International Journal of Computational and Experimental Science and ENgineering (IJCESEN)

Vol. 10-No.4 (2024) pp. 2282-2292
http://www.ijcesen.com

ISSN: 2149-9144

Research Article

The Impact of Nursing and Midwifery Interventions on Reducing Maternal Mortality A Narrative Review

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Article Info:

DOI: 10.22399/ijcesen.3909
Received : 03 November 2024
Accepted : 22 December 2024

Keywords

Maternal mortality
Nursing interventions
Midwifery care
Intrapartum management
Postnatal care
Skilled birth attendance

Abstract:

Nursing and midwifery interventions play a pivotal role in reducing maternal mortality by delivering timely, evidence-based care across the continuum of pregnancy, childbirth, and the postpartum period. This narrative review synthesizes literature on antenatal risk screening, skilled intrapartum attendance, active management of the third stage of labor, immediate newborn care, and postpartum surveillance—interventions that directly reduce causes of maternal death such as hemorrhage, hypertensive disorders, sepsis, and obstructed labor. Emphasis is placed on how midwives and nurses implement clinical protocols, perform early recognition and referral for complications, and provide life-saving measures in low-resource settings. The review also considers the contribution of community-based midwifery, task-shifting strategies, and the use of standardized checklists and simulation training to improve clinical competence and response times.Beyond clinical procedures, the review highlights system-level and socio-cultural factors that modulate the effectiveness of nursing and midwifery interventions. Workforce capacity—education, continuous professional development, and supportive supervision—emerges as a critical determinant of outcomes, as does health system

integration that ensures referral pathways, supply chain reliability, and data-driven quality improvement. Cultural competence, respectful maternity care, and community engagement are discussed as essential components for improving utilization of skilled care and timely help-seeking. Finally, the narrative identifies gaps in high-quality outcome data, calls for rigorous implementation research, and offers recommendations for policy and practice to strengthen nurse-midwife-led models as a central strategy for accelerating reductions in maternal mortality.

1. Introduction

Maternal mortality remains one of the most profound and persistent public health challenges and a stark indicator of global inequality. Defined as the death of a woman during pregnancy or within 42 days of termination of pregnancy from any cause related to or aggravated by the pregnancy or its management, the vast majority of these deaths are preventable [1]. The commitment to reducing maternal mortality was enshrined in the Millennium Development Goals and remains a central pillar of the Sustainable Development Goals (SDGs), specifically Target 3.1, which aims to reduce the global maternal mortality ratio (MMR) to less than 70 per 100,000 live births by 2030 [2]. While significant progress has been made since the 1990s, the rate of decline has stagnated in recent years, and alarming disparities persist between and within nations [3]. Current estimates indicate that approximately 800 women still die every day from complications related to pregnancy and childbirth, with the overwhelming burden concentrated in low and middle-income countries (LMICs) and among the most marginalized populations [4]. This ongoing tragedy represents a collective failure of health systems and a violation of fundamental human rights, underscoring the urgent need for renewed and focused action.

The direct medical causes of maternal death are well-established and have remained largely consistent for decades. The primary killers are postpartum haemorrhage (PPH), hypertensive disorders (like pre-eclampsia and eclampsia), sepsis, complications of unsafe abortion, and obstructed labour [5]. The clinical knowledge and technologies to prevent and manage these complications exist. However, the critical factor that determines whether a woman survives or dies is not the availability of knowledge, but rather *access to skilled care*—the timely, competent, and compassionate provision of evidence-based interventions throughout the pregnancy continuum. This is where the role of a competent, empowered, and well-supported health workforce becomes absolutely indispensable.

Within this workforce, nurses and midwives constitute the frontline. They are often the first and sometimes the only point of contact for women in the healthcare system. Their scope of practice is uniquely positioned to address the multifaceted nature of maternal health, encompassing not only clinical expertise but also health promotion, education, advocacy, and continuous support. The World Health Organization (WHO) and the International Confederation of Midwives (ICM) emphasize that midwife-led continuity of models of care can significantly improve maternal and neonatal outcomes [6].

