwifery care.

WHY WORDS/DEFINITIONS MATTER: EDUCATION STANDARDS PROFESSIONAL IDENTITY AND WHO WE ARE

The midwife is a recognized autonomous professional who provides a range of sexual and reproductive health services including care during pregnancy, birth, and postnatal and obstetrical emergency stabilization, in diverse contexts. Existing cultural, social, and physical inequities may influence professional midwives’ autonomy, agency, and ability to work to their full scope of practice. For example, lack of resources including supplies, pay, and collaborative practice can vary from country to country and even practice to practice (Vedam et al., 2018).

The ICM definitions of a midwife (ICM, 2017) and midwifery philosophy enables midwives, irrespective of geographical location, to advocate for themselves when exercising their legitimate authority to speak about midwives and their work. (ICM 2014) Consequently, these definitions are fundamental when developing quality educational programs. Further, it enables appropriate regulation and thus accurate evaluation of the impact and quality of care midwives provide.

Midwifery holds two characteristics necessary to reach its full potential: the relationship between a woman and her midwife, and an integrated enabling environment to support this. The former is the core of midwifery care: the relationship between the midwife and the woman (Miller & Bear 2019, Guilliland & Pairman, 2010; Leap & Pairman, 2006; Pairman, 2010).

Midwifery needs to function autonomously and be fully integrated into the healthcare system. This creates an environment whereby there is ease of consulting and transferring care when care is identified as outside of the midwife’s scope of practice (ICM, 2017). When barriers prevent either the process of relationship or the process of integration from being fully enabled, midwifery cannot be expressed to its fullest potential. Consequently, this causes a loss of benefits for the woman, the midwife and the healthcare system. When this relationship and philosophy is at the foundation of what a midwife does, care moves beyond providing purely lifesaving or technical skills. The midwife prioritizes the use of respectful, compassionate, relationship driven care that is negotiated in partnership with the woman (Miller & Bear 2019, Guilliland & Pairman, 2010; Pairman, 2010; Vedam et al., 2018). Yet if midwives feel undervalued and unsupported, socially and/or culturally, to enact

and fully engage in the midwifery philosophy of care, then the core of the midwifery model of care and the foundation of the midwifery profession are lost (Filby, McConville, & Portela, 2016; WHO, ICM, & White Ribbon Alliance [WRA], 2016).

Historically there has always been contention between midwives and the medical profession (Willis, 1983). It could be argued the tension is due to the differences between the philosophical stances of the two professions, differences in models of care and the illness and risk lens from which medicine views child-bearing. Further, culturally reinforced gender inequities are often played out in the attempt to keep midwifery and women's health within the dominant medical model (Betro, McClair, Currie, & Banjerie, 2018; Hartigan, 2001). As midwifery refuses to conform to the illness-medical dominated model in healthcare, this may have contributed to the slow promotion of the midwife as an independent, autonomous practitioner. Further, it has contributed to the lack of priority for midwifery as a unique model of care. Additionally, despite men becoming midwives, midwifery remains a woman-dominated profession providing care to women, her partner and family however she defines it. While we acknowledge that both women and trans men and other non-binary identities may become pregnant and access midwifery services, in this article we will refer to women/woman as anyone who is having a baby. Midwifery is and should be in conflict with the medicalization of childbirth when that medicalization is applied unnecessarily. Midwifery guidelines acknowledge that medical intervention is warranted if a mother and/or baby are at risk when a deviation from the physiological process occurs during the perinatal period. Nevertheless, physiological care becomes problematic when played out in the medical model, where healthy "patients" need support, education, and accompaniment rather than the escalating interventions that increase the psychological, physical, and financial costs they often experience. Creating a path to professionalism, without losing the philosophy that is unique to the midwifery profession is paramount if this care model is to be maintained, grown and compliment the medical model rather than be seen as an alternative or in opposition to it.

