THE HUMANISATION OF CHILDBIRTH

2019

Professor Dr Lesley Page CBE

From Medicalization to Humanization

Humanization

Medicalization

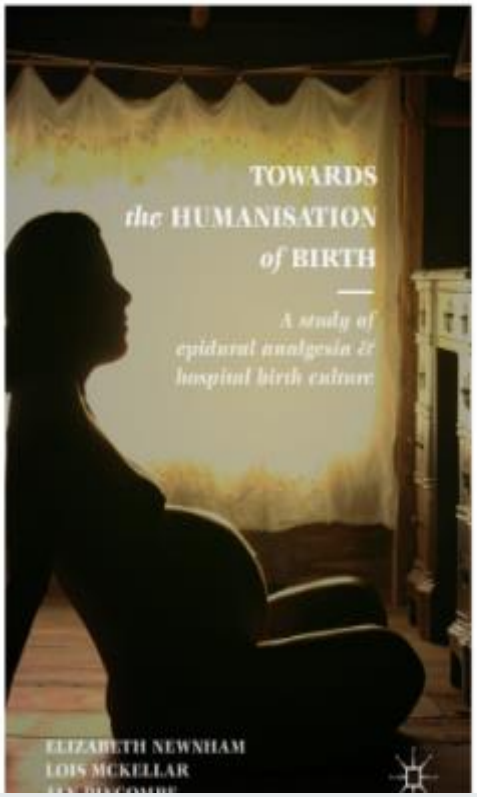
Humanisation of Birth

- Care that recognizes the significance of birth for individuals family and society, and that respects human rights of the woman to access high quality, evidence based care. Humanised care puts the woman at the centre of care, recognizes that the mother and baby are inseparable. The woman and her baby and family are treated with dignity and respect, and the woman has the right to make decisions about her care. This decision-making process will be enhanced by a relationship of reciprocity with her midwife or midwives, and supported through the appropriate provision of high quality information.

- Page 2016 and Umenai et al 2001

In: Midwives and the humanisation of care. ICM. Page, LA, Cadee F, Rheyns M, Bondo, L, Debonnet S, Jokinen, M, Castiaux G on behalf of the Central European Region.

Taking the thinking about humanization forward



E. Newnham, L. McKellar, J. Pincombe

Towards the Humanisation of Birth

A study of epidural analgesia and hospital birth culture

- Uses epidural analgesia as the lens for analysis of the current ontological and epistemological debates in maternity care
- Examines key sociological and philosophical debates in current maternity care practice and provision, with a view to influencing the design and provision of such care in the future
- Tracks historical developments in the field as the background to the wider debates to be addressed in the text

Slide by Dr Liz Newnham

See also: Newnham, L and Page, L 2019
The Humanisation of Childbirth. The Practising Midwife September 2019 14-17.

Medicalisation/Humanisation (see Prosen M and Tavcar Krajnc M (2013) Sociological Conceptualization of the Medicalization of Pregnancy and Childbirth: The implications in Slovenia. Revija Za Sociologiju 43.3:251-272)

Medicalised/ Industrialised/Dehumanised	Humanised
Birth seen as medical event	Wider significance of birth recognised
Mother and baby separate	Mother/baby inseparable
Cultural belief in 'safety' of technology/medical interventions/unnecessary intervention	Evidence based, appropriate care/intervention when indicated
Focus on pathology and risk, fear	Optimal health and wellbeing
Normal physiological is deviant	Science based /renormalizing normal
Depersonalised /fragmented	Respectful, relationship based care
Focus on technology /institution	Woman at centre of care –mitigating effects of vulnerability
Eradication, limitation or mistrust of midwifery	Scaling up and strengthening midwifery

BIRTH IS NOT SIMPLY A MEDICAL EVENT

Thanks to Leah Millinship BirthWorks for photo

BirthWorks, Leah Millinship

THE LOVE THAT TIES

Thanks to Leah Millinship BirthWorks for photo

BirthWorks, Leah Millinship

A short and yet critical period around birth –long term consequences for our capacity to love –Odent 1999

Essential to survival and wellbeing of baby into adulthood

Support for physiology important to health and wellbeing mother/baby

Odent M 1999 The Scientification of Love (Free Association books) Europe.

Buckley S and Uvnas Moberg K 2019 Nature and consequences of oxytocin and other neuro hormones in the perinatal period in Downes S and Byrom S Squaring the circle. Pinter and Martin London.

Rendering love hormones useless for having babies is a turning point in the history of our species (Odent 2019-The Future of Homo)