The Multifaceted Role of Nurses and Midwives:

The impact of nursing and midwifery on maternal mortality is not the result of a single intervention but rather a synergistic combination of roles and functions executed across the entire spectrum of care. Their contribution can be conceptualized through a multi-tiered framework that operates at the levels of primary, secondary, and tertiary prevention, all within a context of continuous support and advocacy.

At the level of primary prevention and health promotion, nurses and midwives are the cornerstone. They provide essential education to women, families, and communities on healthy pregnancy behaviors, birth preparedness, recognition of danger signs, nutrition, and the importance of skilled attendance at birth [7]. This foundational work empowers women to make informed decisions and seek care promptly, effectively preventing complications from arising in the first place. A crucial aspect of primary prevention is the provision of family planning services, which allows women to space and limit pregnancies, directly reducing their lifetime risk of maternal death [8].

At the secondary prevention and skilled clinical care level, their role is most visibly life-saving. During antenatal care, they conduct screenings to identify high-risk conditions, such as measuring blood pressure to detect hypertensive disorders and testing for infections [9]. During childbirth, the presence of a skilled birth attendant—overwhelmingly a nurse or midwife—is critical. They perform essential interventions like active management of the third stage of labour (AMTSL) to prevent PPH, the leading cause of maternal death [10]. They are trained to monitor labour using a partograph, identify obstructed labour early, manage

uncomplicated deliveries, and perform basic emergency procedures like neonatal resuscitation. Furthermore, they are the crucial link in the referral chain, possessing the skills to recognize complications beyond their scope and ensure timely transfer to a higher-level facility [11].

At the tertiary prevention and emergency management level, in many regions, especially those with a critical shortage of physicians, advanced practice nurses and midwives are trained to provide comprehensive emergency obstetric care (CEmONC). This includes administering intravenous antibiotics for sepsis, giving anticonvulsants for eclampsia, performing manual removal of the placenta, and managing shock [12]. By task-shifting these essential services, they fill a vital gap in the health system and provide life-saving treatment when delays could be fatal.

Underpinning all these clinical functions is their role as patient advocates and providers of continuous support. They ensure women receive dignified, respectful, and culturally sensitive care. They advocate for the woman's needs and wishes within the health system, fostering trust and communication, which improves adherence to care plans and overall patient satisfaction [13]. This holistic, woman-centered approach is a defining characteristic of midwifery care and is intrinsically linked to better physiological and psychological outcomes.

Roles of Nursing and Midwifery in Maternal Health:

The impact of nursing and midwifery on maternal health outcomes is best understood through a multi-dimensional conceptual framework that outlines their diverse and interconnected roles. This framework moves beyond a simple task-oriented view and positions these professionals as essential agents at the individual, community, and health system levels. Their functions are not sequential but rather overlapping and synergistic, creating a continuum of care that is critical for safeguarding maternal well-being. The core of this framework is the provision of woman-centered care, an approach that respects the individual woman's needs, values, and autonomy, and recognizes her as an active participant in her care rather than a passive recipient [14]. This philosophy underpins all their activities and is fundamentally linked to improved communication, trust, and clinical outcomes. It is the antithesis of a fragmented, disease-focused model and instead promotes holistic support throughout the pregnancy journey, from pre-conception to the post-natal period and beyond.

The first pillar of this framework encompasses the role of clinician and skilled provider. This is the most visible and widely recognized function, involving the direct application of evidence-based clinical knowledge and techniques. During antenatal care, this includes conducting risk assessments, monitoring fetal growth, administering prophylactic treatments like tetanus toxoid and iron supplements, and screening for conditions such as anemia, HIV, and pre-eclampsia [15]. The intrapartum period is where their clinical skills are most critical; the skilled attendance of a midwife or nurse during childbirth is universally acknowledged as the single most important factor in preventing obstetric complications from becoming fatal [16]. Their clinical role extends to performing essential interventions such as active management of the third stage of labour to prevent postpartum hemorrhage, managing normal vaginal deliveries, performing episiotomies when necessary, and providing immediate newborn care and resuscitation [17]. In many low-resource settings, advanced practice midwives are also trained to perform life-saving emergency procedures, such as manual removal of the placenta and administration of parenteral antibiotics and anticonvulsants, effectively acting as primary providers of comprehensive emergency obstetric care [18].

