

Position Statement

Unnecessary Interventions and the Risk of Harm to Women and Newborns

REVISED 2026

Background

Medical and surgical interventions during pregnancy, birth and the postnatal period (hereafter the perinatal period), are essential components of quality care when used appropriately, for clear clinical indications and with demonstrated evidence of benefit (1). When timely access to these interventions is available, they can be lifesaving and improve outcomes for women and newborns (2). Despite global improvement in maternal and newborn survival (3), timely access to quality sexual, reproductive, maternal, newborn and adolescent health (SRMNAH) care is not assured globally; this persistent gap is frequently described as ‘too little, too late’ (4).

At the same time, interventions are frequently used without clinical indication, contrary to evidence-based guidance, a pattern described as ‘too much, too soon’ (4). These include, but are not limited to, unindicated ultrasound scanning, continuous electronic fetal monitoring, induction of labour, caesarean birth, antibiotics, early cord clamping and use of infant formula. Such overmedicalisation is associated with worse health outcomes at population level (5). For example, the World Health Organisation (WHO)

guidance states that while caesarean birth is lifesaving when indicated, population rates above approximately 10–15% are not associated with further reductions in mortality and are linked to increased short- and long-term maternal and newborn morbidities (5,6). Routine induction of labour provides an example of an intervention that shows only minimal population-level benefit for a single outcome, without full consideration of longer-term effects, including impacts on women’s experiences (7). These patterns are not without consequence.

Unnecessary intervention can disrupt normal physiology, increase the likelihood of further interventions, and contribute to short and long term physical and psychological harm. These include increased rates of unnecessary operative birth, infection, haemorrhage, neonatal respiratory complications, impaired breastfeeding initiation and negative birth experiences. Such practices also impose substantial financial and operational burdens on health systems and individuals (5-8).

Drivers include fear of litigation, health care professional’s convenience, financial and organisational incentives. They also include broader systemic pressures, including medico-legal concerns, culture, and social narratives about risk and safety, that prioritise speed and volume over safe physiological processes (8).

The normalisation of routine intervention without evidence of benefit, together with limited access to midwifery models of care and inadequate antenatal education, can reduce women and families’ confidence in the normal perinatal period. It may also limit opportunities for midwives and other health professionals to develop and maintain competencies in supporting physiological processes (9).

These concerning patterns reflect a broader erosion of women’s sexual and reproductive health and rights (SRHR). When unnecessary interventions become routine, women’s bodily autonomy becomes limited and midwives’ ability to provide safe, individualised, evidence-informed care is reduced (10).

Together ‘too much, too soon’ and ‘too little, too late’ reflect a growing polarisation in SRMNAH, highlighting inequalities and health systems’ failure to provide appropriate, evidence-informed, rights-based and woman-centred care (4).

Position

The International Confederation of Midwives (ICM) maintains that when clinically indicated, medical interventions during the perinatal period must be readily available to all, and avoided when not clinically indicated.

All women require rights-based woman-centred care, that upholds women's bodily autonomy through facilitation of evidence-informed decision making, including about medical interventions.

Midwives play a critical role in addressing the balance between necessary intervention and the protection of physiological and psychological wellbeing through the provision of skilled, continuous care according to the [Midwifery Philosophy and Model of Care](#).

Health systems must enable midwives to work autonomously in partnership with women. This includes, supporting physiological processes, providing continuity of care, facilitating evidence-informed decision making and ensuring timely access to appropriate intervention and referral when complications arise.

Recommendations

ICM urges health authorities and policymakers to:

1. Invest in the education, recruitment, regulation and retention of midwives, recognising them as the most appropriate health professionals to lead care for women without complications throughout the physiological perinatal period.
2. Develop, implement, and monitor policies and guidelines that promote the appropriate, evidence-informed use of medical interventions.
3. Systematically collect and analyse data on intervention rates, and maternal and newborn outcomes to inform evidence-informed policymaking and strategic health system planning.
4. Address structural drivers of unnecessary intervention, including financial and organisational incentives, and health system pressures that prioritise speed and volume of care over physiological processes.

5. Ensure universal access to midwifery models of care, including continuity of midwife care, to reduce unnecessary intervention and support physiological processes.
6. Strengthen referral systems and interprofessional collaboration so that women and newborns with complications receive safe, timely and appropriate care.

ICM urges midwives' associations to:

1. Advocate for regulation, policy, and funding to increase access to appropriate interventions, and enable universal access to midwifery models of care.
2. Promote research generation and dissemination, especially by midwifery researchers, into intervention rates, outcomes and drivers.
3. Advocate for pre-service and in-service education that equips midwives with the knowledge, skills and behaviours to support a safe physiological perinatal period, make or advise on evidence-informed decisions about interventions and promptly identify, manage, and refer women and newborns complications.
4. Foster collaboration with other professional associations to promote interprofessional models of care, recognising that reducing unnecessary intervention is influenced by mutual respect, communication, and effective referral mechanisms across the health system.

ICM urges midwives to:

1. Uphold women's bodily autonomy and support women through personalised care to make informed decisions including about interventions in the perinatal period.
2. In partnership with women, support physiological processes, recommending interventions only when clinically indicated and providing management and timely referral to an interprofessional team when complications of the perinatal period occur.
3. Raise awareness, especially through antenatal education, about the appropriate use of interventions and women's rights in the perinatal period.

4. Commit to interprofessional collaboration, recognising that appropriate intervention is informed by timely consultation, coordinated decision-making and effective referral.
5. Maintain competencies through lifelong learning, reflective practice and adherence to professional standards.

References

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This position statement merges and updates two previous position statements: 'Appropriate use of interventions in childbirth' and 'Appropriate use of Caesarean Section', both adopted at the Brisbane International Council meeting in 2005 and reviewed at the Toronto International Council meeting in 2017.

Merged and updated at the Lisbon International Council meeting, 2026

Due for next review, 2029