Using qualitative research to bring womens voices into global guidelines

Soo Downe
IME Conference, Millennium Gloucester Hotel, London
Nov 13th 2019

With thanks to all who gave permission to use the photographs and to all who contributed to the various slides and activities described in this presentation

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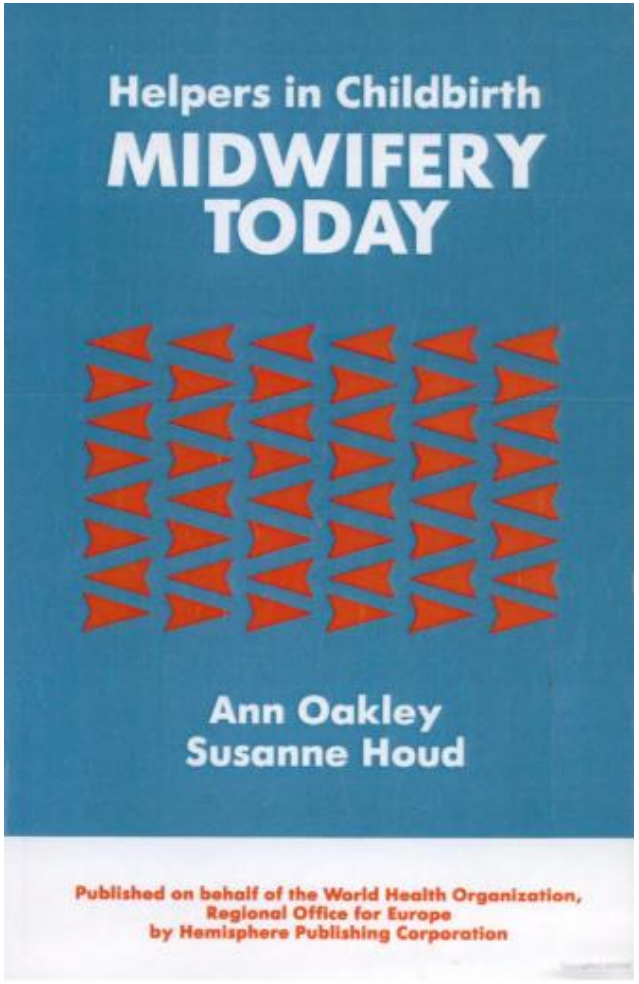
What is the point of guidelines?

Home birth 4th baby

Oakley and Houd 1990

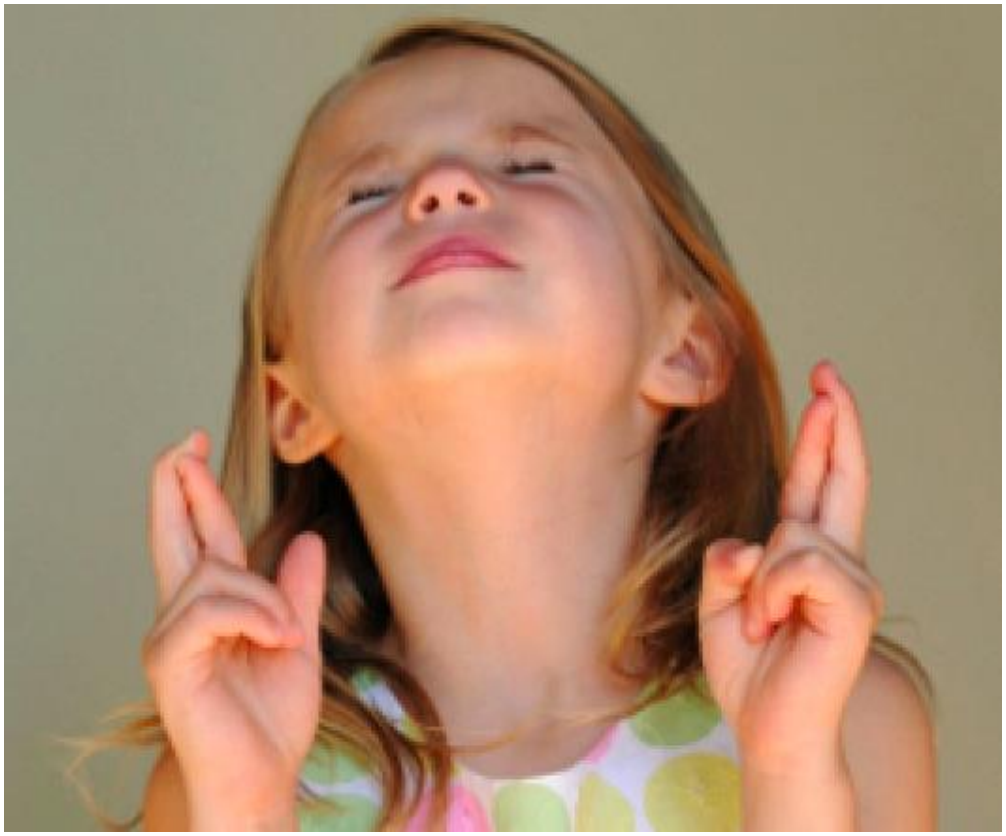
- 40 year old
- Lives in cramped 3 room apartment
- 3rd birth CS after 20 hours SROM

'if no help can be provided , she will give birth on her own…'



Midwife, UK

“I see no problem at all…”



Midwife, Greece

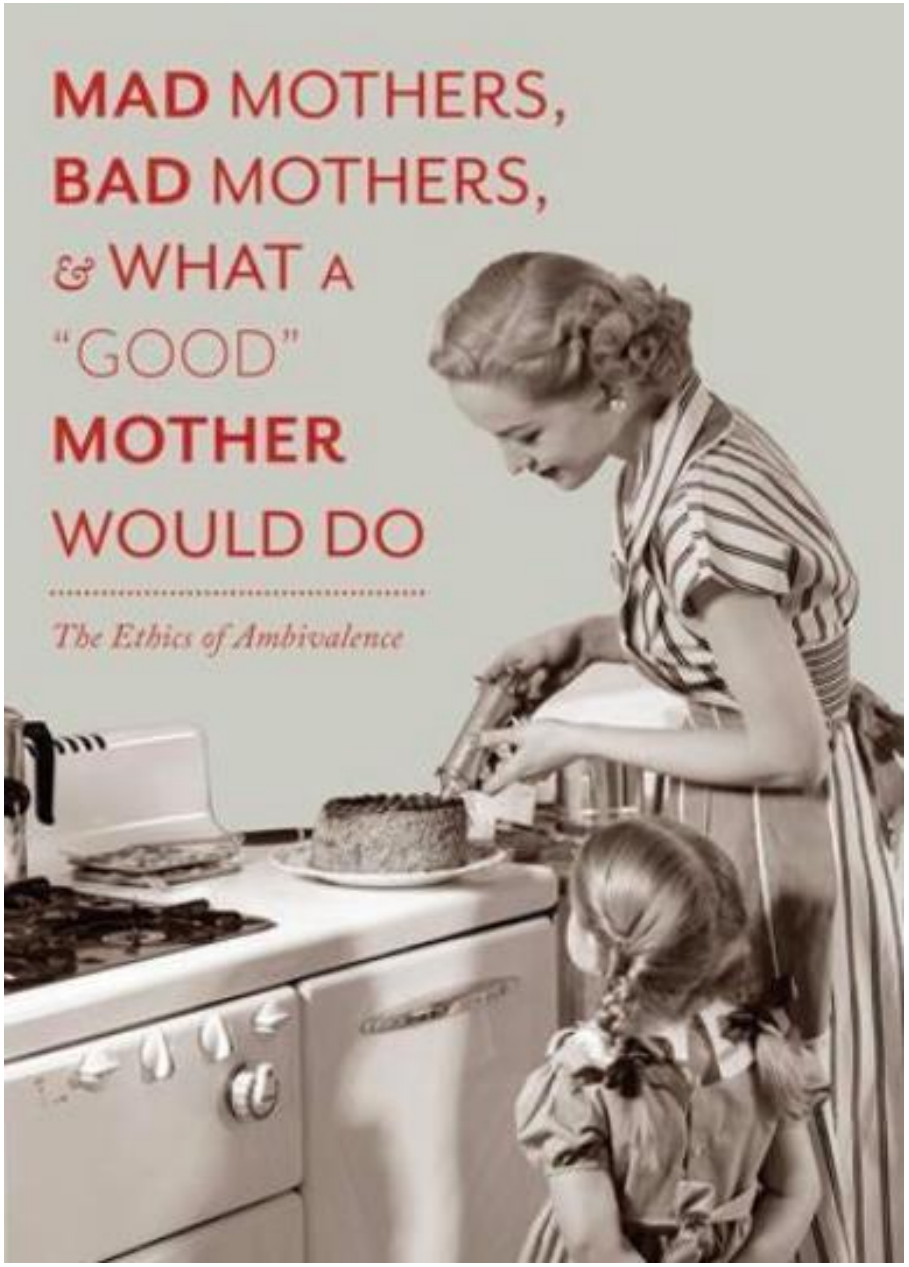
"If she calls me when she's in labour Id go as quickly as possible to get her into hospital…in the end she'd go into hospital, the whole village would persuade her to, and her husband would too…"