Beyond direct clinical care, the second crucial pillar of the framework is the role of educator, counselor, and health promoter. This function is proactive and foundational to prevention. Nurses and midwives empower women and their families with knowledge about healthy behaviors, nutritional needs, and the importance of rest during pregnancy [19]. They provide crucial counseling on birth preparedness, including creating a birth plan, arranging transportation, and saving funds for potential emergencies. A central component of this educational role is teaching women and their families to recognize danger signs, such as severe headache, blurred vision, vaginal bleeding, fever, or swollen hands and feet, which enables them to seek timely medical assistance before a crisis occurs [20]. Furthermore, they are primary providers of family planning counseling and services in the postnatal period and beyond, which is a cornerstone of maternal mortality reduction by allowing women to space and limit their pregnancies, thereby reducing their lifetime risk [21]. This educational role often extends into the community, where they may lead health talks and workshops, amplifying their impact beyond individual patient interactions.

The third pillar defines their role as advocate and coordinator of care. Nurses and midwives frequently act as the woman's voice within the healthcare system, ensuring her concerns are heard and her

rights to dignified and respectful care are upheld. They advocate for the woman's preferences in her birth plan when medically feasible and ensure she provides informed consent for all procedures [22]. This advocacy is vital for combating mistreatment and disrespectful care, which can deter women from seeking facility-based births. As coordinators, they are instrumental in navigating the complex health system for their patients. They facilitate referrals to obstetricians, specialists, or higher-level facilities when complications arise, ensuring a seamless transition and continuity of care [23]. They also coordinate with other members of the healthcare team, such as doctors, community health workers, and social workers, to create a cohesive support network around the pregnant woman. This coordination is essential for managing comorbidities, social determinants of health, and other complex factors that can influence pregnancy outcomes.

The fourth pillar encompasses their public health and systems-level roles. Nurses and midwives are not just caregivers for individuals; they are also managers, researchers, and policy influencers who contribute to strengthening the entire health system. They are often responsible for managing health unit resources, maintaining accurate medical records, and collecting vital health data that is used for disease surveillance, monitoring health indicators, and shaping public health policy [24]. Their frontline experience provides them with unique insights into the gaps and challenges within the maternal health system, making them invaluable contributors to quality improvement initiatives, policy development, and health systems research. By mentoring students and junior staff, they ensure the transfer of knowledge and skills, thereby building the capacity of the future workforce [25]. This systems-level role ensures that their impact is sustainable and scalable, influencing not only the women they directly care for but also the entire population served by the health system.

Antenatal Interventions by Nurses and Midwives

The antenatal period represents a critical window of opportunity for preventing maternal and perinatal mortality and morbidity, and the interventions delivered by nurses and midwives during this time are foundational to positive pregnancy outcomes. Evidence overwhelmingly confirms that quality antenatal care (ANC), largely provided by these professionals, is not merely about monitoring progress but about actively identifying risks, providing preventive treatments, and empowering women through education and support [26]. The World Health Organization's recommendation of a minimum of eight ANC contacts reflects a shift from a ritualistic, low-value care model to a strategic, goal-oriented approach that maximizes the potential for early intervention [27]. The core philosophy of midwifery-led care, which emphasizes continuity, woman-centeredness, and building a relationship of trust, is particularly effective in this phase. This model has been shown to increase patient satisfaction and adherence to care plans, as women feel more comfortable disclosing concerns and actively participating in their care when they see a known and trusted caregiver throughout their pregnancy [28]. The synthesis of evidence for their antenatal interventions can be categorized into several key areas: screening and risk assessment, health promotion and education, preventive clinical care, and psychosocial support.