The challenge in the conflicting definitions of what a midwife is, what she/he does and the philosophy underpinning that must go beyond what is the minimum years of education and demonstrable skills for midwives' education, but the essence of what midwifery is as a profession. A critical comparison is therefore necessary to explore the tensions in existing different countries', not

for profit and professional organizations' definitions of a midwife and midwifery philosophy with the ICM definition (ICM, 2017) and philosophy (ICM, 2014). The guiding questions for this critical comparison are:

1. What are the strengths and limitations of existing definitions of a midwife?
2. What are the strengths and limitations of required education standards?
3. What are the strengths and limitation of existing midwifery philosophies?
4. How do the above aspects impact upon a midwife, a midwifery model of care and the midwifery profession?

STRENGTHS AND LIMITATIONS OF EXISTING DEFINITIONS OF A MIDWIFE: CORE THEMES IDENTIFIED IN CURRENT DEFINITIONS

The ICM states that for a midwife to practice, a country must enable specialized education, regulation, and autonomous practice (ICM, 2017, 2014). Standards for education must result in a cohesive profession that is regulated, allows for quality planning, and accountability (Castro Lopes et al., 2016). The education of a midwife must, therefore represent and be aligned with the philosophy of midwifery as defined by the ICM (2014).

Although it may seem evident that professional education must prepare competent professionals in a specific field, at a global level the education of a midwife often does not prepare autonomous professionals who are skilled in the midwifery philosophy or model of care. This disconnect may emerge from midwives being ignored or suppressed as healthcare providers. This historical suppression stems from when midwifery was/is perceived as a subset of nursing and ultimately to be controlled by medicine (Coburn, 2006; Fahy, 2007; Filby et al., 2016). The midwifery profession rejects such perceptions or limitations on a midwife's right to be seen as an autonomous practitioner. This includes any censorship on midwives to speak about midwives and their work.

STRENGTHS AND LIMITATIONS OF REQUIRED EDUCATION STANDARDS: ANALYSIS OF EDUCATIONAL FRAMEWORKS

The ICM definition of the midwife (2017) and the ICM philosophy of midwifery (2014) provided the baseline

for the critical comparison of WHO (2018), UNFPA (2018), The Lancet (Renfrew et al. 2014), ACNM (2018), and ACM (2018) documents. Thematic analysis was used to identify both explicit and implicit themes (Fahy, 2007; Richardson-Tench, Nicholson, Taylor, Kermode, & Roberts, 2018) around education. This involved a search for key words within ICM definition of a midwife (ICM, 2017). To validate the key words, each author conducted the analysis separately. Upon consensus, these were then placed under seven themes that create a strong, legitimate, autonomous professional. These themes included:

1. A specific midwifery education program
2. State/Country recognized
3. Content is based on core competencies
4. Educational process is unique and has standards
5. Education results in quality assessments that offer validation, regulation, and accountability
6. Education confirms the right to a unique title of Midwife and responsibility
7. Quality of practice is based on ongoing competency.

As the terms midwife and midwifery are often used interchangeably, the next step of the analysis was to critically compare the ICM themes to other major organizations published definitions of a midwife and midwifery (ACNM, 2018; ACM, 2018; Puri et al., 2014; Renfrew et al., 2014; UNFPA, 2018). The aim was to note any similarities, differences, and gaps. While it is acknowledged that several documents authored by these organizations might incorporate reference to midwifery philosophy and/or what a midwife is in some form, the focus of this article is specifically on the explicit documents termed (midwifery) philosophy or definition of a midwife/what is a midwife. The reason for this is that when a search is undertaken on these terms, the key documents cited in this article are located. Additionally, they are often referenced as stand-alone documents, and therefore should be judged as such.

IMPACT ON EDUCATION AND CARE

Most of the definitions by other organizations offer minimal specific guidance on education (ACM, 2018; Puri et al., 2014; Renfrew et al., 2014; UNFPA, 2018). Four of the seven themes identified within the ICM document were lacking in most of the other organizations documents including (ACM, 2018; Puri et al., 2014; Renfrew et al., 2014; UNFPA, 2018):

- National recognition of the profession of midwifery
- Midwifery educational process that is a unique process with unique standards. (pre-service educational faculty and administrative standards)
- Midwifery education that results in a quality assessment offering validation, regulation, and accountability
- Midwifery quality of practice that is based on ongoing competency (in-service education).