Obstetrician Greece

“I would send the police to get her…”

Obstetrician Italy

“Id send her to a psychiatrist…”



Obstetrician Italy

“I wouldn't want to be her doctor unless she paid me a lot…”

Its about whose knowledge matters…

The power of authoritative knowledge is not that it is correct, but that it counts

Jordon B 1997 In: Davis-Floyd and Sargent (eds) Childbirth and Authoritative Knowledge, University of California Press.

Making practice more logical: systematic reviews of RCTs….

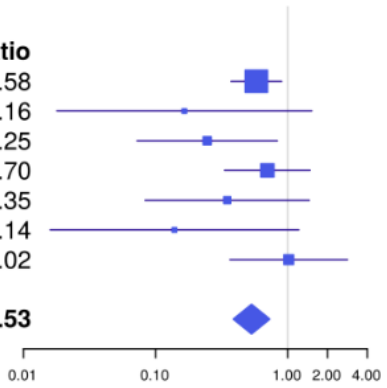
THE COCHRA
COLLABORAT

File:Pre-term corticosteroid data.svg

From Wikipedia, the free encyclopedia

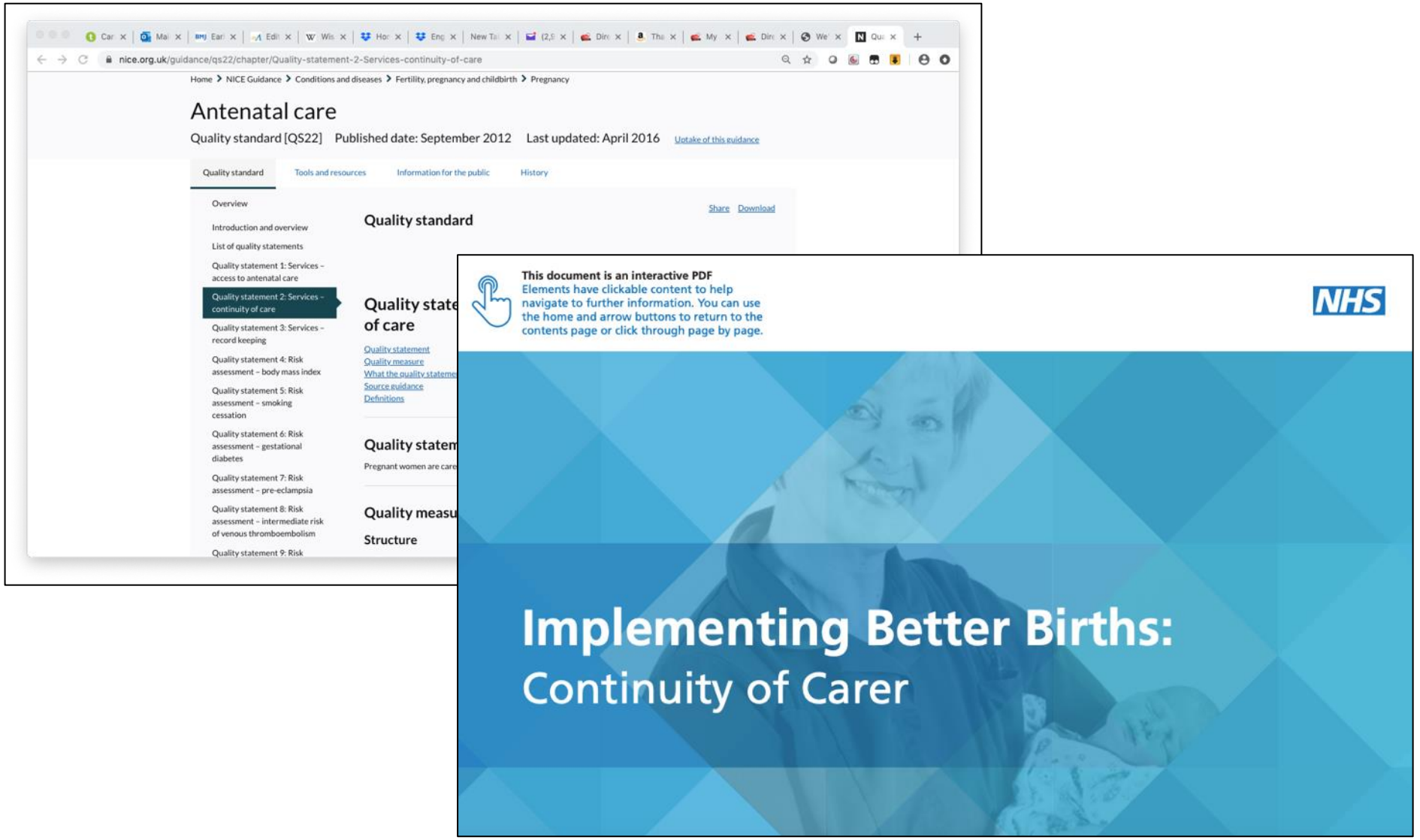
File | File history | File usage | Global file usage | Metadata

Study	Deaths (corticosteroid)	Deaths (placebo)	Odds ratio
Auckland	36	60	0.58
Block	1	5	0.16
Doran	4	11	0.25
Gamsu	14	20	0.70
Morrison	3	7	0.35
Papageorgiou	1	7	0.14
Tauesch	8	10	1.02
Summary			**0.53**



Odds ratio with 95% confidence interval
(1=no effect, <1=treatment has fewer deaths)

Translating systematic reviews into guidelines



But…

What goes in to the trials that go into systematic reviews that go into guidelines?

Well designed trials and external validity
The example of the ARRIVE trial

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from research organizations

Induced labor after 39 weeks in healthy women may reduce the need for cesarean birth

More information is needed before changes to clinical practice are made

Date: February 1, 2018

Source: Society for Maternal-Fetal Medicine

Summary: In a study presented today at the Society for Maternal-Fetal Medicine's (SMFM) annual meeting, researchers unveiled findings that suggest that induction of labor at 39 weeks of gestation among healthy, first-time mothers reduces the rate of cesarean birth as compared to expectant management among the same population.