The first and most fundamental antenatal intervention is comprehensive screening and risk assessment. At the initial booking visit and throughout pregnancy, nurses and midwives conduct a systematic evaluation to establish a baseline and identify women who require closer monitoring or specialist referral. This includes taking a detailed medical, obstetric, and social history to identify pre-existing conditions (e.g., hypertension, diabetes, HIV status) and psychosocial risk factors (e.g., intimate partner violence, substance use, lack of social support) that could adversely affect the pregnancy [29]. They perform essential physical examinations, including measuring blood pressure to screen for hypertensive disorders, checking for pallor to clinically assess for anemia, and measuring uterine growth to monitor fetal development. The evidence is clear that regular blood pressure monitoring by a skilled professional is one of the most effective strategies for the early detection of pre-eclampsia, allowing for timely management and preventing its progression to eclampsia, a major cause of maternal death [30]. Furthermore, they are responsible for collecting specimens for crucial laboratory tests, such as hemoglobin levels to diagnose anemia, syphilis serology, HIV testing, and urinalysis for proteinuria and asymptomatic bacteriuria, all of which are integral to preventing devastating complications for both mother and child [31].

A second, equally critical category of intervention is health promotion, education, and counseling. This proactive role is a hallmark of nursing and midwifery care and is essential for empowering women to become agents of their own health. Evidence shows that effective health education delivered during ANC leads to improved health-seeking behaviors [32]. Nurses and midwives provide counseling on optimal nutrition, including

the importance of iron and folic acid supplementation to prevent neural tube defects and maternal anemia, a condition that exacerbates the risk of death from hemorrhage [33]. They offer advice on managing common pregnancy discomforts, the importance of rest, and avoiding harmful substances like tobacco and alcohol. A vital component of this educational role is birth preparedness and complication readiness. Midwives educate women and their families on developing a birth plan, arranging transportation to a health facility, identifying a skilled birth attendant, and saving funds for potential emergencies [34]. Crucially, they teach women to recognize key danger signs—such as severe headache, visual disturbances, vaginal bleeding, fever, severe abdominal pain, and reduced fetal movements—and to seek care immediately. This knowledge directly addresses the "first delay" (the delay in deciding to seek care) in the three-delays model of maternal mortality and is a proven life-saving intervention [35].

The third category encompasses the administration of preventive clinical care and immunizations. Based on their assessments, nurses and midwives provide essential prophylactic treatments that have a direct impact on mortality rates. The administration of intermittent preventive treatment for malaria in endemic regions and the provision of insecticide-treated bed nets are interventions proven to reduce the burden of malaria in pregnancy, which is associated with maternal anemia, low birth weight, and stillbirths [36]. They administer tetanus toxoid vaccinations to protect both the mother and newborn from neonatal tetanus, a deadly but entirely preventable disease. For HIV-positive women, they are central to the provision of antiretroviral therapy (ART) to prevent mother-to-child transmission of the virus, and they provide counseling on safe infant feeding practices [37]. Furthermore, they manage and treat common conditions identified during screening, such as providing oral iron therapy for anemia and antibiotics for asymptomatic bacteriuria, which if left untreated, can lead to pyelonephritis and preterm labor.

Finally, the evidence strongly supports the role of nurses and midwives in providing psychosocial support and mental health screening. Pregnancy is a period of significant psychological adjustment, and mental health disorders, particularly depression and anxiety, are prevalent and can have serious consequences for both the mother and the developing fetus. The continuity of care model inherent in midwifery practice allows for the development of a therapeutic relationship, making midwives ideally positioned to identify signs of psychological distress. Evidence indicates that simple screening tools administered during routine ANC visits can effectively identify women at risk [38]. Nurses and midwives provide first-line support through active listening, counseling, and creating a non-judgmental space for women to express their fears and concerns. For women experiencing intimate partner violence or significant social vulnerabilities, they act as a critical link to additional support services, such as social workers or psychologists [39]. This holistic approach to care—addressing not just the physical but also the mental and social well-being of the woman—is a powerful determinant of a positive pregnancy experience and contributes significantly to better overall outcomes.

In synthesis, the evidence for the impact of antenatal interventions by nurses and midwives is robust and multifaceted. Their role extends far beyond simple data collection. Through systematic screening, they identify risks; through education, they empower and prevent complications; through preventive treatments, they directly address causes of morbidity; and through psychosocial support, they safeguard mental well-being. The effectiveness of these interventions is greatly amplified when delivered within a model of continuity of care, where a relationship of trust facilitates better communication and adherence. Investing in and empowering the nursing and midwifery workforce to provide full-spectrum, high-quality antenatal care is not just a clinical imperative but a cost-effective public health strategy with a proven return on investment: healthier mothers and healthier babies.