With thanks Jessamy Nick and Toran.
Photo by Nick Yates

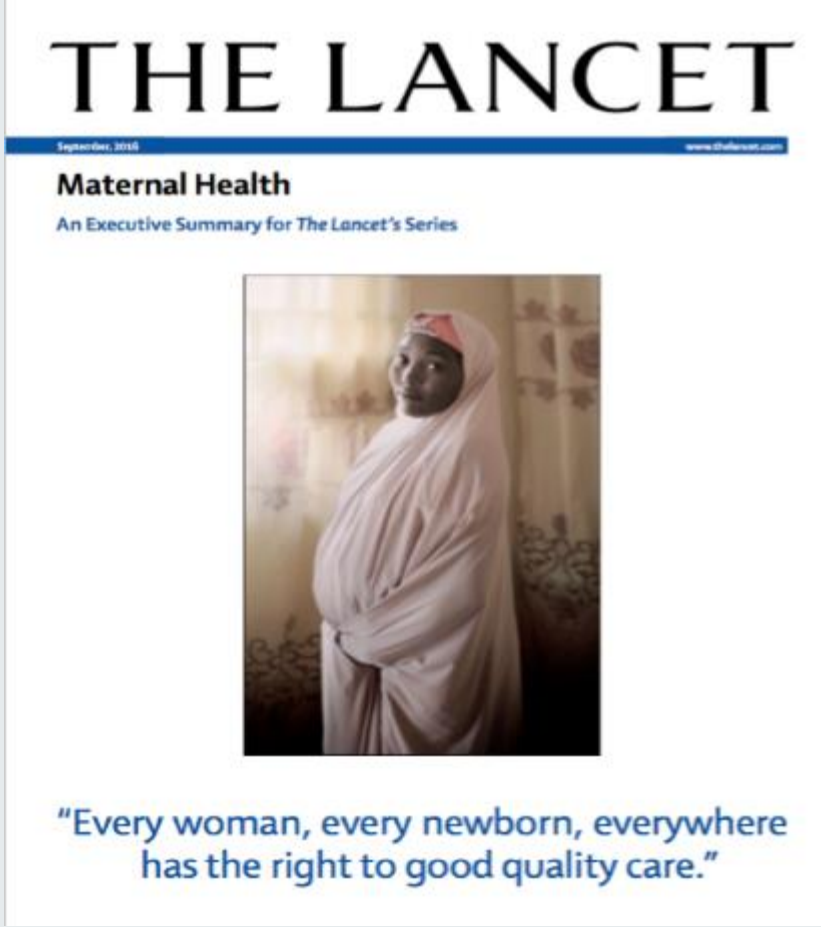
From faith in technology and over intervention to

Evidence based appropriate care

(thanks to Jess Howorth photo by Nick Yates)

Lancet Maternal Health series (Sept 2016)

Too little, too late; too much, too soon

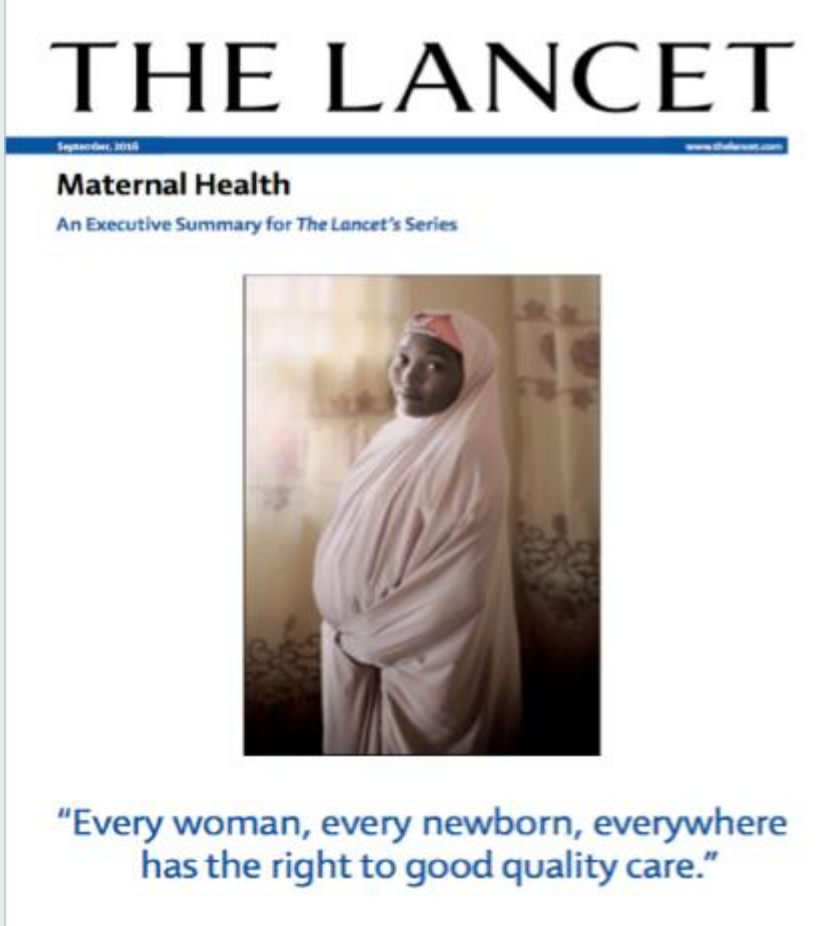


Too little, too late

- Lack of evidence-based guidelines
- Lack of equipment, supplies, and medicines
- Inadequate numbers of skilled providers
- Women delivering alone
- Lack of emergency medical services and delayed inter-facility referrals

Lancet Maternal Health series (Sept 2016)