Interestingly, only the country specific definitions from Australia (Puri et al., 2014) and the United States (ACM, 2018) referred or mentioned ICM definition (ICM, 2017) and competencies (ICM, 2019). Maintaining clarity is particularly important for education as it generally defines the core essence of the profession for full expression of the professions' philosophy. It also provides a framework for professional identity, curriculum development, and assessment. Midwives as part of their education program acquire theoretical and clinical competence. The primary focus is on childbearing being a natural physiological event, which requires the midwife to trust the woman's body to birth. At times, deviations from normal occur and the midwife must be competent to diagnose and immediately respond to and stabilize unexpected emergencies (Richardson-Tench et al., 2018). Midwifery education, however, must not be limited to view childbearing through the medical lens of risk and intervention. Rather midwifery education must prepare midwives to be autonomous providers of comprehensive women's healthcare *within* the philosophy of midwifery. To be a midwife, one needs to embrace midwifery and its philosophical stance, understand it, and strive to enact it daily. It is what makes the care a midwife gives so unique.

Global variations, however, in the definition of a midwife and midwifery has led to different countries and programs having separate understandings and diverse implementation of the professional identity and education of midwives. The ICM has attempted to mitigate variation in midwifery education (ICM, 2018) through its competencies (ICM 2019, 2018) and educational standards (ICM, 2018). However, lack of consensus on the part of WHO (2018), UNFPA (2018), and national associations (ACM, 2018; Puri et al., 2014) on a unified definition and identity of midwifery leaves many wondering what a midwife is, and how is she/he unique and different from a nurse, doula, CHW, or SBA?

In addition, the approach of treating midwifery as less than a legitimate autonomous profession with a unique philosophy and model of care, prevents its full

TABLE 1. Analysis of Education in Midwife and Midwifery Definitions

Education Themes Identified in ICM Definitions of Midwife	ICM-Midwife (ICM, 2017)	UNFPA-What Midwives Do (ICM, 2017)	Lancet-Midwifery (ICM, 2017)	WHO-Midwifery (ICM, 2017)	ACM-Australian Midwifery and Philosophy (ICM, 2017)	ACNM-(United States) Midwifery and Scope of Practice (ICM, 2017)
Specific midwifery education program	Specifies a “midwifery education program”	“A well-trained midwife”	“Skilled, knowledgeable, and compassionate care”	Not mentioned	“Informed by scientific evidence”	“Formal education, graduate degree”
State recognized	“Recognized in the country”	Not mentioned	Not mentioned	Not mentioned	Not mentioned but refers to ICM	“Education program is accredited”
Content is based on core competencies (pre-service educational objectives)	“Based on ICM competencies for basic midwifery practice”	Skills focused	Core characteristics	Not mentioned	Evidence-informed	“meet core competencies for Basic Midwifery Practice of the ACNM” refers to ICM competencies
Education process is unique and has standards (pre-service educational faculty and administrative standards)	Using the “framework of the ICM Global Standards for Midwifery Education”	Not mentioned	Not mentioned	Not mentioned	Not mentioned but refers to ICM	Not mentioned
Education results in quality assessment that offers validation, regulation, and accountability	Education results in “qualifications to be registered and/or legally licensed”	Not mentioned	Not mentioned	Not mentioned	Not mentioned but refers to ICM	“Educational program is accredited”
Education and regulation confirms the right to a unique title and responsibility	Results in legal status to “practice midwifery and use the title ‘midwife’”	Not mentioned	Not mentioned	Not mentioned	“Midwife is authorized to provide maternity care on their own responsibility”	Not mentioned
Quality of practice is based on ongoing competency (in-service education)	The midwife “demonstrates competency in the practice of midwifery”	Not mentioned	Not mentioned	Not mentioned	Not mentioned but refers to ICM	“Must be recertified every 5 years . . . meet specific continuing education requirements”