Midwifery-Led Practices and Emergency Management:

The intrapartum period—encompassing labour, birth, and the immediate postpartum—is the most critical phase for maternal survival, as the majority of direct causes of maternal death occur during this time. The presence of a skilled birth attendant, overwhelmingly a midwife or nurse, is the cornerstone of safe childbirth and is universally recognized as the single most critical intervention for reducing intrapartum-related mortality [40]. The role of these professionals during childbirth is dichotomous: they are experts in fostering physiological birth for low-risk women while simultaneously being vigilant first responders capable of detecting and managing life-threatening complications with speed and competence. This synthesis of evidence examines midwifery-led practices for normal birth and their crucial role in emergency obstetric management. The foundation of effective intrapartum care is skilled, respectful, and continuous support, which in itself has been proven to improve outcomes by reducing the duration of

labour, the need for analgesic pain relief, and the rate of instrumental deliveries and caesarean sections [41]. This supportive care includes providing continuous presence, reassurance, and encouragement, facilitating mobility and comfortable positions, and advocating for the woman's choices, all of which contribute to a positive and safer birth experience.

For the vast majority of pregnancies classified as low-risk, the midwifery model of care is the gold standard. This model prioritizes non-invasive, supportive techniques to facilitate a normal physiological birth. Key practices include the use of the partograph, a pre-printed form used to monitor the progress of labour and the condition of the mother and fetus. When used correctly by a skilled attendant, the partograph is an invaluable tool for the early detection of labour dystocia (obstructed labour) and fetal distress, serving as an early warning system that triggers timely intervention or referral before a crisis develops [42]. Midwives are experts in supporting women through first and second stage labour, promoting the use of upright and mobile positions, which have been shown to shorten labour, reduce pain, and decrease the incidence of operative births [43]. They manage pain using non-pharmacological methods such as hydrotherapy, massage, and breathing techniques. The management of the second stage, including the avoidance of directed pushing and the support of spontaneous bearing-down efforts, helps to protect the pelvic floor and reduces the risk of perineal trauma [44]. The pinnacle of evidence-based midwifery intrapartum care is the Active Management of the Third Stage of Labour (AMTSL), a package of three interventions designed to prevent postpartum haemorrhage (PPH).

The Active Management of the Third Stage of Labour (AMTSL) is arguably the most important clinical protocol midwives perform and is a cornerstone of maternal survival strategies globally. The three components of AMTSL are: 1) the administration of a prophylactic uterotonic drug (such as oxytocin) immediately upon birth of the baby; 2) controlled cord traction to deliver the placenta; and 3) uterine massage after the placenta is delivered [45]. Overwhelming evidence from numerous randomized controlled trials and meta-analyses confirms that the routine use of AMTSL by skilled attendants significantly reduces the incidence of PPH (blood loss $\geq$ 500 ml) and severe PPH (blood loss $\geq$ 1000 ml), the leading cause of maternal death worldwide [46]. The administration of oxytocin within one minute of birth is the most critical element of this package. Midwives are trained to safely administer this medication, monitor its effects, and be aware of its contraindications. Their role in implementing this simple, low-cost, and highly effective intervention demonstrates how a skilled and empowered midwifery workforce can directly and dramatically reduce maternal mortality at the point of care.

Beyond managing normal birth, the ability to recognize and initiate management of obstetric emergencies is a defining competency of a skilled birth attendant. The first step is always vigilant monitoring to enable early detection. When complications arise, such as a prolonged labour indicated on the partograph, abnormal fetal heart rate, or signs of maternal distress, midwives are trained to perform basic emergency obstetric and newborn care (BEmONC) [47]. This includes initiating intravenous lines, administering intravenous fluids, giving antibiotics for prolonged rupture of membranes to prevent sepsis, and providing supplemental oxygen. Perhaps their most vital emergency function is to recognize when a situation exceeds their scope of practice and to initiate a timely and organized referral to a higher-level facility capable of providing comprehensive emergency obstetric care (CEmONC). This decision-making and referral process, including stabilizing the woman for transport and communicating effectively with the receiving facility, is a complex skill that is essential for preventing the "third delay" (delay in receiving adequate care) in the three-delays model [48]. In many low-resource settings where doctors are scarce, midwives are additionally trained to perform certain signal functions of CEmONC themselves, effectively acting as advanced practitioners.