Share:

RELATED TOPICS FULL STORY

No difference in the primary outcome (neonatal mortality/morbidity)

Cesarean birth (secondary outcome) (19% vs 22%):
RR 0.84, 95% CI 0.76 - 0.93
Compare with the outcomes of **continuous support in labour:**

Cochrane review: 26 trials, 15,288 women, 17 countries;
Cesarean birth was the secondary outcome
RR 0.78, 95% CI 0.67 to 0.91

- Context
- Population (values)
- Outcomes
- Assessment timespan

Evidence beyond effectiveness
Horses for courses

Petticrew and Roberts 2003

Table 1 An example of a typology of evidence (example refers to social interventions in children) (adapted from Muir Gray[24])

Research question	Qualitative research	Survey	Case-control studies	Cohort studies	RCTs	Quasi-experimental studies	Non experimental evaluations	Systematic reviews
Effectiveness Does this work? Does doing this work better than doing that?				+	++	+		+++
Process of service delivery How does it work?	++	+					+	+++
Salience Does it matter?	++	++						+++
Safety Will it do more good than harm?	+		+	+	++	+	+	+++
Acceptability Will children/parents be willing to or want to take up the service offered?	++	+			+	+	+	+++
Cost effectiveness Is it worth buying this service?					++			+++
Appropriateness Is this the right service for these children?	++	++						++
Satisfaction with the service Are users, providers, and other stakeholders satisfied with the service?	++	++	+	+				+

But…little qualitative data in guidelines for 10 years…
Indeed, can qualitative data be synthesised across studies ?

To summarize qualitative findings is to destroy the integrity of the individual projects on which such summaries are based, to thin out the desired thickness of particulars…

….and ultimately to lose the vitality, viscerality and vicarism of the human experiences represented in the original studies'

Sandelowski et al 1997 p366

However… if qualitative data are not synthesised…

- Qualitative research risks further marginalisation from policy and practice if works remains isolationist and esoteric
  Silverman, 1997

- Statham et al (1988) refer to ‘analytic interruptus’

- *Current critics include Sally Thorne (2004, 2018, 2019)*

A solution?…

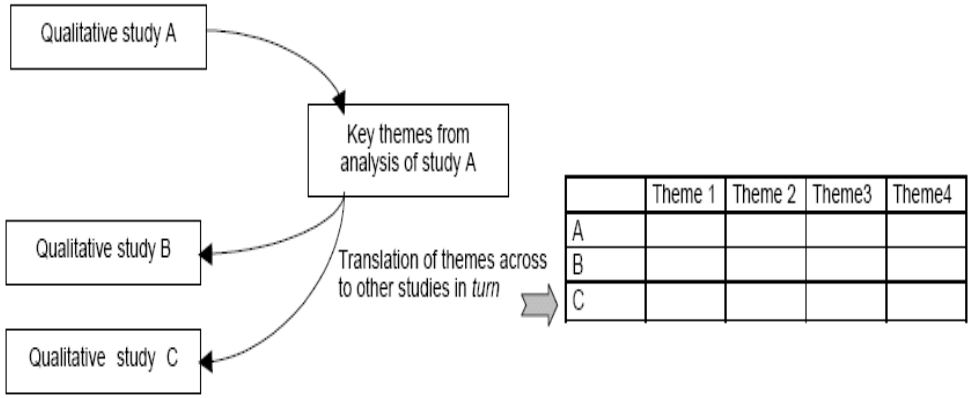
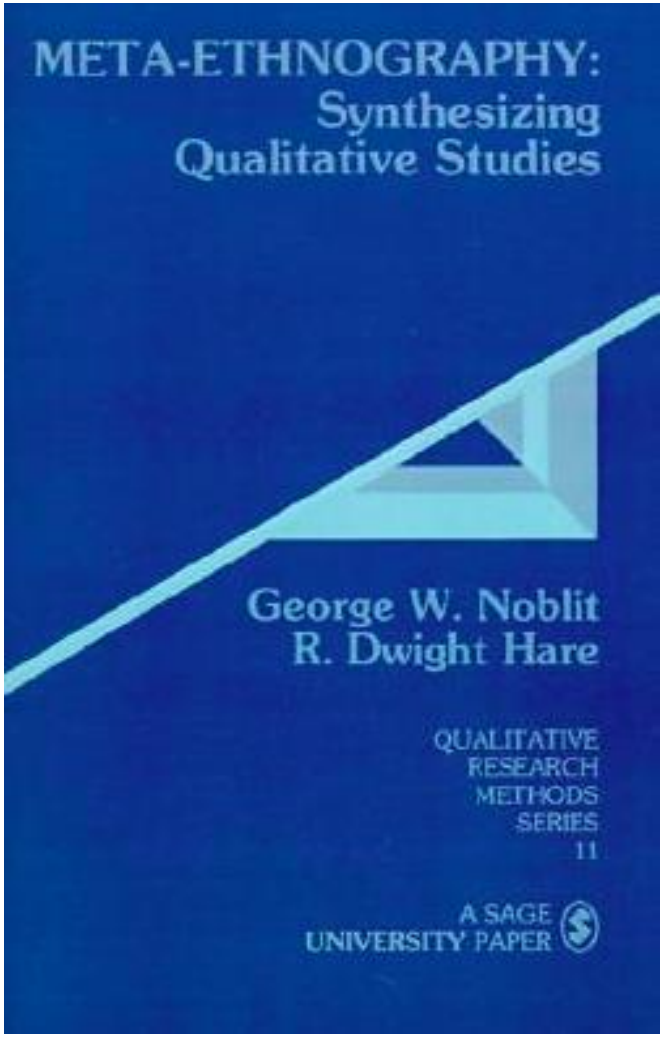


Figure 27. Meta-ethnography by reciprocal retranslation [Noblit & Hare 1988]



The direct precursor to our involvement with WHO: Weighing up and balancing out

Why don't marginalised women in high income countries attend antenatal clinic?

(Downe et al 2009)


BJOG An International Journal of Obstetrics and Gynaecology

General obstetrics

'Weighing up and balancing out': a meta-synthesis of barriers to antenatal care for marginalised women in high-income countries

S Downe,[a] K Finlayson,[a] D Walsh,[a] T Lavender[b]

- Qualitative studies, high income countries, English, 1980-2007
- Marginalised women failing to attend ANC or attending late or irregularly.
- 8 studies.
- Continuing access appears to depend on personal resources alongside service provision issues including the perceived quality of care, the trustworthiness and cultural sensitivity of staff and feelings of mutual respect.

Serendipity: Where we joined in!

The catalyst

Finlayson and Downe 2013

Assumptions about pregnancy versus women's beliefs

There are differences between the assumptions that underpin standard ANC programmes and women's beliefs and attitudes to pregnancy.

Assumptions about pregnancy:		Women's beliefs and attitudes that:
Pregnancy is potentially risky for mother and baby	VS	Pregnancy is a healthy state for mother and baby mother and baby
Pregnancy is a positive social state that will be welcomed by the family and the community	VS	Pregnancy can be socially risky and may be subject to malign forces, superstitions and stigma
Women and families have enough resources to make rational economic choices to access ANC	VS	A choice to access care might mean a risk to survival due to resource challenges

Consequences of the difference between ANC assumptions and woman's beliefs

= ***Lack of initial access to ANC***

Source: Finlayson et al, 2013

Assumptions about service delivery versus woman's experiences

Negative experiences of service provision are common and there is a contrast between the assumptions of service delivery and women's experiences of care.

