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End of year editorial *Journal of Asian Midwives* 2018

This year has again been another eventful year for midwives across the globe and in Asia in particular. One of the key features for midwives was the updating of the ICM (International Confederation of Midwives) 2018 Essential Competencies for Midwifery Practice as announced in our previous editorial (Jan & van Teijlingen 2018).

In this longer, more sociological, editorial for the *Journal of Asian Midwives* we aim to highlight the application of a medical/social model of maternity care in South Asia. First, we start our editorial with an overview of the ICM (2014) model of midwifery care as outlined in Table 1. Next, we shall outline the key aspects of the medical and social model, followed by its application to pregnancy and childbirth in some of the countries whose midwifery organisations established the *Journal of Asian Midwives*.

Table 1 gives a clear overview of the work and responsibilities of the midwife. The ICM model of midwifery care is important in setting the boundaries vis-à-vis other relevant professionals who can be involved in providing maternity care, most notably nursing and obstetrics. This table relates to what a midwife does (or should do). The social/medical model is a different kind of model, it is more about how social scientists can make sense of what a midwife, or an obstetrician or a pregnant woman does (or is expected to do), from a broader perspective.

Table 1: The ICM Model of Midwifery Care (ICM 2014)

Midwives:
• Promote and protect women's and new-borns' health and rights. • Respect and have confidence in women and in their capabilities in childbirth. • Promote and advocate for non-intervention in normal childbirth. • Provide women with appropriate information and advice in a way that promotes participation and enhances informed decision-making. • Offer respectful, anticipatory and flexible care, which encompasses the needs of the woman, her newborn, family and community, and begins with primary attention to the nature of the relationship between the woman seeking midwifery care and the midwife. • Empower women to assume responsibility for their health and the health of their families. • Practise in collaboration and consultation with other health professionals to serve the needs of the woman, her new-born, family and community. • Maintain their competence and ensure their practice is evidence-based. • Use technology appropriately and effect referral in a timely manner when problems arise.

- Are individually and collectively responsible for the development of midwifery care, educating the new generation of midwives and colleagues in the concept of lifelong learning.

Introducing the social/medical model

Health care professionals are socialised into thinking along the lines of a (bio)-medical model, a model largely based on physiology and biology with a rather mechanical view of disease, illness, recovery, and the human body. The disease is assumed to be in the patients, resulting in rather individualistic diagnosis and treatment. The medical model is ‘easy’ to understand, based on medical science and statistics. Consequently, diagnosis relies largely on objective measurement of symptoms and clinical observation (van Teijlingen 2017). Our increased reliance on medical technology, for example, has resulted in increasing rates of caesarean deliveries (Johanson et al. 2002). The social model comes from a different perspective, namely that there exists an inter-dependency between ill people and the way they live their lives and the wider environment. The social model focuses on everyday life and the social, socio-economic, cultural and physical aspects of health. The social model considers a wider range of factors that affect someone’s health, such factors as lifestyle, age, gender, wealth, discrimination, where and how they live. Whilst the process of moving from a more social model to a more medical model is called ‘medicalisation’ (van Teijlingen 2017). Please, note that the contents of the social/medical model is not necessarily static. Mackenzie-Bryers and van Teijlingen (2010) explored how UK maternity services transformed from a social to a medical model over the twentieth century. Generally, as a society we allocate a condition, an impairment, or a patient on a spectrum, ranging from a purely social perspective at one end of the scale to a purely medical one at the other end (van Teijlingen 2017). Often, as a society we bring our social and moral issues into the medical domain and make them medical problems (Conrad 2007).

People adhering to a more social model regard pregnancy and childbirth are largely physiological events that occur in most women’s lives. Often the social model includes the idea of pregnancy and childbirth as ‘rites of passage’ as anthropologist would call it. These rites of passage include rituals, starting with the rites of separation, then the “transition”, resulting in the celebration of successful completion (Van Gennep 1960). In this view childbirth is a rite of passage in many people’s lives. Following this line of thinking, the social model of care accepts childbirth as a normal social event in which preventative

measures can be used (Ireland and van Teijlingen 2013). The medical model, on the other hand, regards childbirth is potentially pathological, and therefore every woman is potentially at risk in pregnancy or whilst giving birth. If this is your view it is easy to understand that one would want every delivery in hospital with high-technology screening equipment supervised by expert obstetricians. In short, adhering to the medical model make one think that pregnancy and childbirth are only safe in retrospect (van Teijlingen 2005).

The social-medical model in South Asia

The following section illustrates the relevance of the social/medical model of childbirth in Asia through some examples. Recently Sharma (2016) wrote about the cultural shift in Indian society–towards "the acceptance of medical models for childbirth", especially rich urban women who do not want to undergo normal childbirth, have a lower pain threshold, or prefer obstetricians who offer Caesarean Sections. In Afghanistan Arnold and colleagues (2018) reported that in a tertiary obstetric hospital in Kabul that social norms were in conflict with the principles of biomedicine. In other words, the social model originating from the wider Afghan society clashed with the hospital's medical model. Whilst in Pakistan Amjad et al. (2018) noted an increased medicalisation in the form of unnecessary CSs in both private and public hospitals. To stem the influence of the medical model they recommend that doctors need to give a detailed medical justification for each CS they do to help reduce the rate (Amjad et al. 2018). We have to be careful not to equate medical model with all things bad about biomedicine and the social model with all that is good. For example, in parts of rural Nepal, India, Bangladesh and elsewhere in the world, colostrum is not given to the baby for a number of days after birth as it is considered to be dirty milk (Sharma et al. 2016). This is a clear example where adhering to a social model is not a good idea.

One way to promote a more social model of childbirth is the development of birthing centres and offer midwife-led women-centred care, giving them both a choice and control and a greater continuity of care (Keating & Fleming 2009). We hope this editorial offered some initial insights into the medical/social model, which has also been widely applied, not just in the field of childbirth and maternity care.

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