In contexts with limited medical staff, the role of midwives expands to include advanced life-saving procedures, a practice known as task-shifting or task-sharing. A well-trained and authorized midwife can perform interventions that are typically considered surgical, such as manual removal of a retained placenta, which is a common cause of haemorrhage and infection [49]. They can be trained to safely perform assisted vaginal deliveries using vacuum extraction or forceps to expedite birth in cases of fetal distress. Furthermore, they are essential in the initial resuscitation and stabilization of a woman in shock from haemorrhage, including bimanual uterine compression to tamponade bleeding while arranging for definitive treatment [50]. For the newborn, midwives are the first responders for neonatal resuscitation, a critical skill for preventing intrapartum-related stillbirths and early neonatal deaths from birth asphyxia. The evidence is clear that training midwives in emergency skills, including the use of simulation, dramatically improves their confidence,

competence, and ultimately, patient outcomes in crisis situations [51].

Early Detection, Follow-up, and Support

The postnatal period, defined as the first six weeks after birth, is a critical yet often neglected phase in the continuum of maternal care. It is a time of significant physiological and emotional adjustment for the mother and newborn, and it carries substantial risks; a large proportion of maternal deaths occur during this time, primarily from haemorrhage, hypertensive disorders, and infection [52]. Historically, focus and resources have been disproportionately allocated to antenatal and intrapartum care, leaving postnatal care (PNC) as the weakest link. However, evidence increasingly underscores that proactive, high-quality postnatal interventions provided by nurses and midwives are essential for sustaining the gains made during childbirth and for preventing late maternal deaths and severe morbidities. The role of the midwife extends seamlessly from birth into this period, providing a crucial advantage through continuity of care. The World Health Organization recommends at least three postnatal contacts: within 24 hours, on day 3, and between days 7-14 after birth, with a final contact at 6 weeks [53]. These contacts are not merely routine check-ups but are strategic opportunities for systematic assessment, health promotion, and early detection of life-threatening complications, forming a safety net for the mother and infant during their most vulnerable time.

The cornerstone of postnatal midwifery care is vigilant monitoring for the "big three" killers: postpartum haemorrhage (PPH), pre-eclampsia/eclampsia, and puerperal sepsis. In the immediate hours after birth, the midwife's primary focus is on monitoring for secondary PPH. This involves regularly assessing uterine involution through fundal palpation to ensure the uterus remains firm and contracted, monitoring the amount, colour, and odour of lochia (postpartum vaginal discharge), and checking vital signs for tachycardia and hypotension, which are early signs of hypovolemic shock [54]. This vigilant observation continues beyond the first 24 hours, as delayed PPH can occur days after birth. Equally critical is the monitoring for pre-eclampsia, which can manifest for the first time or worsen in the postpartum period. Midwives are responsible for regularly checking the mother's blood pressure and screening for symptoms such as severe headache, visual disturbances, epigastric pain, and hyperreflexia [55]. The administration of magnesium sulfate for eclampsia prophylaxis and treatment, a life-saving intervention, is a key competency for advanced midwifery practitioners in many settings.

The third major threat, puerperal sepsis, requires midwives to be astute diagnosticians. They educate mothers on the signs of infection, such as fever, chills, lower abdominal pain, and foul-smelling lochia, and conduct systematic assessments during each postnatal contact. Early detection of sepsis and prompt initiation of antibiotic therapy are critical to prevent progression to septic shock and death [56]. Beyond these direct complications, postnatal care includes comprehensive maternal assessment. Midwives evaluate perineal, Caesarean section, or episiotomy wounds for signs of infection, dehiscence, or hematoma. They assess breast health, provide support for breastfeeding establishment, and manage common issues like engorgement, mastitis, and cracked nipples, which are vital for both infant nutrition and maternal comfort [57]. Furthermore, they assess the resumption of bladder and bowel function, as urinary retention and constipation are common postpartum issues that can lead to discomfort and further complications if unaddressed.