Assumptions about service delivery:		Women's views and experiences:
ANC is affordable	VS	ANC is subject to unexpected costs levied at the point of need
Staff attitude is not relevant and/or is generally positive	VS	Staff attitude is highly relevant and can be discriminatory, neglectful or even abusive
All the resources needed for the level of care on offer are present	VS	Resources are often not available, and transfer is then necessary to the next level of care

Consequences of the difference between ANC assumptions about service delivery and woman's experiences

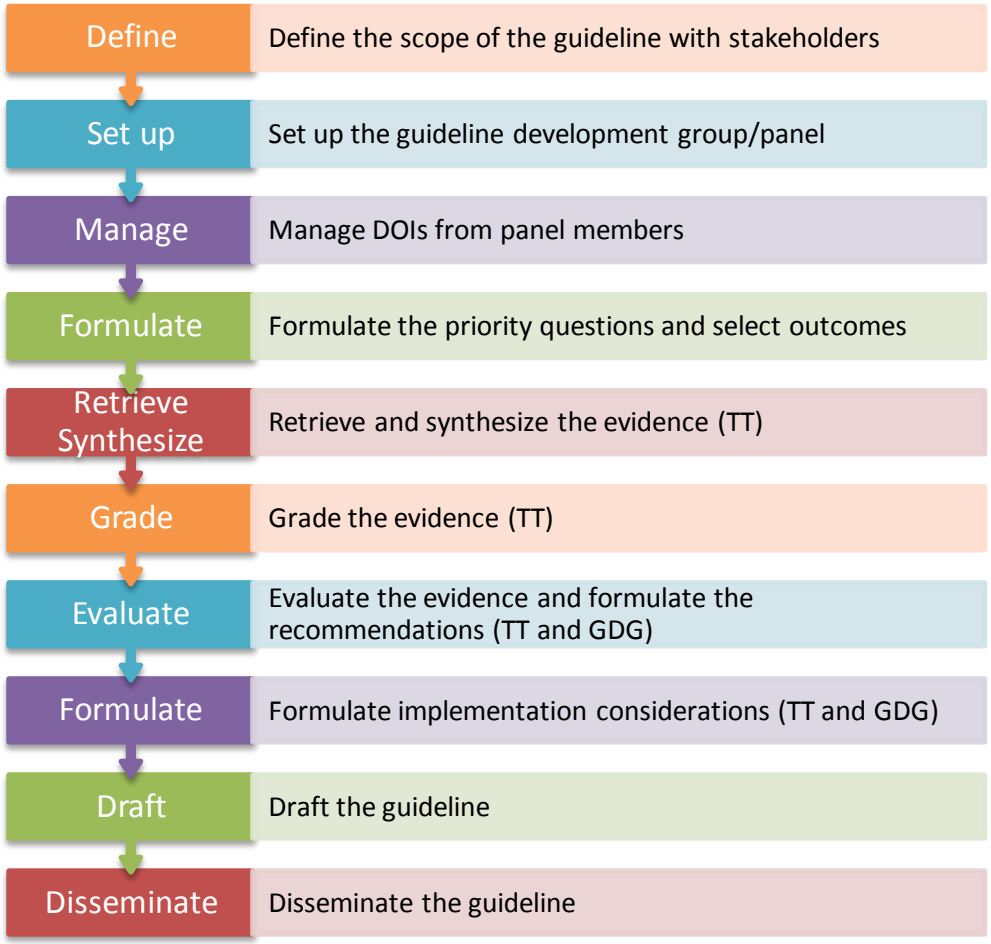
= *Lack of repeat access to ANC*

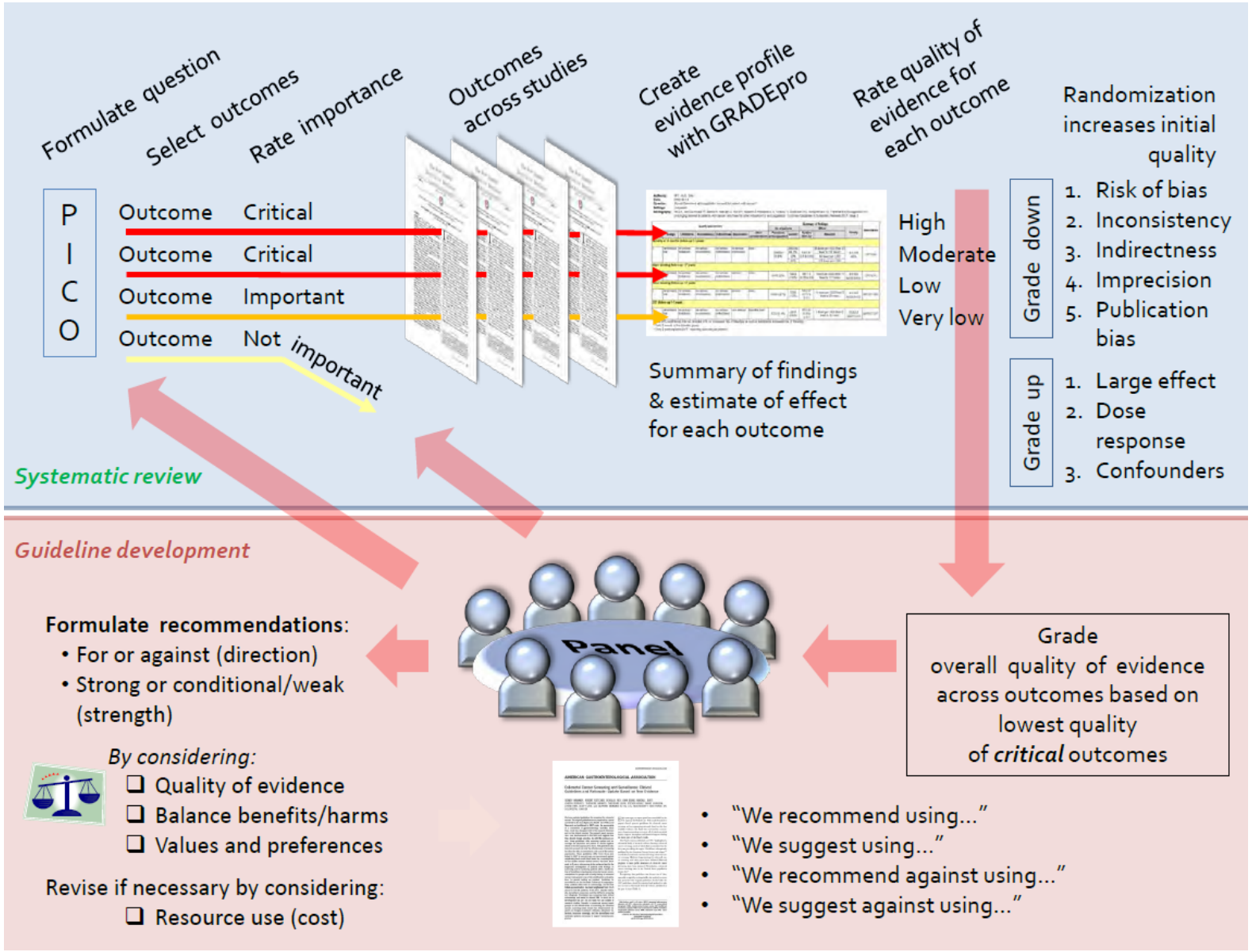
Source: Finlayson et al, 2013

World Health Organization


Lack of initial access to ANC + Lack of repeat access to ANC
=
Increased maternal and infant morbidity and mortality
Photo: WHO/Natalie Behring-Chisholm
World Health Organization