(Continued)

TABLE 1. Analysis of Education in Midwife and Midwifery Definitions (Continued)

Education Themes Identified in ICM Definitions of Midwife	ICM-Midwife (ICM, 2017)	UNFPA-What Midwives Do (ICM, 2017)	Lancet-Midwifery (ICM, 2017)	WHO-Midwifery (ICM, 2017)	ACM-Australian Midwifery and Philosophy (ICM, 2017)	ACNM-(United States) Midwifery and Scope of Practice (ICM, 2017)
Overall impression	Comprehensive, reference definition	No reference to ICM. Focused on skills a midwife can provide. Mentions “people with midwifery skills”	No reference to ICM. No specifics on education. Focused on scope, some philosophy and consultation and referral	No reference to ICM. Very brief, focused on scope and skills. Nothing on education or philosophy	Refers and links to ICM for definition. Midwife. Philosophy is comprehensive (see philosophy chart)	NO reference to ICM definition, focuses on scope, and skills, accreditation and discusses relationship with nursing. Refers to ICM competencies

Note. ACM = Australian College of Midwives; ACNM = American College of Nurse Midwives; ICM = International Confederation of Midwives; UNFPA = United National Population Fund; WHO = World Health Organization.

development and impact on a healthcare system. The current overemphasize on skills needed to save lives, without emphasizing the autonomy of the profession and its philosophy, demonstrates a lack of vision for quality in women’s health and midwifery. It also reflects persistent tensions that place women within the contested space of being viewed through the dominate medical-illness model, rather than the woman-centered midwifery model. It can be postulated, midwives who are solely educated within a medical risk lens will not necessarily practice woman-centered care, rather, they will focus on identifying obstetric risk and managing obstetric emergencies. It could also be inferred that in countries where midwives are limited to having a set of life-saving skills, medical interventions such as inductions, and cesarean sections will remain high. The impact of this maybe that women will feel undervalued in their birthing experience (Leap & Pairman, 2006). Alternatively, midwives who are educated within a specific woman-centered philosophy and model that emphasizes values such as human rights, and informed consent, are healthcare providers who may contribute to social, cultural, and health justice in an integrated model. In countries where midwifery operates in an autonomous model, evidence demonstrates that interventions are low and maternal satisfaction is high (UNFPA, 2018). Ultimately the experience of care, outcomes, and cost-effectiveness of midwifery will vary according to the educational model under which midwives are trained.

It would appear from the thematic analysis undertaken for this article, that some organizations do not see

midwifery education as a pathway to create unique professionals that practice within the framework of midwifery philosophy. Rather it could be postulated that some organizations focus on training a provider with a specific set of clinical skills who may call themselves midwives. The difference between the two approaches to midwifery education is important in a global context where national and international organizations are working to improve women’s experience of care, clinical outcomes, and the health of women and babies.

STRENGTHS AND LIMITATION OF EXISTING MIDWIFERY PHILOSOPHIES: UNDERSTANDING MIDWIFERY BEYOND SKILLS

To assess the framework available for midwifery and midwifery care philosophy, a thematic analysis was used to identify both explicit and implicit themes within the ICM’s Philosophy and Model of Midwifery Care (ICM, 2017, 2014). Five themes were identified that form the foundation of how midwifery care is to be provided.

1. Promotion of human rights through the provision of shared care based on principles of justice, equity, and respect for human dignity
2. Attitude surrounding care provided is that pregnancy is a normal physiological state. The goal is to optimize the process with a supportive, non-intervention approach, honoring its uniqueness for each woman

3. The foundation of all care is the relationship with a woman. This requires respectful, personalized partnership throughout care with the goal of self-determination for the woman
4. The midwife is an autonomous professional, responsible for self and professional development including collaboration and consultation relationships with other professionals, with the goal to serve women and their communities
5. Midwifery care is evidence-informed, competent, and ethical.