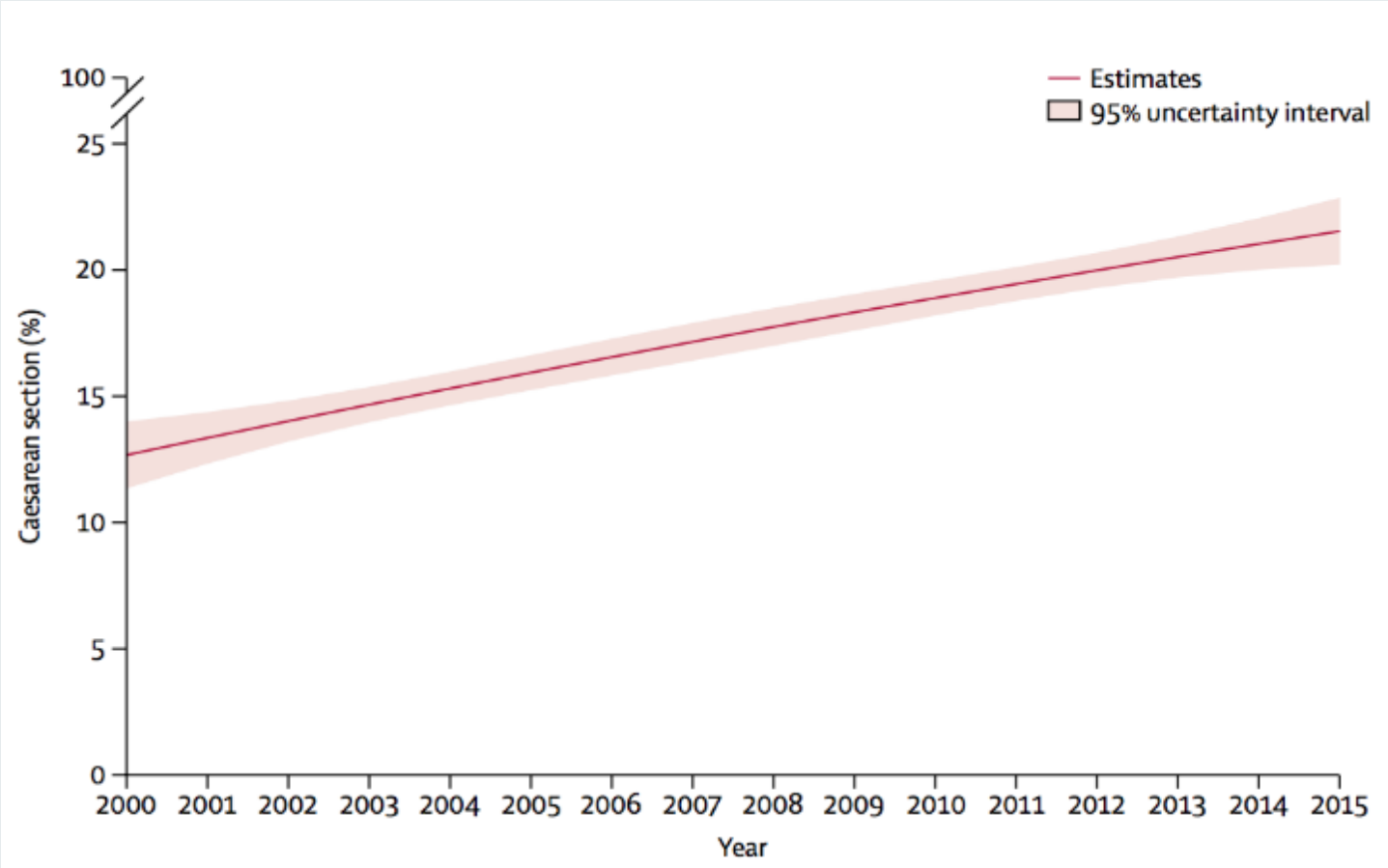
Too little, too late; too much, too soon



Too much, too soon

- Unnecessary caesarean section
- Routine induced or augmented labour
- Routine continuous electronic fetal monitoring
- Routine episiotomy
- Routine antibiotics postpartum

The global C-section rate has almost doubled in less than a generation, from 12 percent of all births in 2000 to 21 percent in 2015



Slide Prof J Sandall

FIGO position paper: how to stop the caesarean section epidemic

See Series pages 1341, 1349, and 1358

Worldwide there is an alarming increase in caesarean section (CS) rates. The medical profession on its own cannot reverse this trend. Joint actions with governmental bodies, the health-care insurance industry, and women's groups are urgently needed to stop

and perinatal consequences, including direct maternal morbidity and mortality derived from anaesthetic and urological complications, bleeding, infection, and thromboembolism, with more respiratory problems in newborn babies because of iatrogenic preterm

Appropriate use of caesarean section globally requires a different approach

See Series pages 1341, 1349, and 1358

Increasing global rates of caesarean section are debated because of evidence that medically unnecessary caesarean sections are associated with worse outcomes for mothers and their children.[1] There is consensus that caesarean sections are overused in some countries and underused in others. As Ties Boerma and colleagues[2] report in this *Lancet* Series on optimising caesarean section use,[3–5] there are unacceptable disparities: caesarean section rates of 44% in Latin America and the Caribbean compared with 4·1% in western and central Africa. Challenges have arisen as low-income and middle-income countries attempt to rectify insufficient access to caesarean sections. The investment in workforce training and facilities to increase

12·9 million women from the USA, Ireland, and Australia showed that caesarean sections were more likely to be done for privately insured women than for women with public health insurance coverage.[4] Conjecture that blames mothers for the high caesarean section rate, either because of their poor health (eg, obesity or hypertension) or because they are demanding medically unnecessary caesarean sections due to fear or disinterest in labour ignores the wider systems issues that drive the growing reliance on caesarean sections.

Commitment to women-centred care is a key strategy to achieve equitable and optimal use of caesarean section.[5] Women-centred care calls for a different approach to how

Strategic measures to reduce the caesarean section rate in Brazil

See Series pages 1341, 1349, and 1358

Quality health care during deliveries and births is essential for reducing maternal and neonatal morbidity and mortality. Birth should not be treated as a set of medical procedures, but as a physiological act, an important family and cultural event, and a unique time between mother and child. In Brazil, 98% of women have their babies in hospitals.[1,2] Such progress has not, however, ensured more favourable perinatal outcomes and public policies need to be adopted to ensure quality maternal health care.

Within this context, the national Born in Brazil survey was done in 2011 and encompassed 83% of the births in the country. The survey identified an excess of unnecessary and possibly iatrogenic interventions and sparked debate among academics, professional associations, civil society, and government about the need for changes.[3] In 2011, the Stork Network was implemented in hospitals from Brazil's Unified Health System (SUS) to ensure access to quality care for deliveries and births to reduce maternal and neonatal morbidity and mortality. This strategy also aims to restructure the health-care network and provide

low rate of serious complications. Caesarean sections can be life-saving and must be accessible to women who need the procedure. A caesarean section done for clinical reasons is effective in reducing maternal and perinatal risks and has a positive impact on morbidity and mortality. There are data from countries where rates of caesarean section are close to zero because women do not have access to this procedure and there is an increased risk of death for mother and infant.