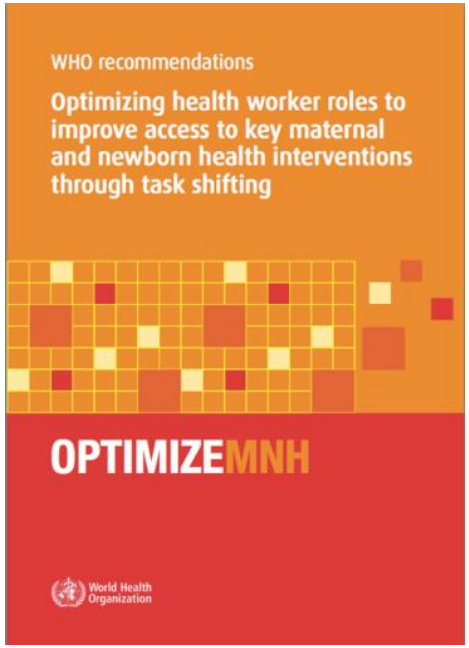
The WHO guideline development process

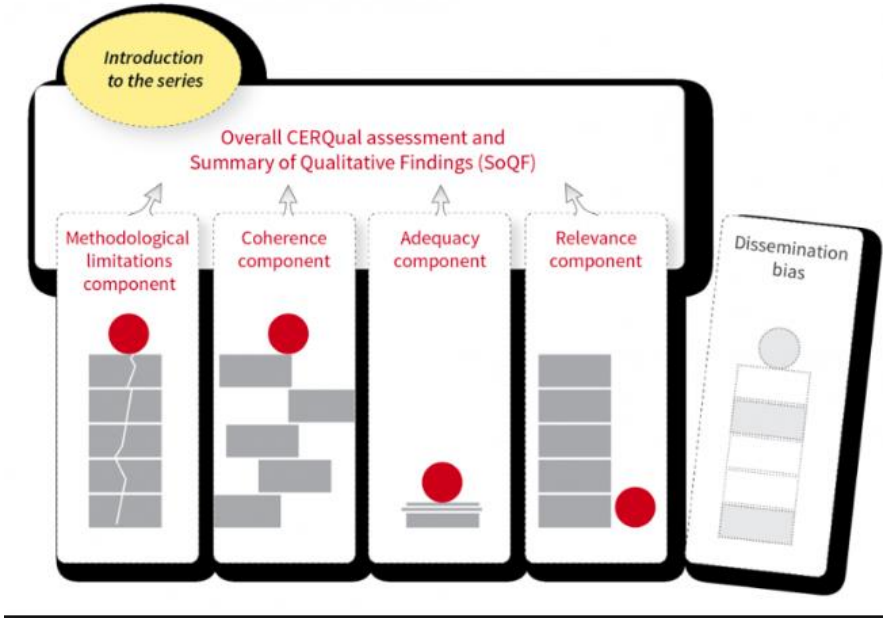



Formulate question
Select outcomes
Rate importance
Outcomes across studies
Create evidence profile with GRADEpro
Rate quality of evidence for each outcome
P
I
C
O
Outcome Critical
Outcome Critical
Outcome Important
Outcome Not important
Summary of findings & estimate of effect for each outcome
High
Moderate
Low
Very low
Randomization increases initial quality
Grade down
1. Risk of bias
2. Inconsistency
3. Indirectness
4. Imprecision
5. Publication bias
Grade up
1. Large effect
2. Dose response
3. Confounders
Systematic review
Guideline development
Panel
Grade overall quality of evidence across outcomes based on lowest quality of critical outcomes
Formulate recommendations:
• For or against (direction)
• Strong or conditional/weak (strength)
By considering:
❑ Quality of evidence
❑ Balance benefits/harms
❑ Values and preferences
Revise if necessary by considering:
❑ Resource use (cost)
• "We recommend using…"
• "We suggest using…"
• "We recommend against using…"
• "We suggest against using…"

WHO and other developments

2012, 2015





Benefits and harms

Resources and cost-effectiveness

Values

Acceptability

Feasibility

Equity implications

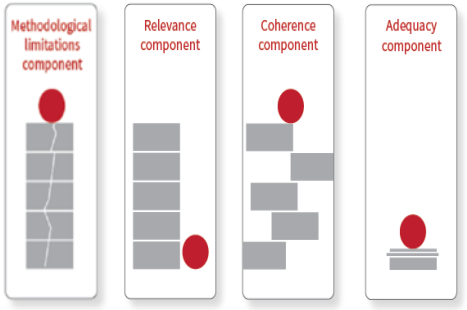
For option X versus option Y…

Qualitative evidence synthesis (QES) process

Systematically identify qualitative studies on a phenomenon of interest

Assess the quality (methodological limitations) of these individual studies

Summarize the findings according to the common themes that emerge



Assess the confidence in the summary findings (synthesized evidence)

GRADE CERQual

Confidence in the Evidence from Reviews of Qualitative Research

THE EVIDENCE - BASED MEDICINE CONSULTANCY LTD

Moving from there to here: our experience so far

World Health Organization

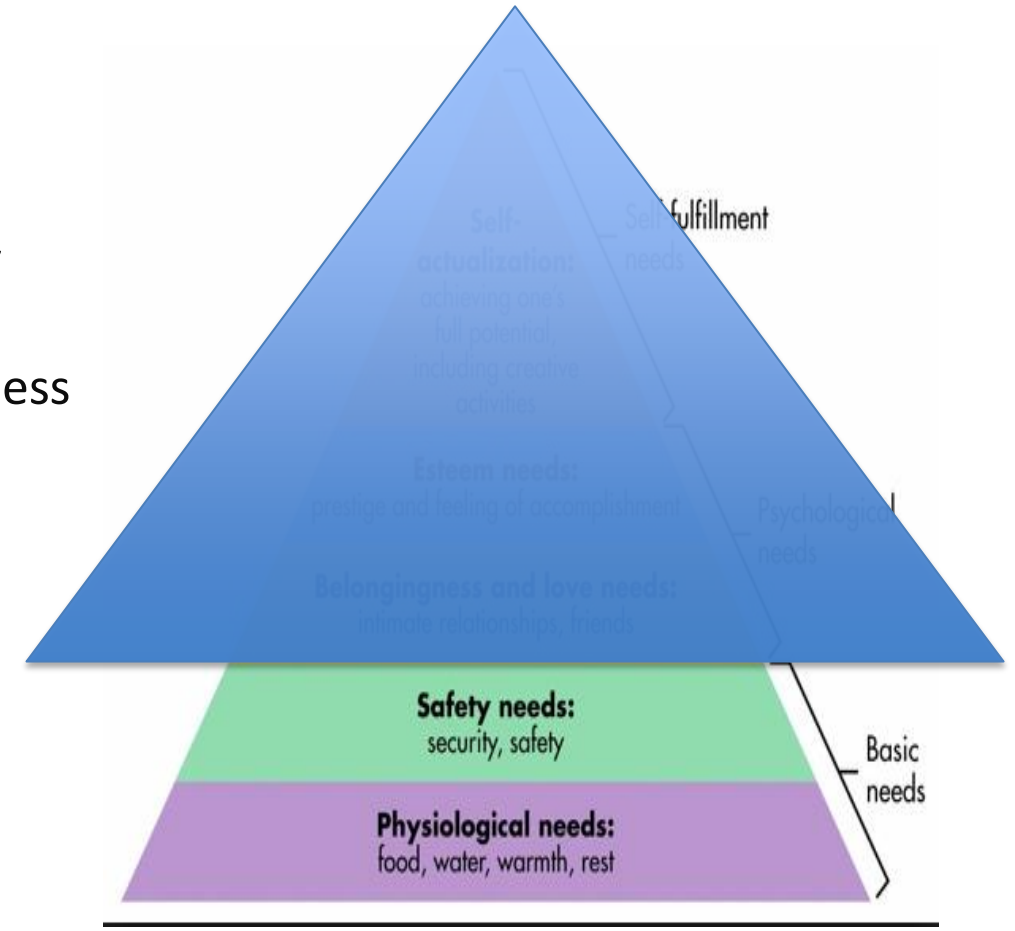
What matters to women

(Downe et al BJOG 2016)

Both-and not either-or

Women want, need, and value a positive pregnancy experience:-

- Maintaining physical and sociocultural normality.
- Maintaining a healthy pregnancy for mother and baby (including preventing and treating risks, illness and death).
- Effective transition to positive labour and birth.
- Achieving positive motherhood (including maternal self-esteem, competence, autonomy)



Operationalising what women want and need

- 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

What makes the ANC guideline different?