The next stage of the critical comparison was to see if these ICM identified themes were within the midwifery philosophy documents authored by WHO (2018), UNFPA (2018), *The Lancet* (Renfrew et al., 2014), ACNM (2018), and ACM (2018). The Table 2 offers a summary of the critical comparison.

IMPACT ON A MIDWIFE, THE MIDWIFERY MODEL OF CARE, AND THE MIDWIFERY PROFESSION

Definitions by other international and professional organizations offer a range of guidance on the midwifery philosophy and model of care and reinforce the lack of clarity over the unique model of midwifery. (ACNM, 2018; ACM, 2018; Puri et al., 2014; Renfrew et al., 2014; UNFPA, 2018). Two of the five themes stated above were absent by all but one other organization namely :

- The midwife is an autonomous professional, responsible for self and professional development including collaboration and consultation relationships with other professionals with the goal to serve women and their communities
- Midwifery care is evidence-informed, competent, and ethical (Renfrew et al., 2014).

Midwives and advocates of midwifery argue both these themes (professional autonomy and evidence-informed care) are necessary for legitimizing the profession. Neglecting these two themes within the definition of a midwife and midwifery care has the potential to undermine any authority midwifery may have by suggesting it is not a “real” or independent profession. The recognition of the autonomy of the profession stands at the heart of midwifery policy and has deep implications in practice and outcomes.

The three other themes noted in Table 1 provide direction for how midwifery care and skills should be

taught and provided. They highlight human rights, how to support physiological birth, and the goal of the partnership with a woman as a woman’s self-determination in her own care. These themes, not explicit in any definition other than ICM’s, (2017, 2014), form the foundation of the unique nature of the midwifery model of care (ACNM 2018; ACM, 2018; Puri et al., 2014; Renfrew et al., 2014, UNFPA, 2018; Miller & Bear, 2019).

The relationship between a woman and midwife is explicitly acknowledged as core to midwifery in all but two of the definitions (Renfrew et al., 2014; UNFPA, 2018). Although UNFPA (2018) and WHO (2018) do not mention the relationship between a woman and midwife, on their websites, they do consistently refer to ICM’s definition (ICM, 2017), which does mention the relationship. This relationship, however, is more than a pleasant experience that midwives value. Rather, the focus of a non-authoritative, respectful partnership, is more about the quality of the relationship and its goal of a woman’s self-determination over her body and the care she/he receives. The partnership is the practical implementation of midwifery’s human rights-based approach to care. This relationship requires time and continuity so the woman and midwife can get to know and trust each other. Further it requires the midwife to be flexible and humble, acknowledging that although she/he may be an expert in midwifery care, she/he is not an expert in the woman’s experience or her values (Kuo, Wu, & Mu, 2010; Thorstensson, Nilsson, Olsson, Wahn, & Ekström, 2015; Tinkler & Quinney, 1998). This relationship is the one of the greatest strengths of midwifery. It could potentially inform the medical model if the revolution of woman-centered care is allowed to transform mainstream care. Ultimately healthcare should be driven by the unique person receiving that care rather than the authority of the provider.

DISCUSSION

Using the ICM definitions of midwife (2017) and midwifery (2014) as a baseline, this article compares definitions of a midwife and midwifery from around the world. This was done deliberately as these documents provide midwives legitimate authority to practise the art and science of midwifery, as well as to use the title Midwife. Further, these documents provide a framework that promotes confidence for midwives to speak about midwives and their work. It could be suggested, therefore, that some organizations are modifying the

TABLE 2. Analysis of the Philosophy of Midwifery in Midwife and Midwifery Definitions