In other settings, high rates of caesarean section have been identified that are associated with increased risk of perinatal morbidity and mortality compared with vaginal deliveries. To ensure feasibility and safety of low rates of the procedure, the influence of population-related factors must be taken into account. On the basis of WHO's Instrument C-Model[6] the reference caesarean rate adjusted for the Brazilian population should be around 25–30%.[9,10]

High rates of caesarean section continue to be an important challenge in Brazil. Between 2000 and 2014, the caesarean rate increased from 38·02% to 57·07%.[1] Since this period, the first fall in the caesarean section

Optimising caesarean section use 1

Global epidemiology of use of and disparities in caesarean sections

Ties Boerma, Carine Ronsmans, Doruclagn Y Melesse, Aluisio J D Barros, Fernando C Barros, Liang Juan, Ann-Beth Moller, Lale Say, Ahmad Reza Hosseinpoor, Mu Yi, Dácio de Lyra Rabello Neto, Marleen Temmerman

In this Series paper, we describe the frequency of, trends in, determinants of, and inequalities in caesarean section (CS) use, globally, regionally, and in selected countries. On the basis of data from 169 countries that include 98·4% of the world's births, we estimate that 29·7 million (21·1%, 95% uncertainty interval 19·9–22·4) births occurred through CS in 2015, which was almost double the number of births by this method in 2000 (16·0 million [12·1%, 10·9–13·3] births). CS use in 2015 was up to ten times more frequent in the Latin America and Caribbean region, where it was used in 44·3% (41·3–47·4) of births, than in the west and central Africa region, where it was used in 4·1% (3·6–4·6) of births. The global and regional increases in CS use were driven both by an increasing proportion of births occurring in health facilities (accounting for 66·5% of the global increase) and increases in CS use within health facilities (33·5%), with considerable variation between regions. Based on the most recent data available for each country, 15% of births in 106 (63%) of 169 countries were by CS, whereas 47 (28%) countries showed CS use in less than 10% of births. National CS use varied from 0·6% in South Sudan to 58·1% in the Dominican Republic. Within-country disparities in CS use were also very large: CS use was almost five times more frequent in births in the richest versus the poorest quintiles in low-income and middle-income countries; markedly high CS use was observed among low obstetric risk births, especially among more educated women in, for example, Brazil and China; and CS use was 1·6 times more frequent in private facilities than in public facilities.

Lancet 2018; 391: 1341–48
This is the first in a Series of three papers on optimising caesarean section use
See Editorial page 1279
See Comment pages 1286, 1288, and 1290

Department of Community Health Sciences, Rady Faculty of Health Sciences, Max Rady College of Medicine, University of Manitoba, Winnipeg, MB, Canada (Prof T Boerma PhD, D V Melesse PhD); Department of Infectious Disease Epidemiology, London School of Hygiene & Tropical Medicine, London, UK

Optimising caesarean section use 2

Short-term and long-term effects of caesarean section on the health of women and children

Jane Sandall, Rachel M Tribe, Lisa Avery, Glen Mola, Gerard HA Visser, Caroline SE Homer, Deena Gibbons, Niamh M Kelly, Holly Powell Kennedy, Hussein Kidanto, Paul Taylor, Marleen Temmerman

A caesarean section (CS) can be a life-saving intervention when medically indicated, but this procedure can also lead to short-term and long-term health effects for women and children. Given the increasing use of CS, particularly without medical indication, an increased understanding of its health effects on women and children has become crucial, which we discuss in this Series paper. The prevalence of maternal mortality and maternal morbidity is higher after CS than after vaginal birth. CS is associated with an increased risk of uterine rupture, abnormal placentation, ectopic pregnancy, stillbirth, and preterm birth, and these risks increase in a dose–response manner. There is emerging evidence that babies born by CS have different hormonal, physical, bacterial, and medical exposures, and that these exposures can subtly alter neonatal physiology. Short-term risks of CS include altered immune development, an increased likelihood of allergy, atopy, and asthma, and reduced intestinal gut microbiome diversity. The persistence of these risks into later life is less well investigated, although an association between CS use and greater incidence of late childhood obesity and asthma are frequently reported. There are few studies that focus on the effects of CS on cognitive and educational outcomes. Understanding potential mechanisms that link CS with childhood outcomes, such as the role of the developing neonatal microbiome, has potential to inform novel strategies and research for optimising CS use and promote optimal physiological processes and development.

Lancet 2018; 392: 1349–57
This is the second in a Series of three papers on optimising caesarean section use
See Editorial page 1279
See Comment pages 1286, 1288, and 1290

Department of Women and Children's Health, School of Life Course Sciences, Faculty of Life Sciences and Medicine, St Thomas' Hospital Campus (Prof J Sandall PhD, Prof R M Tribe PhD, N M Kelly BSc, P Taylor PhD) and Peter Gorer Department of Immunobiology, School of Immunology and Microbial Sciences (D Gibbons PhD),

Optimising caesarean section use 3

Interventions to reduce unnecessary caesarean sections in healthy women and babies

Ana Pilar Betrán, Marleen Temmerman, Carol Kingdon, Abdu Mohiddin, Newton Opiyo, Maria Regina Torloni, Jun Zhang, Othniel Muvanu, Sikolia Z Wanyonyi, Ahmet Metin Gülmezoglu, Soo Downe

Lancet 2018; 392: 1358–68
This is the third in a Series of three papers on optimising caesarean section use
See Editorial page 1279
See Comment pages 1286,

Optimising the use of caesarean section (CS) is of global concern. Underuse leads to maternal and perinatal mortality and morbidity. Conversely, overuse of CS has not shown benefits and can create harm. Worldwide, the frequency of CS continues to increase, and interventions to reduce unnecessary CSs have shown little success. Identifying the underlying factors for the continuing increase in CS use could improve the efficacy of interventions. In this Series paper, we describe the factors for CS use that are associated with women, families, health professionals, and health-care organisations and systems, and we examine behavioural, psychosocial, health system, and financial factors. We

Thanks Jane Sandall for slide

Background

Caesarean section—the most common surgery in many countries around the world—can save women's and babies' lives when complications occur during pregnancy or birth, and should be universally accessible.