The WHO has listened to, and prioritised, women's voices throughout the development of the new ANC guideline.

To complement evidence from systematic reviews on the effectiveness of ANC interventions, WHO looked to qualitative research to answer the following questions:

1. What do women want, need, and value in ANC?
2. What are women's views and experiences of using ANC services?
3. What are health providers' views and experiences of providing ANC services?

Photo UNICEF/Nesbitt

World Health Organization

What matters to women during childbirth

(Downe et al PLOS One 2018)

- 35 studies (19 countries)
- Confidence in most results was moderate to high.
- What mattered:
  - a positive experience that fulfilled or exceeded their prior personal and socio-cultural beliefs and expectations.
  - giving birth to a healthy baby in a clinically and psychologically safe environment
  - practical and emotional support from birth companions, and competent, reassuring, kind clinical staff.
  - Most wanted a physiological labour and birth, while acknowledging that birth can be unpredictable and frightening and that they may need to 'go with the flow'.

Counting what counts

Making guidelines work (1)

Ozge Tuncalp, Geneva, Switzerland: adapted by SD for QESymposium Brasilia October 2019

WHO Guideline on Antenatal Care (2016)

Using qualitative findings in dissemination and implementation

Reproductive Health and Research (RHR)
Nutrition for Health and Development (NHD)
Maternal, Newborn, Child and Adolescent Health (MCA)

World Health Organization

human reproduction programme hrp
research for impact
UNDP · UNFPA · UNICEF · WHO · THE WORLD BANK

ANC model – positive pregnancy experience

Overarching aim

To provide pregnant women with *respectful, individualized, person-centred care* at every contact, with implementation of effective **clinical practices** (interventions and tests), and provision of relevant and timely **information**, and psychosocial and emotional **support**, by *practitioners with good clinical and interpersonal skills* within a **well functioning health system.**

Dissemination

- Policy briefs
  - ANC model
  - Early USG
  - Malaria in pregnancy
- Interactive website
- Tools for implementation
- Regional dissemination workshops
- Translation of the guideline
- Webinar

New guidelines on antenatal care for a positive pregnancy experience

7 NOVEMBER 2016 | GENEVA – The World Health Organization has issued a new series of recommendations to improve quality of antenatal care to reduce the risk of stillbirths and pregnancy complications and give women a positive pregnancy experience. By focusing on a positive pregnancy experience, these new guidelines seek to ensure not only a health pregnancy for mother and baby, but also an effective transition to positive labour and childbirth and ultimately to a positive experience of motherhood.

A community health worker checks a pregnant woman's health condition at her home, Bangladesh.

Sumon Yusuf/Photoshare

WHO site on antenatal care guideline and related documents:

https://www.who.int/reproductivehealth/publications/maternal_perinatal_health/anc-positive-pregnancy-experience/en/

Case study: Supporting policymakers for ANC

- Based on demand from countries, a toolkit to help **policymakers** adapt and implement the ANC model focusing on:
  - Integrating ANC platform: care, supplies, workforce, data systems
    - Designed for the context and needs of the country
  - Testing different models of care and digital innovations (i.e. midwife-led continuity of care, task-sharing)

QES and Implementation

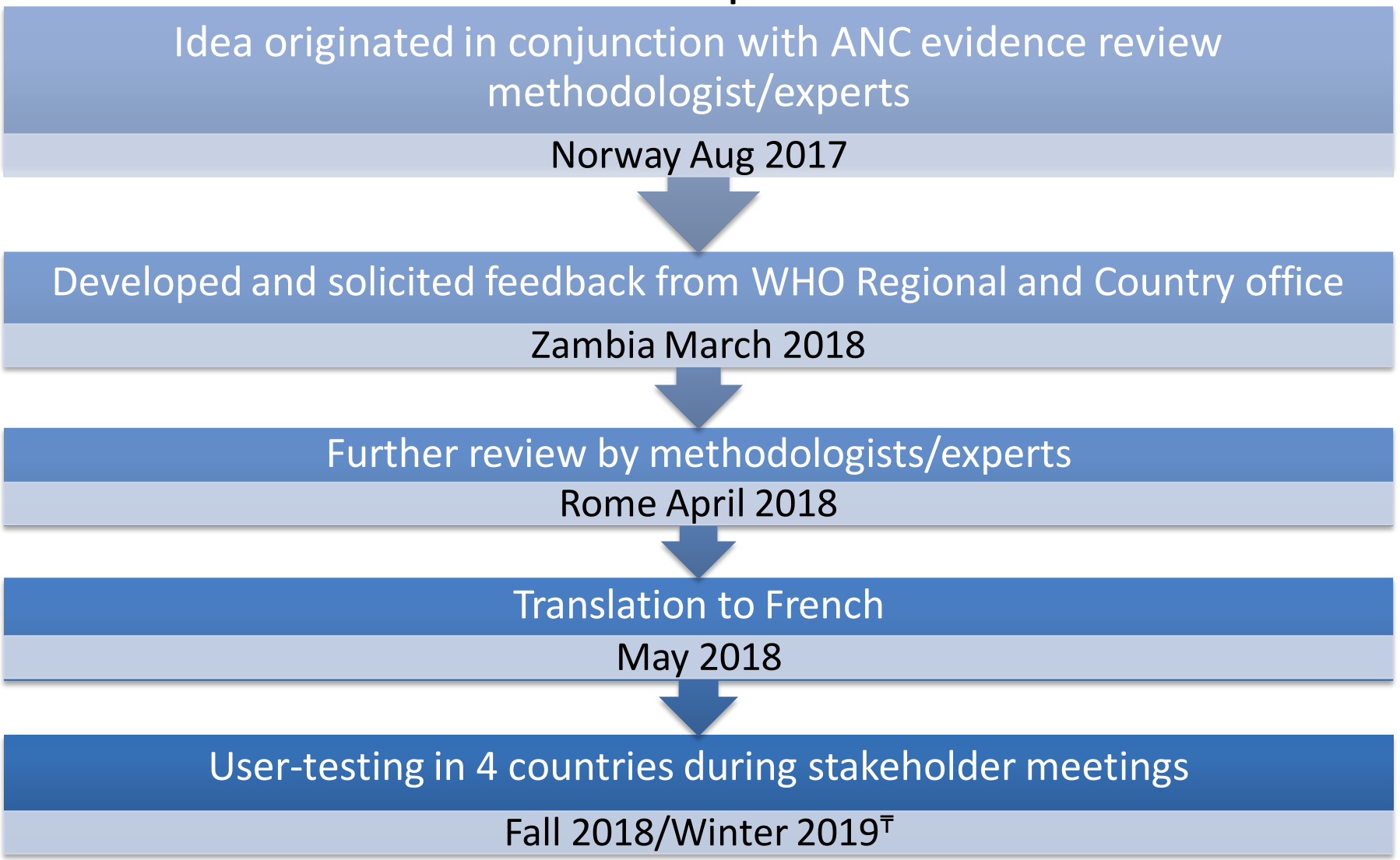
-Adaptation and implementation at country level – **monitoring and evaluation** (M&E) and **learning** are crucial