Care Philosophy Themes Identified in ICM Definitions of Midwife and Midwifery	ICM—Philosophy and Model of Midwifery Care (ICM, 2017)	UNFPA—What Midwives Do (ICM, 2017)	Lancet—Midwifery (ICM, 2017)	WHO—Midwifery (ICM, 2017)	ACM—Australian MW and Philosophy (ICM, 2017)	ACNM—(United States) Midwifery and Scope of Practice (ICM, 2017)
Promotion of <i>human rights through the provision of SRH care based on principles of justice, equity, and respect for human dignity</i>	“Promotes, protects, and supports women’s human, reproductive, and sexual health and rights” “Based on the ethical principles of justice, equity, and respect for human dignity”	“Advance women’s and girls’ rights,” “prevent FGM . . . offer support and assistance to survivors of gender-based violence . . .”	“Respect for women’s individual circumstances and views” <i>Human Rights not mentioned</i>	Human Rights not mentioned	“Founded on respect for women . . . value of women’s work, . . . protects and enhances the health and social status of women . . .” <i>Human Rights not mentioned</i>	“. . . right to equitable, ethical, accessible quality healthcare . . . that respects human dignity, individuality, and diversity among groups.”
Attitude surrounding care provided is that <i>pregnancy is a normal physiological state. The goal is to optimize the process with a supportive, non-intervention approach, honoring its uniqueness for each woman.</i>	“Pregnancy and childbearing are usually normal physiological processes” “Optimize[s] the normal, biological, psychological, social, and cultural processes of childbirth” “Promote and advocate for non-intervention”	Childbirth as physiological and how to promote is not mentioned	“Optimizing normal biological, psychological, social, and cultural processes of reproduction and early life”	“Measures aimed at preventing health problems in pregnancy, the detection of abnormal conditions” <i>Childbirth as physiological and how to promote is not mentioned</i>	“. . . childbirth . . . to be undertaking healthy processes . . .” <i>How to promote a physiological process is not mentioned</i>	“. . . honor the normalcy of women’s lifecycle events . . . watchful waiting and non-intervention in normal processes. . . appropriate use of interventions and technology . . .”
The foundation of all care is <i>the relationship with a woman. This requires respectful, personalized partnership throughout care with the goal of self-determination for the woman</i>	Midwifery care takes place in partnership with women, recognizing the right to self-determination, and is respectful, personalized, continuous and non-authoritarian	Foundation of relationship with woman and goal of self-determination not mentioned	“Working in partnership with women to strengthen women’s own capabilities to care for themselves and their families”	Foundation of relationship with woman and goal of self-determination not mentioned	“Woman-centered . . . founded on the relationship between a woman and her midwife” “Encompasses the needs as identified and negotiated by the woman herself . . . as defined by the woman herself”	“. . . a continuous and compassionate partnership” “Involves therapeutic use of human presence and skillful communication” “Self-determination and active participation in healthcare decisions”

(Continued)

TABLE 2. Analysis of the Philosophy of Midwifery in Midwife and Midwifery Definitions (Continued)

Care Philosophy Themes Identified in ICM Definitions of Midwife and Midwifery	ICM—Philosophy and Model of Midwifery Care (ICM, 2017)	UNFPA—What Midwives Do (ICM, 2017)	Lancet—Midwifery (ICM, 2017)	WHO—Midwifery (ICM, 2017)	ACM—Australian MW and Philosophy (ICM, 2017)	ACNM—(United States) Midwifery and Scope of Practice (ICM, 2017)
The midwife is an <i>autonomous professional, responsible for self and professional development</i> including collaboration and consultation relationships with other professionals with the goal to serve women and their communities	“... individually and collectively responsible for the development of midwifery care, educating the new generation of midwives” ... “concept of lifelong learning” ... “practice in collaboration ... with other health professional” “... to serve the needs of the woman ... and community”	“The main caregivers for women and their newborns during pregnancy, labor, childbirth, and in the post-delivery period” <i>No mention of individual responsibility, professional development, or relationship with other healthcare professionals</i>	“Consultation with and referral to other services” <i>No mention of individual responsibility, professional development</i>	“The procurement of medical assistance when necessary, the execution of emergency measures in the absence of medical help” <i>No mention of individual responsibility, professional development</i>	Midwifery includes collaboration with and consultation between health professionals. <i>No mention of individual responsibility, professional development</i>	“Consultation collaboration and referral with other members of the healthcare team as needed to provide optimal healthcare” “formal education, lifelong individual learning”
Midwifery care is evidence-based, competent, and ethical	“Ethical and competent midwifery care is informed and guided by formal and continuous education, scientific research, and application of evidence” “Midwives maintain their competence and ensure their practice is evidence-based”	“Provide family planning counseling and services ... perform breast and cervical cancer screenings ... perform basic emergency obstetric care, and in humanitarian crises ... implement the Minimum Initial Services Package” <i>No mention of care as evidence-based, competent and ethical</i>	“Timely prevention and management of complications” <i>No mention of care as evidence-based, competent, and ethical</i>	No mention of care as evidence-based, competent, and ethical	Midwifery is informed by scientific evidence, by collective and individual experience, and by intuition <i>No mention of care as competent and ethical</i>	“Includes individualized methods of care and healing guided by the best evidence available.” ... the development and application of research to guide ethical and competent midwifery practice”

