

A call for critical midwifery studies: Confronting systemic injustice in sexual, reproductive, maternal, and newborn care

Critical Midwifery Collective Writing Group

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1 | INTRODUCING CRITICAL MIDWIFERY STUDIES

Systemic injustice is a threat to sexual, reproductive, maternal, and newborn (SRMN) health. The effects of this injustice are reflected in the high maternal and neonatal

morbidity and mortality rates in former colonized countries of the Global South, in marginalized communities of the Global North, and in underprivileged classes around the world.¹ Current research, clinical guidance, and global health politics all point to an inadequate response to injustice on the part of SRMN care systems. Consider, for

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instance, four examples of ongoing injustices globally: the lack of workforce to meet SRMN,² the lack of access to safe abortion,³ the “ethnic”, “racial”, and socioeconomic disparities present in maternal and newborn outcomes during the Covid-19 pandemic,^{4,5} and the severity and persistence of obstetric violence and obstetric racism.⁶

Midwifery is often suggested as a solution to the SRMN inequalities resulting from systemic injustice. It is assumed, for example, that recruiting more midwives will increase access to abortion and preconception care, and reduce maternal and neonatal morbidity and mortality.^{2,7,8} We argue, however, that midwifery cannot offer an effective alternative without sufficient understanding of the roots of injustice. Five separate *Lancet* Series—on miscarriage,⁹ midwifery,⁸ maternal health,¹⁰ stillbirth,¹¹ and optimizing caesarean use¹²—have addressed inadequacies in the delivery of SRMN care but fail to consider how systemic injustice, including structures of power and institutional discrimination, exclusion, and deprivation, contribute to health inequality. For example, the *Lancet* series on midwifery, like most midwifery research, is silent on competencies that enable just care as essential for midwives.^{8,13,14} This is because, at present, the professional and academic discipline of midwifery lacks the necessary epistemological foundations and theories to fully understand and address systemic injustice in SRMN health. We are a growing transnational collective consisting of members from the Global South and North, including midwives, doulas, scholars, educators, and mothers calling for an expansion of midwifery research to include what we coin “*Critical Midwifery Studies*”. In this commentary, we describe the need to develop this field of inquiry and discuss the preliminary foundations and principles required. We conclude with a call to action, inviting a collaborative endeavor.

2 | THE GLOBAL NEED FOR CRITICAL MIDWIFERY STUDIES

Over the years, we have witnessed a growing evidence basis for a unique midwifery perspective on SRMN, including data confirming the safety of homebirth, the importance of continuity of care and carer, and the value of a noninterventionist approach for facilitating intrapartum care.^{15,16} However, this convincing biomedical and epidemiological research—supporting the value of uninterrupted, physiological birth—has not resulted in clinical change largely, we argue, because of the marginalized position of midwifery globally. Midwifery has a complex history of resistance and power-based struggles. Across a diversity of localities, midwives and other midwifery practitioners have faced colonial, gendered, and class-based

expropriation and persecution, marginalization by biomedicine, and a loss of autonomy within obstetric institutions.^{17,18} Mainstream midwifery research, education, practice, policy, and regulations are largely White and Western-centric, using positivistic and universalist principles of biomedical research. Although we recognize the global struggle for legitimacy that midwives face as they work to make their models of care more accessible, this coincides with pressure to engage with dominant and dominating paradigms, using language and approaches that are valued by regimes of power. As poet Audre Lorde reminds us: “The master’s tools will never dismantle the master’s house.”¹⁹

Midwifery as a professional and academic discipline has developed a thorough critique of the politics and processes through which SRMN is medicalized, industrialized, and subsumed within patriarchal power structures. Individual midwives and other midwifery practitioners are advocates for respectful maternity care and the humanization of SRMN. Despite this work and this advocacy, midwifery lacks the necessary awareness, understanding, and agency to fully address, position itself within, and provide care in an increasingly complex world characterized by systemic injustice. Midwifery’s critique of medicalization falls short of an adequate and thorough analysis of the intersecting politics, processes, and practices of racism, colonialism, neoliberalism, heteronormativity, environmental devastation, and the associated dangers of the climate crisis. Midwifery’s analysis of medicalization has been trenchant yet has largely been contained within the borders of White Euro-American feminisms—a reality we take as further evidence of the need for a more critical approach to addressing the problems in SRMN care. If we are to abolish injustice in SRMN and proliferate in its place an equitable and just ethics of care that is life-affirming for all, the moment to broaden our scope of critique and care is now.