-Toolkit User testing in Rwanda, Burkina Faso, Zambia, India

-Toolkit includes presentation on positive pregnancy experience, including views and experiences data from guideline QES

-Key components of guideline scoping review (‘*what matters to women*’) are included in the implementation toolkit

WHO ANC Recommendations Adaptation Toolkit development



* AFRO : Burkina Faso, Rwanda, Zambia,

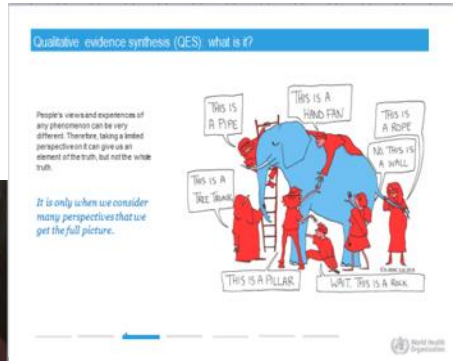
Ŧ India : Assam & Tamil Nadu

WHO ANC recommendations adaptation toolkit's components

1. **Baseline Assessment Tool (BAT) – Excel sheet**
   a) Situational analysis
   a) Output 1: integrated package of ANC services
   a) Output 2: SWOT analysis of possible innovations

Strengths	**W**eaknesses
Opportunities	**T**hreats

2. **Qualitative Evidence Syntheses (QES) slidedoc for the country stakeholder meetings – Power point presentation**



Making guidelines work (2)

WHO recommendations non-clinical interventions to reduce unnecessary caesarean sections

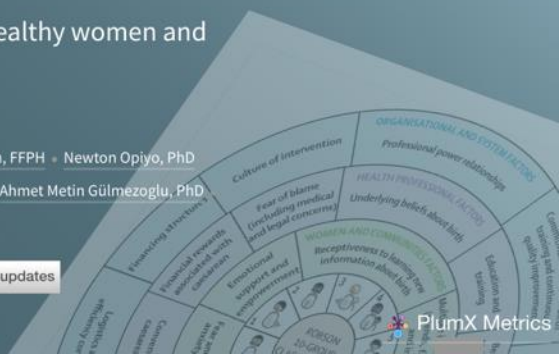
THE LANCET

SERIES | OPTIMISING CAESAREAN SECTION USE | VOLUME 392, ISSUE 10155, P1358-1368, OCTOBER 13, 2018

Interventions to reduce unnecessary caesarean sections in healthy women and babies

Ana Pilar Betrán, PhD • Prof Marleen Temmerman, PhD • Carol Kingdon, PhD • Abdu Mohiddin, FFPH • Newton Opiyo, PhD • Maria Regina Torloni, PhD • Jun Zhang, PhD • Othiniel Musana, MMed • Sikolia Z Wanyonyi, MRCOG • Ahmet Metin Gülmezoglu, PhD • Prof Soo Downe, PhD • Show less

Published: October 13, 2018 • DOI: https://doi.org/10.1016/S0140-6736(18)31927-5 • Check for updates



PlumX Metrics

Interventions that may reduce unnecessary caesarean section

Interventions targeted at women, communities, and/or to the general public	Prenatal education
	Group therapy for women with a fear of childbirth
	Decision-aids for mode of childbirth
	Labour companionship
Interventions targeted at healthcare providers	Audit and feedback (including Robson classification and external review of labour and delivery records)
	Mandatory second opinion for caesarean birth
	Continuous training and implementation of clinical protocols
	Equalizing physician pay for vaginal and caesarean birth
	Use of opinion leader education at a facility-level
	Goal setting at a hospital level
	Public dissemination of caesarean rates at a facility-level
	Policies limiting legal liability and malpractice lawsuits

What women said

Childbirth education

- I felt a lot of pain and lost confidence when giving birth last time. I felt very different this time. Because I had taken this course I felt very confident when I was giving birth***"(Mother, China,*** *Wang 2006:5).*

Content and consistency of education materials

"I find that's very clear … the number format. The figure format, that wouldn't be the way I would choose to view it … and probably not the pie chart format either"… *(Mother, UK, Emmett 2017)*

"[I liked] the pie charts … If you see 2 in a 100 you think oooh, but on the grand scale of a pie chart, you think, oh yeah it is small" *(Mother, UK, Emmett 2007:168).*

(Need for consistency between education and clinical practice)

Picture from https://www.nhs.uk/Conditions/pregnancy-and-baby/Documents/Birth_place_decision_support_Generic_2_.pdf

Emotional support as well as knowledge

- Women wanted health professionals to acknowledge their prior knowledge of birth, especially previous traumatic birth experiences “for the massive thing that it is” to them (Mother*, UK, Farnworth 2008;p.120*
- I wasn’t particularly happy with [Decision analysis] at all. I thought a lot of the things, was just a lot of scary information” *(Mother, UK, Frost 2009:900)*
- “You could get yourself quite wound up about it all" (*Mother, UK, Emmett 2007:168)*
- “I cried a lot, was completely torn apart, and could not say anything” *(Mother Norway, Ramvi 2011:271)*

Interventions targeted at women

Recommendation 1

Health education for women is an essential component of antenatal care. The following educational interventions and support programmes are recommended to reduce caesarean births only with targeted monitoring and evaluation

(*Context-specific recommendation, low-certainty evidence*)

Childbirth training workshops

Nurse-led applied relaxation training programme

Psychosocial couple-based prevention programme

.

Psychoeducation for women with fear of childbirth

.

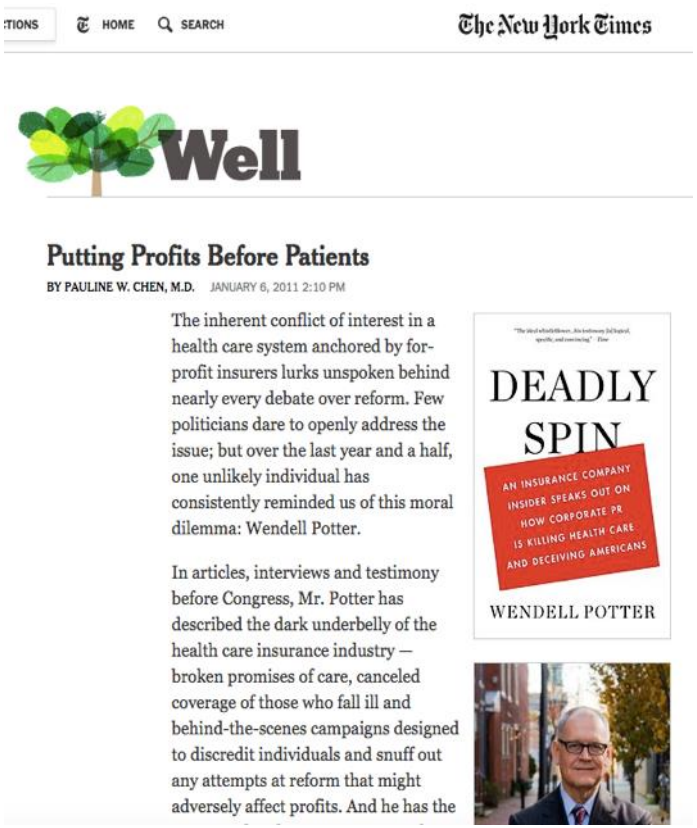
Fear of blame and recrimination

‘Obstetricians are in a constant fear of being sued, so they’re taking a path of least resistance” *(Doctor, USA, Cox 2011:5)*

“I am coming towards retirement, I don’t want to go to court” (*Midwife, UK Kamal 2005:1058)*

“Our society has spent more time on teaching the process of suing rather than introducing the labor to the general public” *(Midwife, Iran, Yazdizeh 2011:5).*

Value attached to financial reward



TIONS HOME SEARCH The New York Times

Well

Putting Profits Before Patients

BY PAULINE W. CHEN, M.D. JANUARY 6, 2011 2:10 PM

The inherent conflict of interest in a health care system anchored by for-profit insurers lurks unspoken behind nearly every debate over reform. Few politicians dare to openly address the issue; but over the last year and a half, one unlikely individual has consistently reminded us of this moral dilemma: Wendell Potter.