CS has increased over the past 30 years, without significant maternal or perinatal benefits.

CS for non-medical reasons is a cause for concern because the procedure is associated with considerable short-term and long-term effects and health-care costs.

Slide Prof J Sandall

Short- and long-term effects of Caesarean Section on the health of women and children

CS is a life-saving intervention for complications during pregnancy and childbirth that should be available to all women in need.

CS has an increased risk of maternal mortality, severe acute morbidity and adverse outcomes in subsequent pregnancy compared with vaginal birth. Multiple CSs are associated with a higher risk of maternal morbidity and mortality.

Some benefits of CS, such as less frequent incontinence and urogenital prolapse have been described.

Sandall J, Tribe R, et al. Short-term and long-term effects of caesarean section on the health of women and children. The Lancet 2018.

Short-term and long-term effects of Caesarean Section on the health of women and children

Gestational age is not always available leading to rise of iatrogenic preterm birth.

Infants born by CS have different hormonal, physical, bacterial, and medical exposures (such as intrapartum antibiotics and uterotonics) and are exposed to more short-term risks, such as altered immune development, allergy, atopy, asthma, and reduced diversity of the intestinal gut microbiome, compared with those born vaginally.

Emerging research has shown biological mechanisms that underlie the acute and chronic effects of CS on child health and the long-term effects of CS on children, including how these effects might be mitigated.

Sandall J, Tribe R, et al. Short-term and long-term effects of caesarean section on the health of women and children. The Lancet 2018.

BJOG Perspective

Induction of labour should be offered to all women at term

AGAINST: Induction of labour should not be offered to all women at term: first, do no harm

Anna E Seijmonsbergen-Schermers
Sicco Scherjon
Ank de Jonge

First published: 03 October 2019
https://doi.org/10.1111/1471-0528.15887

FROM PATHOLOGY RISK AND FEAR TO OPTIMAL WELLBEING

Global move towards positive childbirth experiences (continuity, safety, physiology, kindness, compassion)

WHO Guidelines (ANC, IP, CS, PN) (2016, 2018x2, forthcoming)

Hot off the press: Place of birth

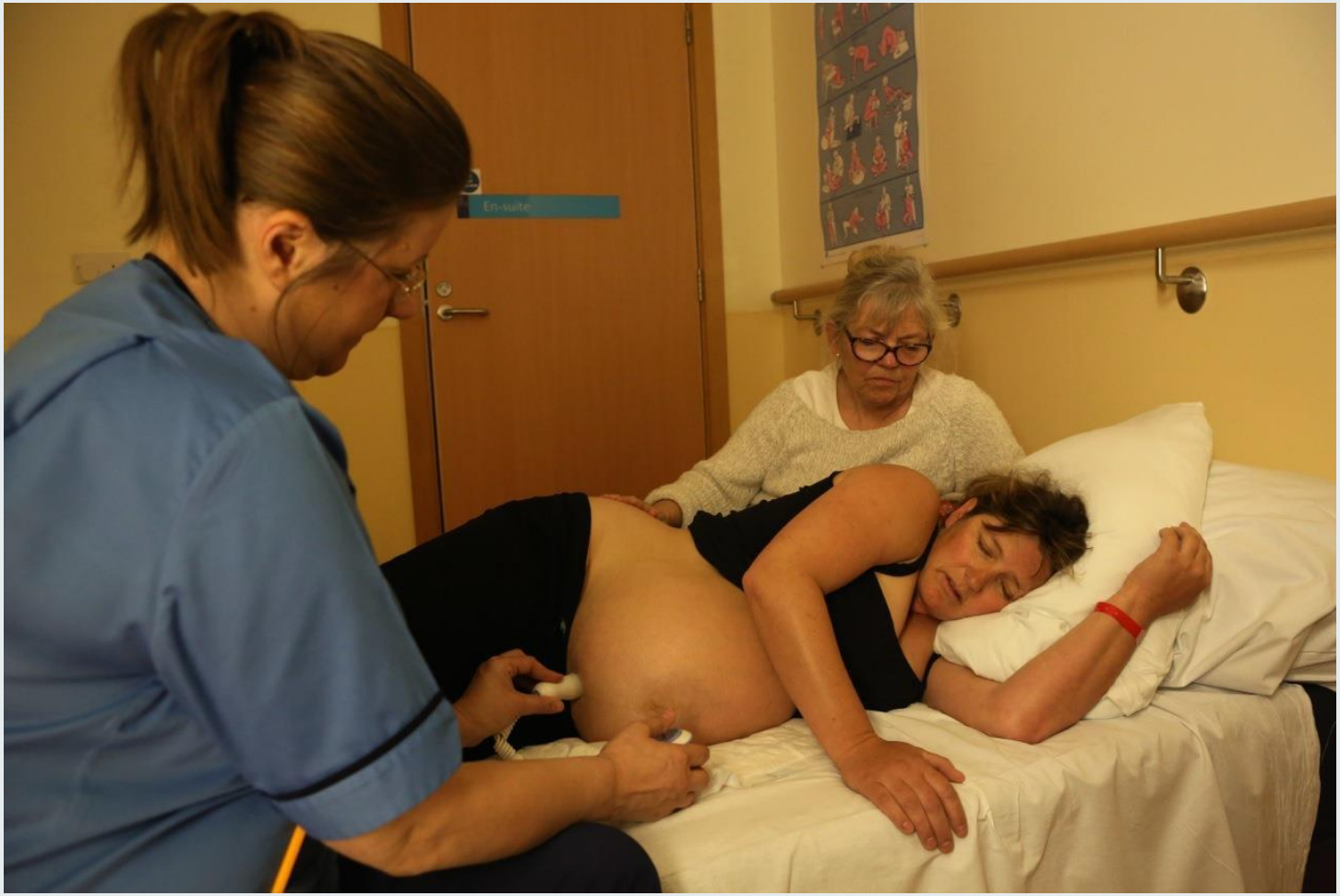
- Homer C et al, (2019) Maternal and perinatal outcomes by planned place of birth in Australia 2000-2012: a linked population study. BMJ Open Volume 9, Issue 10

- Compared with planned hospital births, the odds of normal birth
  - 2X birth centre
  - 6x home
  - No statistically significant differences SB, early or late neonatal deaths 3 different places of birth.

