Letter to Editor

Evidence-based Midwifery: The Key to Enhancing Clinical Decision-making and Promoting Maternal Health

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Dear Editor

I recently read the article titled "Implementation of evidence-based practice: The experience of nurses and midwives" by AH Dagne and MH Beshah published in the PLoS One journal [1]. In addition to individual and resource barriers, the limited clinical autonomy of midwives constitutes a structural barrier that directly impedes the translation of evidence. I want to congratulate the authors on their successful and valuable research and make some contributions. The article explores the implementation of evidence-based midwifery from the perspective of midwives and nurses in Ethiopia. It highlights barriers, such as a lack of knowledge and skills, poor time management, insufficient motivation, inadequate resources, and unclear job descriptions.

Although this study professionally captures important individual and systemic barriers in the Ethiopian context, we would like to expand the discussion by highlighting a critical, but often overlooked, structural factor: the lack of independent clinical decision-making authority for midwives, especially in delivery rooms. This important limitation is not only accompanied by a reported lack of motivation and unclear tasks, but also represents a major barrier to translating evidence into practice. Evidence from high-income countries consistently shows that midwife-led and accountable models of care, where such autonomy exists, lead to better outcomes, including reduced maternal and neonatal mortality and reduced intervention rates [2, 3].

Although these findings are significant and noteworthy, our research team believes that one of the most critical barriers to implementing evidence-based midwifery is the lack of dedicated delivery rooms for midwives and healthcare professionals. In many hospital settings in Iran, intrapartum care is obstetrician-led, which can limit midwives' autonomy. Midwives, as sexual and reproductive health researchers and midwifery leaders in Iran, are marginalized in clinical decision-making in delivery rooms. A national study analyzing the attitudes of midwives in Iran identified the lack of midwives' authority in clinical settings as a systemic barrier to the development of midwifery-centered care [4]. In practice, delivery rooms are typically supervised by obstetricians and gynecologists, and midwives, along with their assistants, are required to follow their orders. This practice prevents midwives from independently making decisions about physiological delivery and from reducing unnecessary interventions, creating a critical constraint that impedes the effective translation of evidence into practice.

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Research from developed countries has consistently demonstrated the benefits of midwifery-led care. Evidence from high-income settings suggests that midwife-led models of care are associated with improved maternal and neonatal outcomes and lower intervention rates among low-risk women [2, 3]. In developed countries, such as Germany and Australia, midwifery care has reduced maternal mortality [5, 6], improved the childbirth experience, reduced epidural use, and shortened labor [7].

This global evidence contrasts with the clinical context in Iran and points to an important implication: barriers, such as unclear job descriptions, limited motivation, and inadequate support may not only reflect individual or resource constraints, but can also be manifestations of a deeper structural issue—namely, constrained professional autonomy for midwives in intrapartum decision-making. When midwives' clinical authority is limited, their ability to operationalize evidence-based recommendations for physiological birth may be confined, even when knowledge and guidelines are available. National evidence from Iran similarly highlights perceived lack of professional authority as a systemic barrier to developing midwife-centered care [4]. Addressing evidence implementation, therefore, requires moving beyond training and resources alone and also considering governance, role clarity, and accountability within collaborative models of maternity care. Notably, an Iranian 'best evidence implementation' project published in the Iranian Journal of Health Sciences demonstrated measurable improvements in midwives' adherence to evidence-based pelvic floor muscle training practices, supporting the feasibility of structured evidence implementation in routine maternity care [8]. In this regard, we propose the following recommendations to support effective translation of evidence into practice:

Strengthen interdisciplinary collaboration by establishing structured mechanisms for shared decision-making and role clarification between midwives and obstetricians. Develop and implement evidence-based intrapartum protocols with joint leadership from midwives and obstetricians, aligned with international guidelines. Integrate interprofessional education on evidence-based midwifery and clinical decision-making into medical and midwifery curricula.

Support policies that enable midwives' professional autonomy within collaborative models of maternity care, with clear accountability and governance.

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