3 | THE STANDPOINT OF MIDWIFERY

Despite, or perhaps because of, the continuous subjugation of midwifery to structural forms of epistemic injustice globally, it is ideally located to take the lead on dismantling the institutionalized racism and global inequality that underpins SRMN care in most contexts.^{20–22} We can build on the critical work of many grassroots organizations, practitioners, and scholars who have contributed to postcolonial theory, praxis, and restorative justice.^{23–42}

Midwifery as a standpoint entails (a) an emphasis on locality and plurality instead of universality, (b) a history of suppression rather than hegemony, and (c) a holistic,

biopsychosocial approach over clinically-driven biomedical perspectives.

First, midwifery is a unique discipline in which relational care is central and practiced through partnership and reciprocity within its community. As such, midwifery, in contrast to obstetrics, is vastly plural, as it is shaped by the community it comes from. Thus, it does not represent a homogenous group or “universal” view on birth, care, or science but is instead defined by its locality of practices and knowledge. Also, midwifery differs across settings depending on the degree to which it has been appropriated by obstetrics.

Second, midwifery relies on a rich tapestry of knowledge, including not only biomedical understandings of bodies, but diverse, specific, and critical meaning-making, ritual practice, and spirituality. It thereby provides a biopsychosocial foundation for an approach to SRMN health that can offer healing and forms of care that abound beyond the biomedical or clinical.

And third, the contemporary discipline of midwifery has emerged historically through the devaluing, prosecution, and expropriation of people, due to colonialism and gender-based violence. This has left midwifery in an ambiguous position: on the one hand, White dominated midwifery is defined by coloniality, on the other hand, the praxis of traditional, indigenous, and autonomous midwifery has managed to survive both in the Global South and North. Additionally, midwifery is entangled with reproductive politics but never fully coincides with them, as midwifery seldom possesses a hegemonic position of power over SRMN care. If we can be self-critical and dismantle midwifery’s dominating second-wave White feminism, we believe that midwifery’s standpoint as both appropriated and independent, as both colonial and marked by expropriation, as both traditional and fugitive, is uniquely situated to work towards reproductive justice for all. This plural epistemic position of midwifery is suppressed rather than hegemonic, generating potential for solidarity across marginalized communities, and the epistemic privilege to both study and help redress systems of entangled oppressions. Based on these three characteristics, midwifery, as a standpoint, has the potential to work against the reproduction of neo-colonial power structures, resist universalist assertions, and support plural, context-specific, and polyvocal models of care.²²

4 | THE PRINCIPLES OF CRITICAL MIDWIFERY STUDIES

We envision a Critical Midwifery Studies that uses three principles to guide the development of a theoretical framework for analyzing injustice in SRMN care:

Critical Midwifery Studies engages and collaborates with rapidly developing fields within critical theory, such as intersectional, transnational, and postcolonial feminisms, womanism, critical feminist theory, critical race theory, Black studies, social reproduction theory, cultural health capital theory, queer studies, social configuration theory, reproductive justice theory, decolonial and postcolonial theories, standpoint theory, dis/ability studies, planetary studies, environmentalism, anticapitalist critique, critical pedagogy, and care ethics. These fields have developed insights that are vital for understanding the existing and continuous reproduction of injustice within SRMN care.

Critical Midwifery Studies is midwifery-led. “Midwifery” is understood broadly, including all practitioners offering relational and inclusive care from a biopsychosocial perspective throughout pregnancy and childbirth. “Midwifery” is rooted in the positionality of midwives and other midwifery practitioners, offering a unique and critically important epistemological standpoint.

Critical Midwifery Studies is self-critical. It reflects on the role of midwifery, midwives, and other midwifery practitioners in shaping, causing, maintaining, sustaining, and (re)producing injustice in the content and conduct of research, education, administration, regulation, and practice. It asks midwifery to reflect on its own position alongside the perspectives of those it serves, by examining the discrimination, exclusion, and oppression created by social, economic, political, cultural, geographical, medical, and obstetric systems, and on the more equitable and just reproductive futures it can contribute to.