Midwifery Unit NETWORK

'Midwifery Unit Network (MUNet) is a European community of practice with a shared interest in supporting and promoting the development and growth of midwifery units (birth centres), which are managed and staffed by midwives'

Renormalising normal: the science base



FROM FRAGMENTED DEPERSONALISED CARE TO RESPECTFUL RELATIONSHIP BASED CARE

With thanks to Sadie Holland, King's College London

Importance of Pregnancy and Birth

'A woman's relationship with her maternity providers is vitally important. Not only are these encounters the vehicle for essential lifesaving health services, but women's experiences with caregivers can empower and comfort or inflict lasting damage and emotional trauma.'

White Ribbon Alliance, Respectful Maternity Care, 2011

The prevention and elimination of disrespect and abuse during facility based birth (WHO)

Many women experience disrespectful and abusive treatment during childbirth in facilities worldwide. Such treatment not only violates the rights of women to respectful care, but can also threaten their rights to life, health, bodily integrity, and freedom from discrimination. This statement calls for greater action, dialogue, research and advocacy on this important public health and human rights issue.

Midwife led continuity model vs other models of care
(Sandall et al 2016 Cochrane review)

- Small team or caseloading vs standard care
- 15 Randomised controlled trials with 17,647 women
- Australia, Canada, Ireland and UK
- 1989 – 2013
- Low and mixed risk women

Slide by Lia Brigante RCM

Midwifery continuity of care:

‘

Less likely:

- Premature birth
- Death of the fetus/baby
- An epidural in labour
- Episiotomy
- Instrumental birth

More likely:

- Spontaneous birth
- ’Satisfaction’
- ‘Cost saving’ (trend)

HUMANISING BIRTH IS ABOUT MITIGATING EFFECTS of VULNERABILITY

Inequality
Ethnicity Geography
Gender and Violence
Indigenous women
Migration
Custody and Detention
Warfare Humanitarian
Disasters
Commercialization
Health Services
Mental health

Medicalisation

Vulnerability

"Pregnant women who experience a distance in accessing maternal healthcare, as refugees/ migrants/ ethnic minorities/ second or third generation immigrants, due to problems in speaking the language and/ or understanding the culture, and/ or due to lack of income, housing or social support"

Women Political Leaders Global Forum 2018

Putting every woman at the centre : hope for the future
Teresa McCreery MSF Iraq and Lesley Page CBE

https://www.all4maternity.com/humanising-birth-hope-for-the-future-even-in-war/

Sheffield Hallam University

Perinatal care of migrant women in Europe

ORAMMA: Next stage

Oramma
Operational Refugee And Migrant Maternal Approach

N&M Management Time-Out Day
October 23rd, 2019 - Sheffield

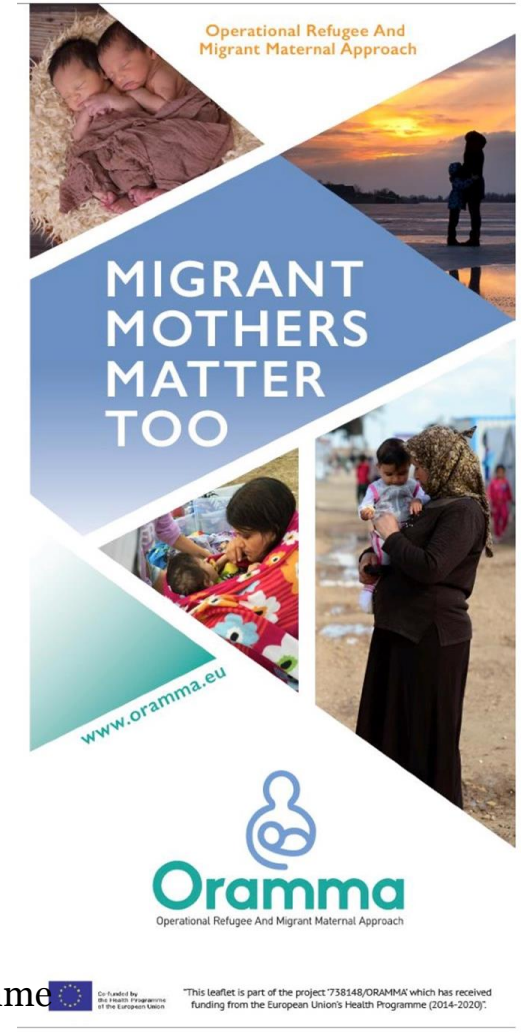
H Soltani, F Fair, C Burke & ORAMMA Team*
*: [M. vanden Mijsenberghu, **M. Jokinen; M. Papadakaki; H Watson, L. Raben; E. Shaw; D. CastroSandoval; D. Aarendonk;A. Markatou; E.Sioti; T. Mastrogiannakis, V. Vivilaki (Co-ordinator)**]

Acknowledgement: Helen Baston, Hilary Rosser & Midwifery Research Team from Sheffield Teaching Hospitals

ORAMMA Team

Partners

- Faculty of Health and Caring Professions (Athens), Greece
- Sheffield Hallam University, UK
- Radbound University- The Netherlands
- Technological Institute of Crete, Greece
- European Forum for Primary Care
- European Midwives Association
- CMT Prooptiki



https://oramma.eu/

Funded by the European Union's Health Programme

"This leaflet is part of the project '738148/ORAMMA' which has received funding from the European Union's Health Programme (2014-2020)".