Note. ACM = Australian College of Midwives; ACNM = American College of Nurse Midwives; FGM = female genital mutilation; ICM = International Confederation of Midwives; UNFPA = United National Population Fund; WHO = World Health Organization.

globally accepted definitions for two potential reasons: (a) they do not perceive or frame midwives as autonomous practitioners as defined by the ICM

definition of a midwife (ICM, 2017) and thus separate from nursing or (b) they mis-interpret the philosophy and scope of practice of midwifery as defined by the

ICM (2017; 2014). Midwifery autonomy is further hindered when other cadres who have not been educated, and are not "midwifery" providers, hijack or misuse the noun 'midwife' and verb 'midwifery'. It could be argued that, as many languages do not have the same noun and verb midwife/midwifery construct as the English language this leads and compounds the confusion around our profession. The result of which fuels the debate of the terms used across regions applied to a professional midwife as defined by the ICM (2014, 2017, 2018). What is clear, regardless of where in the world one is, use of the title Midwife should only be sanctioned if a person has been educated to the minimum level, in accordance with the ICM Global Standards for Midwifery Education (ICM, 2018) and philosophy (ICM 2014).

While diversity in practice may and should reflect cultural and social nuances, the concern discussed in this article is that the perception and understanding of the role of a midwife, the philosophy and function of the model varies and is contradicted among international and national agencies as noted in Tables 1 and 2. This critical comparison reveals that most organizations agree midwives provide women-centered care, which aligns with the advancement of human rights. Organizations differ and are vague on the specifics of how to implement this. In addition, many of these documents neglect to mention a consistent approach to sexual health which raises issues around policy and regulation of women's health and rights. Only the ICM (2017) and UNFPA (2018) make explicit mention of midwifery as protector of "rights." While there is no mention women's or girls' rights protection as a value or practice in midwifery by the ACNM (2018) and the ACM (2018). Such a lack of consensus among key health provider agencies, particularly at the level of WHO (2018), UNFPA (2018), and ICM (2017) limits a global approach around women's health and quality of care.

It is important to acknowledge many countries lack a professional group bearing the title, education, or scope of practice of the midwife. This means childbearing women are cared for by many cadres of workers with varied levels of skills and philosophies. In a global context, WHO (2018) and UNFPA (2018) and others are funding and leading midwifery education and regulation programs with the aim to reduce maternal and neonatal mortality globally. It is imperative to provide some level of training and care to avoid no care at all. This should only occur, however, until appropriately qualified and skilled midwives can be educated in accordance to the ICM competencies (WHO, 2018).

CONCLUSION

Midwifery's strength and uniqueness is how it provides the human rights-based midwifery model of care. Midwifery's opposition to the medical lens applied to what is a natural physiological event (until it is not) causes a healthy tension, yet the current situation of a global lack of consensus on the definition of the midwife and/or midwifery may undermine the development of this autonomous profession and unique philosophy that could compliment the medical model and strengthen healthcare systems. This article calls for all parties involved in providing care to childbearing women to open discussions and strive for consensus to ensure that the global push to increase access to midwives and midwifery care occurs under a common understanding of what a midwife and midwifery care is. It is therefore important to work collaboratively in order to keep critical attention on the plight of women and their newborns.

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