Models That Work

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Introduction to Midwifery

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November 21, 2019

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The intent of this essay is to review birth models that work by highlighting current and past models and providing insight into common challenges. Key themes were highlighted by Floyd, Barclay, Daviss, & Tritten (2009) in Birth Models That Work. Three key themes were employing the midwifery (humanistic/holistic) model of care, providing individual care within the birthers' community, and demonstrating patience and flexibility with the normal physiological birth process. The outcomes of many of the models researched reflect the successful work of activist birth workers who have provided a foundation for the growth of the midwifery profession. It is inspiring to review the strength, determination, and leadership provided; however, the common thread I noted for success was a team-based approach. This paper will also follow up on one birth model that is working and review current status of the program.

First, these models respected the midwifery model of care with respectful, compassionate, birther-centered care emphasized in each of the successful programs. Respectful of the nature of birth and the uniqueness of the individuals birthing. The theme of respectful care was extended even to the staff in the example of the freestanding birth center in England that provided work/life balance to the staff with flexible shifts and caring coverage for a work environment that was described as "...a congruence of values and an authenticity around their expression (Davis-Floyd et al., 2009, p.177).

Second, for successful models of care the models emphasized assessing the individual needs of their clients in relation to their community/culture. The examples of CASA hospital and professional midwifery school in Mexico was insightful. The midwifery students go into the

rural communities with the traditional midwives as part of their training program equipping them with cultural literacy (Davis-Floyd et al., 2009). 41% of the women birthing at CASA were from rural Guanajuato and could have chosen other hospitals in the area; however, those locations were based in the biomedical model of care. Infant and maternal mortality rates were significantly lower than the rest of the surrounding facilities (Davis-Floyd et al., 2009).

The third common theme noted was the patience and flexibility in the normal physiological birth process. Not limiting the number of family members in the support process, providing a variety of comfort measures: eating and drinking in labor, hydrotherapy, massage, birth stools, and professional labor support/doulas. The Mercy in Action program highlighted the use of spiritual support for their birthing clients, offering prayers before, during and after the births. This program also recorded 7, 565 births between 1996-1999 with very low intervention rates including: .4% episiotomy rate, 3% infant resuscitation-PPV or CPR, 2% newborn transfer to hospital, .5% neonatal mortality, and .05% maternal mortality (Davis-Floyd et al., p. 352-354).

Mercy in Action in the Philippines was the training ground for a midwife friend who recently stated she thought the program was no longer training students internationally. According to updates on their website, the midwife, Vicki Penwell took a three year stateside hiatus caring for aging/dying parents. In September of 2018 she announced that she and husband were returning. Their website looks current and up to date stating, “As of January 2019, we have delivered more than 15,000 babies free of charge, and have birth centers or maternity care outreaches in five communities in the Philippines, on three different islands.” It also notes that,“All of Mercy in Action’s birth centers, clinics, and outreach programs are directed and staffed by Filipina Licensed Midwives (Mercy In Action, 2019). There is no longer any

information on this MEAC accredited school having international midwifery training programs. They have a Birth Center in Boise, ID and they rely on the student midwives finding preceptors in their communities. The program is now modified to be a distance-based program with short intensives to the campus and then a final two-week session/NARM study retreat.

In conclusion, the three key themes reviewed were: employing the midwifery model of care, providing individual care within the birthers' community, and demonstrating patience and flexibility with the normal physiological birth process. In preparing this paper, several recent studies mentioned the need for collaborative care between the midwife and the obstetricians in the event of a transfer of care (Souter et al., 2019, Caughey & Cheyney, 2019). A clinical series journal article provided a current overview of the need for collaboration across models of care and the researchers stated, "U.S. perinatal outcomes will not improve without collaboration between community- and hospital-based providers (Caughey & Cheyney, 2019)." I realize I did not touch on the importance of this in the body of this paper; however, research supports this recommendation for improving maternal and infant health outcomes. Midwives have an opportunity to ignore or address the role we play in this collaboration. We, as midwives, can view it as an opportunity to find shared purpose and collaborate for the betterment of birthing people and infants. The goal is worthy of our efforts!

References

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