Critical Midwifery Studies includes developing ways to implement critical theory into practice. A critical theoretical framework is necessary to inform pathways to equitable care. However, for any theoretical field to have an impact, it must impact everyday practice, and transform research, education, administration, regulation, and clinical practice.

5 | CALL FOR THOUGHT AND ACTION

There is an urgent need to confront systemic injustice in SRMN care globally. The position of midwifery and its epistemological standpoint uniquely qualify the profession and academic discipline to develop theories and practices aimed at dismantling systemic injustice. These are central to improving not only midwifery but also biomedical and public health approaches to SRMN. Critical Midwifery Studies requires midwifery to draw on its own rich traditions, to illuminate its place in the provision of care using contemporary critical theories,

and to unite them in a way that promotes and protects the health and wellbeing of all those it cares for, and for the planet they inhabit. Critical Midwifery Studies, as we envision it, aims to inspire midwifery thinkers and scholars to develop the theoretical foundations needed to confront systemic injustice in SRMN care. We call on midwives, and other midwifery practitioners, scholars, and theorists to join our effort to achieve just and equitable SRMN care by developing Critical Midwifery Studies as an explicit field of academic inquiry and emancipatory praxis. This is a transgenerational effort, where we build on the work that has come before within a culture of critique, yet, without tearing down those who have paved the way. We invite multiple perspectives and voices to contribute to this collaborative endeavor. We start this effort in collaboration with *Birth: Issues in Perinatal Care*, in a call for a special issue on Critical Midwifery Studies (see [link] for the full theme issue, author guidelines, and submission details).

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DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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REFERENCES

- World Health Organization. *World health statistics 2019: monitoring health for the SDGs, sustainable development goals* [Internet]. World Health Organization; 2019.
- UNFPA, WHO, ICM. *The state of the world's midwifery 2021* [Internet]; 2021; <https://www.unfpa.org/publications/sowmy-2021>. Accessed May 6, 2022.
- WHO. *Abortion* [Internet]. WHO. 2021; <https://www.who.int/news-room/fact-sheets/detail/abortion>. Accessed May 6, 2022.
- Chmielewska B, Barratt I, Townsend R, et al. Effects of the COVID-19 pandemic on maternal and perinatal outcomes: a systematic review and meta-analysis. *Lancet Glob Heal* [Internet]. 2021;9(6):e759-e772.
- Jardine J, Walker K, Gurol-Urganci I, et al. Adverse pregnancy outcomes attributable to socioeconomic and ethnic inequalities in England: a national cohort study. *Lancet* [Internet]. 2021;398(10314):1905-1912.
- Šimonović D. A human rights-based approach to mistreatment and violence against women in reproductive health services with a focus on childbirth and obstetric violence. Note by the Secretary-General [Internet]. 2019. <https://www.ohchr.org/EN/Issues/Women/SRWomen/Pages/Mistreatment.aspx>. Accessed Oct 4, 2021.
- Nove A, Friberg IK, De Bernis L, et al. Potential impact of midwives in preventing and reducing maternal and neonatal mortality and stillbirths: a lives saved tool modelling study. *Lancet Glob Heal* [Internet]. 2021;9(1):e24-e32.
- The Lancet. Series Midwifery. *Lancet* [Internet]. 2014; <https://www.thelancet.com/series/midwifery>
- The Lancet. Series Miscarriage matter. *Lancet* [Internet]. 2021; <https://www.thelancet.com/series/miscarriage>
- The Lancet. Series Maternal health. *Lancet* [Internet]. 2016; <https://www.thelancet.com/series/maternal-health-2016>
- The Lancet. Series Stillbirth 2016: Ending preventable stillbirths. *Lancet* [Internet]. 2016; <https://www.thelancet.com/series/ending-preventable-stillbirths>
- The Lancet. Optimising caesarean section use. *Lancet* [Internet]. 2018; <https://www.thelancet.com/series/caesarean-section#:~:text=Athree-partLancetSeries,to reduce unnecessary caesarean sections>
- Butler MM, Fullerton J, Aman C. Competencies for respectful maternity care: identifying those most important to midwives worldwide. *Birth* [Internet]. 2020;47(4):346-356.
- Kennedy HP, Yoshida S, Costello A, et al. Asking different questions: research priorities to improve the quality of care for every woman, every child. *Lancet Glob Heal* [Internet]. 2016;4(11):e777-e779.
- Hutton EK, Reitsma A, Simioni J, Brunton G, Kaufman K. Perinatal or neonatal mortality among women who intend at the onset of labour to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital: a systematic review and meta-analyses. *EclinicalMedicine* [Internet]. 2019 Sep;14:59-70.
- Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database Syst Rev* [Internet]. 2016; [doi:10.1002/14651858.CD004667.pub5](https://doi.org/10.1002/14651858.CD004667.pub5)
- Nestel S. *Obstructed labour: race and gender in the re-emergence of midwifery*. UBC Press; 2007.
- Donnison J. *Midwives and Medical Men. A History of the Struggle for the Control of Childbirth*. 2nd ed. Historical Publications; 1988.
- Lorde A. The master's tools will never dismantle the master's house. *Sister Outsider: Essays and Speeches*. Crossing Press; 1984:110-114.
- Rolin K. Standpoint theory as a methodology for the study of power relations. *Hypatia* [Internet]. 2009 Mar 11;24(4):218-226.
- Collins PH. *Black Feminist Thought: Knowledge, Consciousness, and the Roots of Empowerment*. Routledge; 2009.
- Mohanty CT. *Feminism without Borders*. Duke University Press; 2003.
- Davis D-A. Obstetric racism: the racial politics of pregnancy, labor, and birthing. *Med Anthropol* [Internet]. 2019;38(7):560-573.

