Reclaiming Midwifery through a Structured Midwife-Led Unit: An Actionable, Non-Overlapping Scope of Work for Primary Maternal and Newborn Care

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Abstract

Midwife-Led Units (MLUs) are considered effective, person-centered platforms for providing quality primary maternal and newborn health services. Its implementation in most low- and middle-income countries is still limited by role ambiguity, task overlap, and insufficient accountability, which reduces the clinical impact of midwives and the overall efficiency of the system. The short communication suggests a non-overlapping scope of work structured to define what is to be done in the MLUs to enhance service delivery. The framework has categorized care into four integrated pillars: preventive (risk identification and referral), promotive (education and informed choice), curative (protocol-based management of normal birth and first-line complications), and rehabilitative (postnatal recovery and continuity of care). Effective functional delimitation will reduce duplication, enhance workflow, and assist midwives as evidence-based independent clinicians. The indicators, which are measurable and midwife-attributable, focus on quality, timeliness, and continuity, but not service volume.

Keywords: *Midwife-led units, primary care, maternal and newborn care, workforce, Pakistan.*

INTRODUCTION

Reclaiming the Role of Midwifery: A Framework for Midwife-Led Units

Midwife-Led Units (MLUs) have always been regarded as the cornerstone of a high-quality maternal and newborn health (MNH) system, particularly in primary care. Although there is strong evidence for the use of midwifery-led models worldwide, in most low- and middle-income countries, these models are not fully implemented [1]. The lack of a clear, quantifiable, and non-overlapping scope of work that would make midwifery practice accountable to the health system has been a major hindrance [2]. This has led to the underutilization of MLUs' potential to enhance maternal and newborn outcomes.

This short communication proposes a four-pillar scope-of-work framework for Midwife-Led Units, organized around preventive, promotive, curative, and rehabilitative services (**Fig. 1**). It includes clear goals, boundaries, and performance indicators. Each pillar is linked through structured referral pathways, communication systems, and continuity-of-care mechanisms to ensure seamless integration across the mother-newborn dyad. This framework begins to reposition midwifery as an effective, evidence-based, clinical profession at the center of maternal, newborn, and child health MNCH outcomes by explicitly defining what it is. It is not done by midwives [3]. This organized practice ensures that midwifery is responsible, effective, and integrated into the broader health system, ultimately improving health outcomes for mothers and newborns.

Between Role Ambiguity and Role Clarity

Midwives are expected to be in most health systems, which leads to diluted roles, poor quality, and poor accountability. The roles are delineated particularly along the care continuum in this structure:

- **Prevention services:** Only emphasize early detection of risk and prevention of complications.
- **Promotive services:** Emphasis on informed choice, education, and self-efficacy.
- **Curative services:** All active clinical management and first-line treatment fall under curative services.
- **Rehabilitative services:** Are guaranteed to provide recovery, continuum, and long-term well-being.
- The pillars are non-overlapping, eliminating task duplication and professional confusion, yet remain fully integrated within the mother-newborn dyad. Women identified with complications in one pillar are transitioned to the next level of care through standardized referral and follow-up mechanisms to maintain continuity of care.

Prevention Not Treatment: A Paradigm Shift

The preventive pillar clearly limits midwifery practices to risk identification and prevention, but not counseling and treatment. It is a conscious differentiation. Counseling is intentionally shifted to the promotive pillar to ensure that preventive services remain focused on timely clinical

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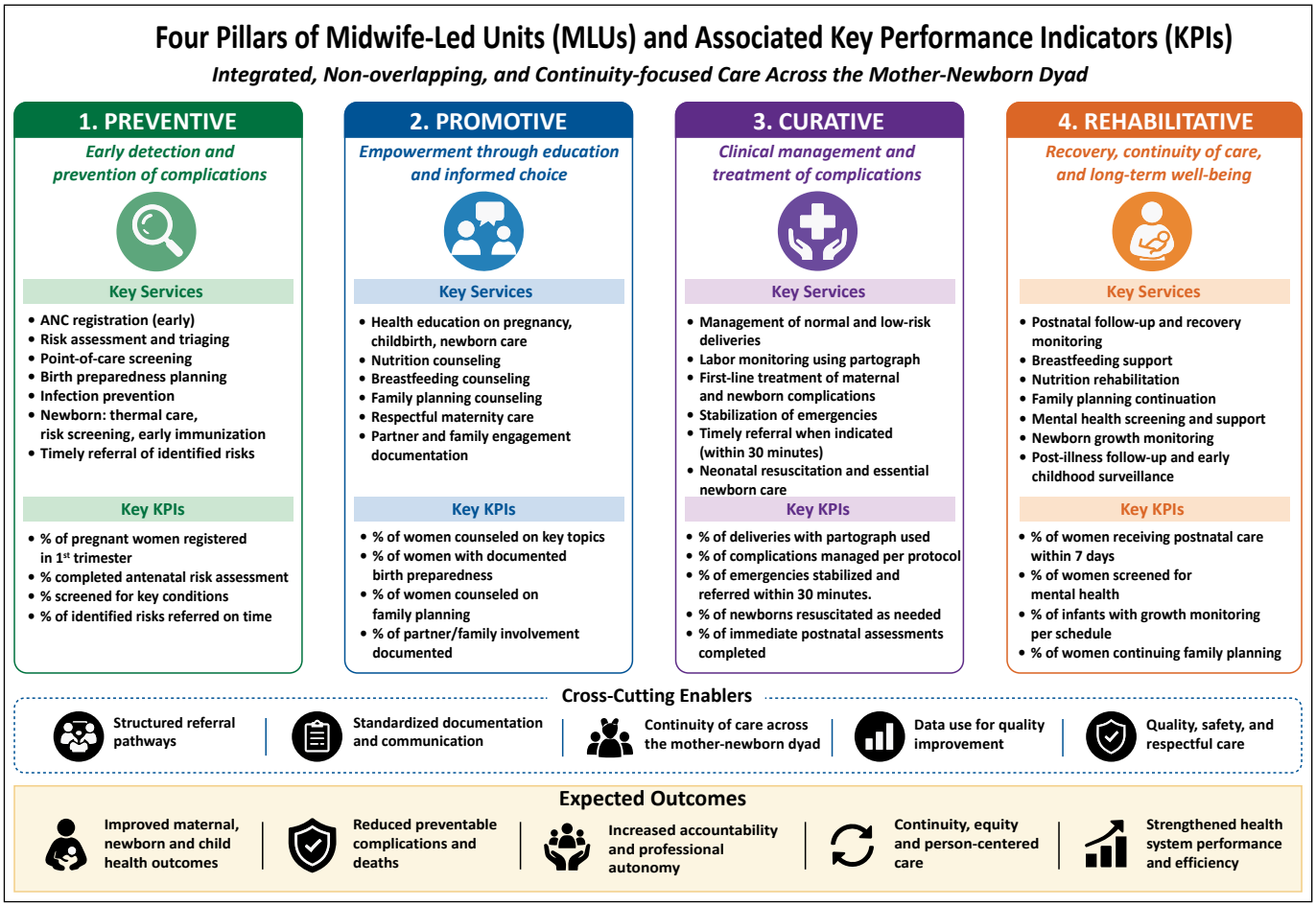