ORAMMA Training for Health Care Professionals

The E-learning package is freely available online, register at

https://oramma.eu/

Oramma

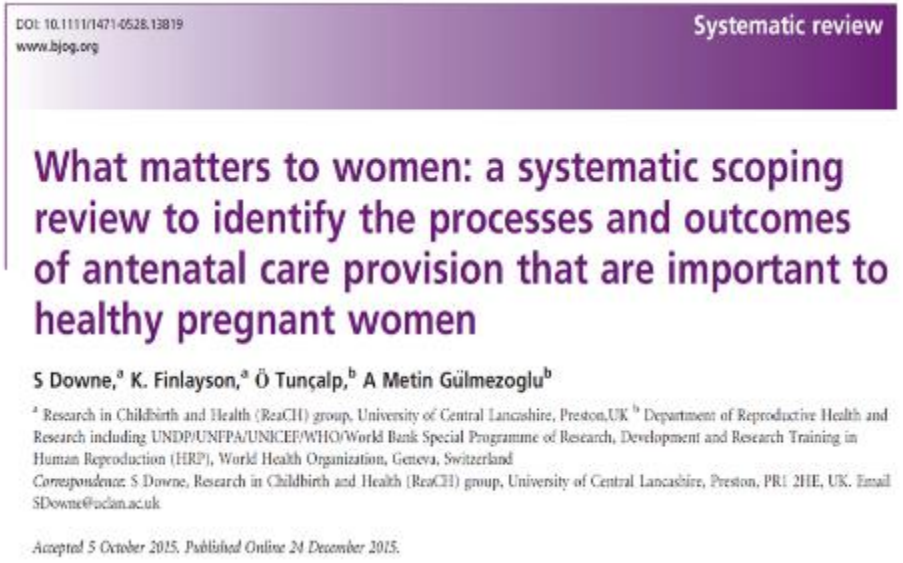
Operational Refugee And Migrant Maternal Approach

What matters to women about childbirth
BOTH safety AND wellbeing
(Downe et al 2018)

- Metasynthesis: 35 studies, 19 countries, moderate to high confidence
- What matters to most women is a positive experience that fulfils or exceeds their prior personal and socio-cultural beliefs and expectations.

What women want and need to achieve a positive pregnancy (birth) experience

- Support
  - social, cultural, emotional and psychological
- Relevant and timely information
  - physiological, biomedical, behavioural, sociocultural
- Clinical care/therapeutic practices
  - biomedical interventions and tests, integrated with therapeutic spiritual and religious practices, where appropriate



DOI: 10.1111/1471-0528.13819
www.bjog.org

Systematic review

What matters to women: a systematic scoping review to identify the processes and outcomes of antenatal care provision that are important to healthy pregnant women

S Downe,[a] K. Finlayson,[a] Ö Tunçalp,[b] A Metin Gülmezoglu[b]

[a] Research in Childbirth and Health (RaCH) group, University of Central Lancashire, Preston,UK [b] Department of Reproductive Health and Research including UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP), World Health Organization, Geneva, Switzerland

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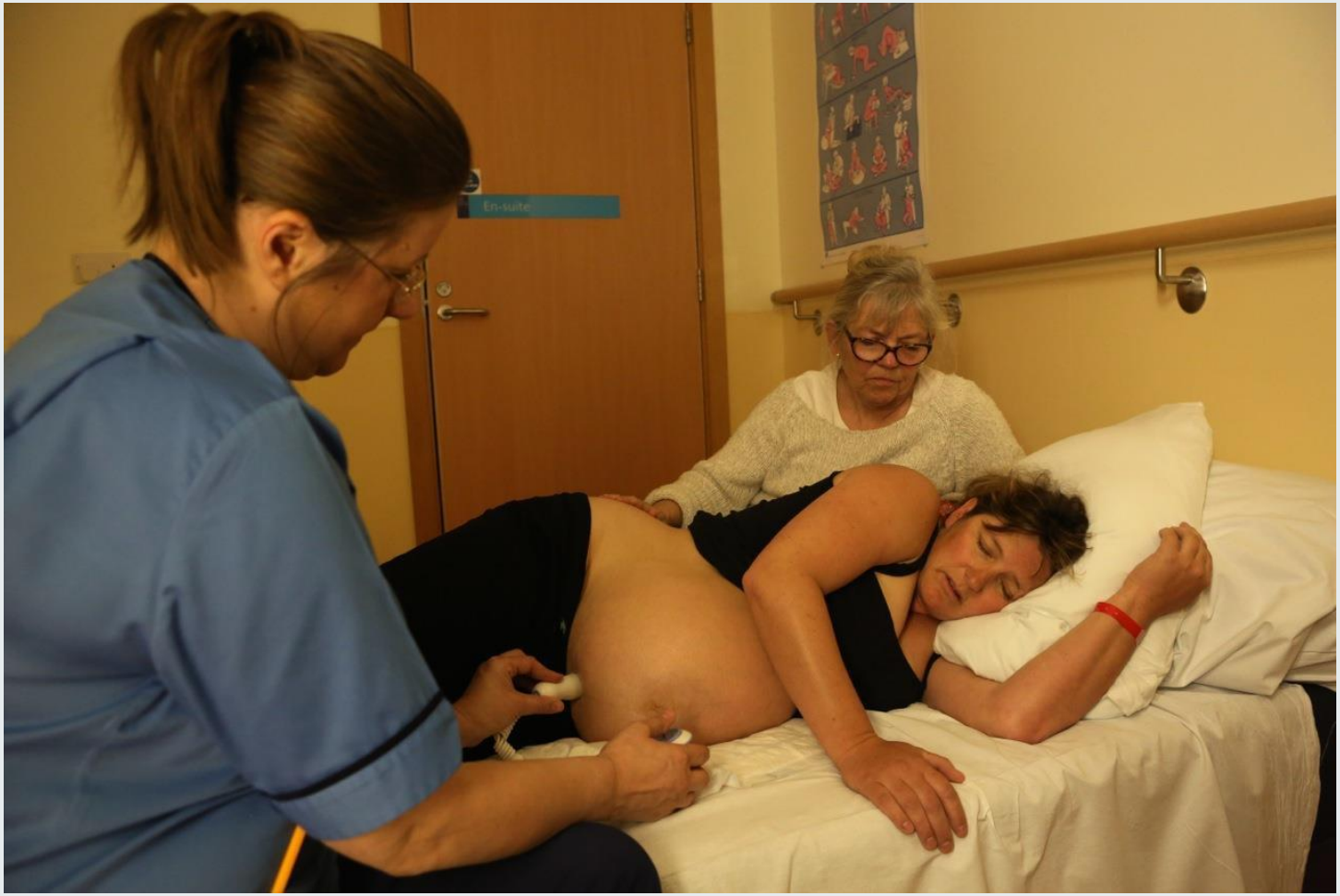
Accepted 5 October 2015. Published Online 24 December 2015.