24. Vedam S, Stoll K, Taiwo TK, et al. The Giving Voice to Mothers study: Inequity and mistreatment during pregnancy and childbirth in the United States. *Reprod Health [Internet]*. 2019;16(1):77.
25. Abuela. Where black birth matters [Internet]. <https://abueladoulas.co.uk/>. Accessed Jan 24, 2022.
26. Davis-Floyd R. The technocratic, humanistic, and holistic paradigms of childbirth. *Int J Gynecol Obstet [Internet]*. 2001;75:S5-S23.
27. Birth monopoly [Internet]. <https://birthmonopoly.com/>. Accessed Jan 24, 2022.
28. Sister song [Internet]. <https://www.sistersong.net/>. Accessed Jan 24, 2022.
29. Kirkham M. Fundamental contradictions: the business model versus midwifery values. In: Edwards N, Mander R, Lawless M, eds. *Untangling the Maternity Crisis*. Routledge; 2018:75-83.
30. Williams CR, Jerez C, Klein K, Correa M, Belizán JM, Cormick G. Obstetric violence: a Latin American legal response to mistreatment during childbirth. *BJOG*. 2018 Sep;125(10):1208-1211.
31. Fivexmore. Fivexmore [Internet]. <https://www.fivexmore.com/>. Accessed Jan 24, 2022.
32. Association of Ontario Midwives. Bringing birth home: Restoring Indigenous midwifery [Internet]. <https://www.ontariomidwives.ca/bringing-birth-home-restoring-indigenous-midwifery>. Accessed Jan 24, 2022.
33. Apfel A. *Birth Work as Care Work: Stories from Scitivist Birth Communities*. PM Press; 2016.
34. Women on Web. Women on web [Internet]. <https://www.womenonweb.org/nl/>. Accessed Jan 24, 2022.
35. Academy for nursing studies and women's empowerment research studies [Internet]. <https://www.facebook.com/answers.mytri/>. Accessed Jan 24, 2022.
36. Manhães B. bianca_manhaes [Internet]. Humanizando nascimentos. Accessed Jan 24, 2022.
37. King Y. Birthing beyond the binary [Internet]. <https://www.kingyaa.co.za/birthing-beyond-the-binary>. Accessed Jan 24, 2022.
38. Joseph J. Jennie Jospheh [Internet]. <https://jenniejoseph.com/>. Accessed Jan 24, 2022.
39. De Souza R. Race, health, cultural safety, birthing and justice podcast [Internet]. <http://www.ruthdesouza.com/podcast/>. Accessed Jan 24, 2022.
40. Abortcja bez granic [Internet]. <https://abortion.eu/nl/>. Accessed Jan 24, 2022.
41. Guajardo Johnson E. Decolonial approaches to healing & reproductive care [Internet]. <https://www.birthbruja.com/>. Accessed Jan 24, 2022.
42. Irth app [Internet]. <https://irthapp.com/>. Accessed Jan 24, 2022.

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