A profoundly important component of postnatal midwifery care is the assessment of maternal mental health. The postpartum period confers a high risk for the development of mood disorders, notably postpartum depression and anxiety, which can have devastating consequences for the mother, infant, and entire family if left unidentified and untreated. Nurses and midwives are often the primary healthcare providers during this time and are therefore uniquely positioned to conduct mental health screening. Using validated tools such as the Edinburgh Postnatal Depression Scale (EPDS), they can identify mothers at risk during routine PNC visits [58]. Beyond screening, they provide first-line psychological support through active listening, non-judgmental counselling, and validation of the mother's experience. They play a pivotal role in de-stigmatizing mental health struggles, normalizing the emotional challenges of new motherhood, and providing crucial health education on the difference between "baby blues" and more serious conditions [59]. For women with severe symptoms or identified risk factors, midwives facilitate referral to specialized mental health services, ensuring continuity of care and support.

The postnatal period is also a key window for health promotion, education, and family planning. This is a teachable moment when mothers are highly motivated to learn about their health and the health of their newborns. Midwives provide essential education on nutrition, rest, hygiene, and safe sleep practices for the infant [60]. They offer comprehensive support and counselling on exclusive breastfeeding, addressing challenges and reinforcing

correct technique, which is fundamental for child survival, growth, and development. A critical and life-saving intervention provided during postnatal contacts is the provision of postnatal family planning. Midwives counsel mothers on the various contraceptive options available, helping them make an informed choice that aligns with their preferences and health status. Enabling women to space their next pregnancy by at least two years is a cornerstone of maternal mortality reduction, as it reduces the cumulative risk associated with repeated pregnancies and allows the mother's body to fully recover [61]. By integrating family planning into postnatal care, midwives directly contribute to reducing unmet need for contraception and empowering women to control their fertility.

Finally, the midwife's role as a coordinator of care is paramount in the postnatal period. They ensure a seamless transition from facility-based care to home-based care and are responsible for scheduling and, in some models, conducting follow-up visits. They act as a link between the mother and other community health resources and social support services, which is especially critical for vulnerable women, those experiencing intimate partner violence, or those with limited social support [62]. The evidence is clear that structured, proactive postnatal support programs led by nurses and midwives, which include home visits, telephone follow-up, and clinic-based reviews, significantly improve maternal outcomes. These programs increase breastfeeding rates, enhance maternal confidence and mental well-being, improve adherence to health advice, and reduce hospital readmission rates [63]. In conclusion, the postnatal care provided by nurses and midwives is a complex and indispensable package of surveillance, support, and education. It transforms the vulnerable postnatal period from one of potential risk into a protected time of recovery, bonding, and empowerment, ensuring that mothers not only survive childbirth but thrive beyond it.

Conclusion

In conclusion, this narrative review provides a comprehensive synthesis of the undeniable impact of nursing and midwifery interventions on reducing maternal mortality. The evidence is clear and consistent across all stages of care: the presence of a skilled, empowered, and supported nurse or midwife is the critical determinant between life and death for mothers. From providing life-saving education and screening in the antenatal period, to executing essential protocols like AMTSL and managing emergencies during childbirth, to conducting vigilant follow-up and mental health assessment postnatally, these professionals form the indispensable backbone of any effective maternal health system. Their role transcends mere clinical task completion, encompassing advocacy, continuous support, and health systems strengthening. The persistent tragedy of preventable maternal deaths is not a failure of medical knowledge but a failure to adequately invest in, deploy, and support the nursing and midwifery workforce. Therefore, the most strategic and urgent imperative for global and national health policymakers is to prioritize investments in the education, regulation, and enabling work environments for nurses and midwives. Empowering them to practice to their full scope is not merely an option but the fundamental pathway to achieving equitable, dignified, and safe motherhood for all women.

Author Statements:

- **Ethical approval:** The conducted research is not related to either human or animal use.
- **Conflict of interest:** The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper
- **Acknowledgement:** The authors declare that they have nobody or no-company to acknowledge.
- **Author contributions:** The authors declare that they have equal right on this paper.
- **Funding information:** The authors declare that there is no funding to be acknowledged.
- **Data availability statement:** The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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