SCALING UP AND STRENGTHENING MIDWIFERY



Framework for quality maternal and newborn care

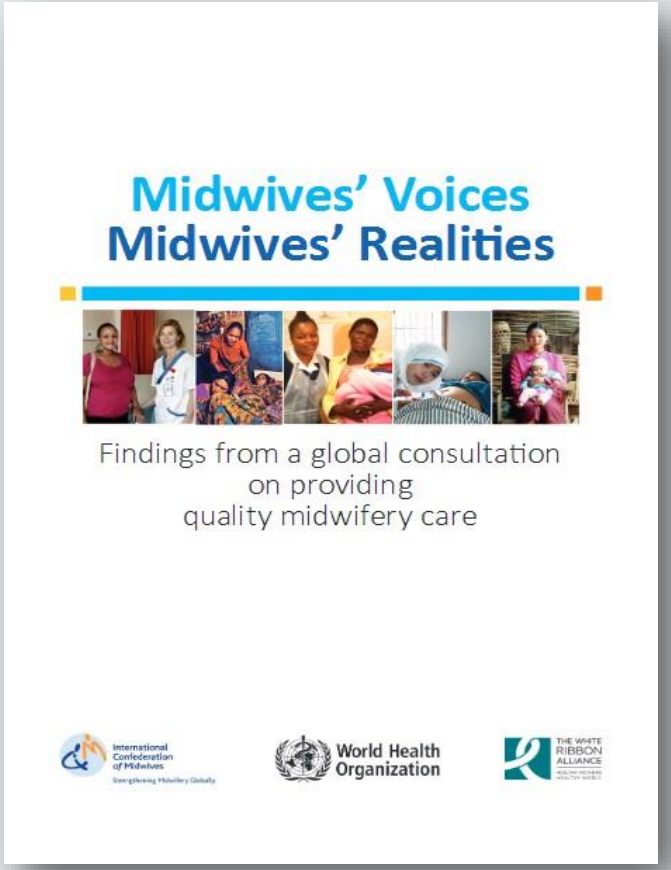
	For all childbearing women and newborns			For women and newborns with complications	
Effective practices	Education, information, health promotion	Assessment, screening, care planning	Promotion of normal processes, prevention of complications	First-line management of complications	Medical obstetric neonatal services
Organisation of care	Available, accessible, acceptable, good quality services – adequate resources, competent workforce Continuity, services integrated across community and facilities				
Values	Respect, communication, community knowledge and understanding Care tailored to women's circumstances and needs				
Philosophy	Optimising biological, psychological, social and cultural processes, strengthening women's capabilities. Expectant management, using interventions only when indicated				
Care providers	Practitioners who combine clinical knowledge and skills with interpersonal and cultural knowledge Division of roles based on need, competencies and resources				

Renfrew, McFadden, Bastos et al The Lancet 384, I9948, 1129 – 1145, 2014

Midwives' Voices, Midwives' Realities

WHO Survey of 2,400 midwives in 93 countries

- Midwives "hindered through a lack of voice in creating the change and delivering the creative solutions they know are so badly needed."
- Similar problems regardless of whether midwives are in high-, middle- or low-income countries.
- 36% of respondents said there was lack of respect by senior medical staff and 32% said they would value "being listened to"
- Between 20–30% of all respondents said that they are treated badly because of discrimination against women and gender inequality.
- 37% of all the midwives have experienced harassment at work, with many describing a lack of security and fear of violence



Midwifery is a vital solution-what is holding back global progress? Renfrew et al (2019)

- Birth: 2019 p1-4
- Despite growing evidence of the extensive impact of midwifery midwives and the women they look after are disempowered by patriarchal strctures and professional, socio cultural and economic barriers.

There is a long road ahead –

- Journey would be shorter by implementation of midwifery that meets ICM standards

MIDWIVES DEPRESSION ANXIETY AND STRESS

Hunter B, Fenwick J, Sidebotham M, Henley J (2019) Midwifery 79, 102526

- An exploration of relationship between emotional well being of UK midwives and their work environment
- Cross sectional design online survey using Whelm survey tool
- A total of 1997 midwives 16%of RCM membership

- Key results: indicate that the UK's Midwifery workforce is experiencing significant levels of emotional distress
- There is considerable scope for change across service
- Proactive support for younger recently qualified midwives
- Profession should lobby for systems level change in how service is resourced and provided
- Commitment from range of stakeholders

Widening our view: sustain and thrive

Relationships and connections, connecting science, human rights, enlightened policy, unified health systems

Thank you

RCM, 2012

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