Fig. (1): Conceptual framework of midwife-led units illustrating four service delivery pillars and associated key performance indicators (KPIs).

screening, triaging, and risk identification without delays caused by lengthy educational sessions Midwives are the initial line of defense against preventable complications in the system through prioritizing the registration of antenatal care (ANC), the triaging of risk assessment, point-of-care screening, and the preparation of birth plans [4]. For newborns, universal infection control, thermal control, risk screening, and early immunization can provide a basis for safety before discharge. Notably, full referral activation of identified risks serves to entrench accountability in prevention [5].

Promotion, Not Screening as Empowerment

Promotional services aim to empower autonomy and independent decision-making, rather than clinical surveillance. Organized enlightenment on pregnancy and childbirth, nutrition, breastfeeding, family planning, and respectful maternity care makes the midwife an educator and advocate whom people can trust [6]. This pillar, therefore, assumes responsibility for counseling and behavioral education, allowing preventive services to remain operationally efficient and clinically focused. By making it clear that screening and treatment are excluded, this pillar helps guard against promotion care becoming a watered-down version of clinical services. Partner and family involvement documentation also supports the social aspect of maternal and newborn health further [7].

The Curative Care is Anchored in the Protocols

The curative pillar is the clinical center of the Midwife-Led Unit. In this case, the midwives, when performing and overseeing normal and low-risk deliveries, manage labor using partographs, administer first-line care for obstetric- and neonatal-related complications, and stabilize and arrange referrals for emergencies within specified timeframes [8]. This pillar confirms that midwives are not support staff but experienced clinicians who can provide protocol-based care that directly affects survival and safety. Neonatal resuscitation and essential newborn care further reinforce continuity in maternal and newborn outcomes [9].

Rehabilitation: The Missed Pillar of MNCH

The weak point in MNCH systems is usually postnatal care. The rehabilitative pillar fills this gap by institutionalizing follow-up, recovery monitoring, mental health screening, nutrition rehabilitation, and continuity of family planning [10]. For newborns, monitoring growth and feeding, post-illness recovery, and early childhood surveillance will ensure that survival translates into well-being in later life. Rehabilitative care is results-oriented

with respect to recovery, retention, and resilience, excluding acute treatment and prevention [11].

Measuring What Matters: KPIs of High Impact MNCH

The positive aspect of this framework is its alignment with high-impact Key Performance Indicators (KPIs). All the indicators are practical, quantifiable, and assignable to midwife-led care. Signs such as early ANC registration, full antenatal risk assessment, early initiation of breastfeeding, normal delivery with protocols, timely emergency response, and postnatal continuity of care translate midwifery performance into system accountability [12]. Additional indicators may include referral completion rates, documentation of counseling sessions, partner involvement, and adherence to emergency stabilization timelines. This KPI architecture enables MLUs to shift from service delivery counts to quality, timeliness, and continuity metrics that facilitate performance management, learning, and scale-up.

Policy and Practice Implications

By embracing this four-pillar scope of work, there are several implications:

1. Professionalization of the midwifery profession by defining the role and protocol practice.
2. Improved MNCH outcomes are achieved by improved prevention, early intervention, and follow-up.
3. Health system efficiency in minimizing duplication and the transfer of the wrong tasks.
4. Increased accountability with measures that are attributable and measurable to the midwife.

   Most importantly, it redefines midwifery as a systems solution rather than a workforce category.
5. Improved continuity of care through integrated referral pathways and communication systems between pillars.

CONCLUSION

Midwife-Led Units have the potential to deliver on their pledge through well-defined, safeguarded, and quantified promises. It is an actionable model that is not overlapping, a practical model for countries that want to strengthen primary MNCH care and promote equity, quality, and sustainability within maternal and newborn health systems. Midwifery is emphasized by aligning the scope of work with results, positioning midwives at the center of accountable, evidence-based maternal and newborn healthcare delivery.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

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