In articles, interviews and testimony before Congress, Mr. Potter has described the dark underbelly of the health care insurance industry — broken promises of care, canceled coverage of those who fall ill and behind-the-scenes campaigns designed to discredit individuals and snuff out any attempts at reform that might adversely affect profits. And he has the

- "…Profit from CS surgery is much high than vaginal delivery" (*Healthcare provider, China, Liu, 2010)*
- …participants reported government payments for each CS performed were viewed as the "cash-cow" of the hospital. The administrator spoke of this increased revenue as a source of pride and power, suggestive of additional value in increasing CSRs ***(Administrator, Senegal, Mbaye 2011)***

Convenience, efficiency, scheduling

- "The main problem with natural delivery is its unpredictability, as it may occur anytime and disturb the physician's program" (*Specialist, Iran, Yazdiadeh 2011:4)*
- 'We know that CS is not indicated in low-risk pregnancy, but to avoid the night pressure and the work during the night…'' (*Obstetrician, Nicaragua, Colomar 2014:2385)*
- "Some of them (women), they just quite like a planned thing. They have the caesarean." (*Midwife, Australia, Foureur 2017:6*)

Beliefs about women and birth

"In the end of the day, when they come to deliver, they are so weak, they cannot push the babies. So the patients themselves are the ones requesting for CS, because they cannot tolerate the labor pain" *(Resident, Tanzania, Litorp 2015:235).*

"…not following a healthy diet have reduced the capabilities of our girls in this regard [to undergo vaginal delivery]" (*Physician, Iran, Yazdiadeh 2011:10)*

Sometimes it is the mother's mother and her sister and all that out there [general agreement], I am afraid, I am reading this. And it is the Internet, its Dr Google" *(Clinician, Ireland, Lundgren 2016:6)*

Interventions targeted at health-care professionals

Recommendation 2.1

Implementation of evidence-based clinical practice guidelines combined with structured, mandatory second opinion for caesarean section indication is recommended to reduce unnecessary caesarean sections in settings with adequate resources and senior clinicians able to provide mandatory second opinion for caesarean indication

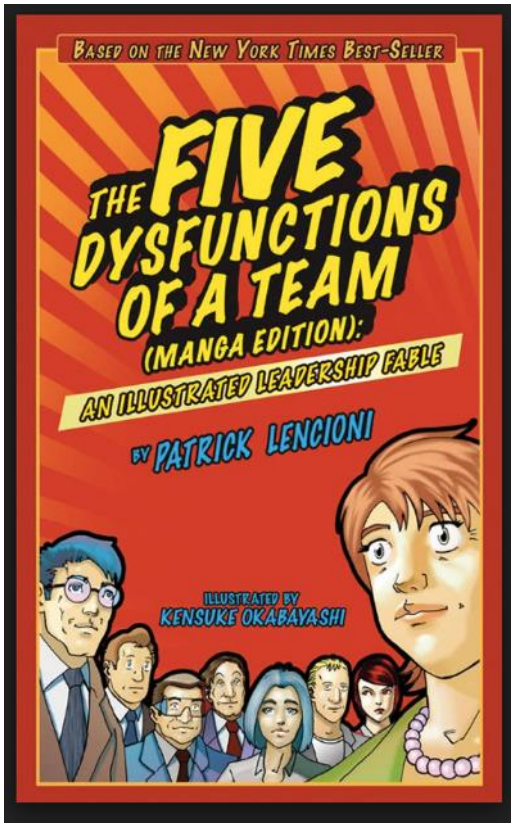
(*Context-specific recommendation, High-certainty evidence*)

Recommendation 2.2

Implementation of evidence-based clinical practice guidelines, caesarean section audits and timely feedback to health-care professionals are recommended to reduce unnecessary caesarean sections.

(*Recommended, High-certainty evidence*)

Dysfunctional teamwork



- "Maybe they [residents] say that it was 'fetal distress' but it was not fetal distress, it was 'doctor's distress' … [laughter]" *(Specialist, Tanzania, Litorp 2015:235)*
- "I think we should realize that we are the ones who have done them that way" [trained residents in hierarchical structures where admonishment has made them reluctant to seek a second opinion] *(Specialist, Tanzania, Litorp 2015:235).*
- "In our hospital, the residents are not allowed to independently consult the anaesthesiologist at night" *(Resident, The Netherlands, Melman 2017:5)*

What those in organisations said

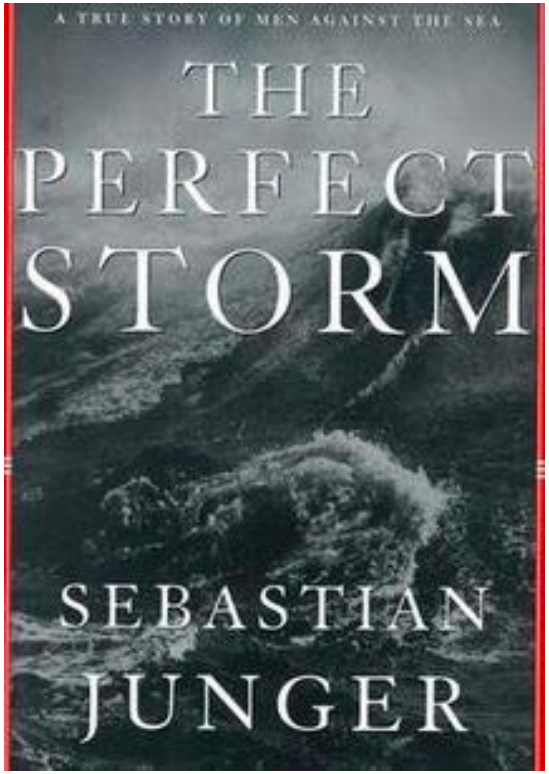
Marginalization of midwives

- “"There is no joint meeting between the midwifery and obstetricians associations.*”(Midwife, Iran, Yazdiadeh 2011:9)*

- What I have witnessed in medical assemblies during these years was that we were the last; our efforts are not rewarded neither from financially or spiritually. And not recognizing our profession and its hardships takes all the encouragement away” (*Midwife, Janani 2015:1376, Iran).*

- “You might enter into a situation of decision of unnecessary CS because of the, you know, friction with the midwives” *(Resident, Tanzania, Litorp 2015:236)*

Payment issues



- "'In the private sector, providers are reimbursed approximately $700 for normal childbirth and $1,500 for CS, so the doctor prefers to perform a CS'' *(Manager, Nicaragua, Colomar 2014:2388)*

- it's almost like the perfect storm. You're going to pay me more, I get to worry less, you're not going to sue me, and I'll be done in an hour (*obstetrician, US).*"

Interventions targeted at health organizations, facilities or systems

Recommendation 3.1

For the sole purpose of reducing caesarean section rates, collaborative midwifery-obstetrician model of care (i.e. a model of staffing based on care provided primarily by midwives, with 24-hour back-up from an obstetrician who provides in-house labour and delivery coverage without other competing clinical duties) is recommended only in the context of rigorous research

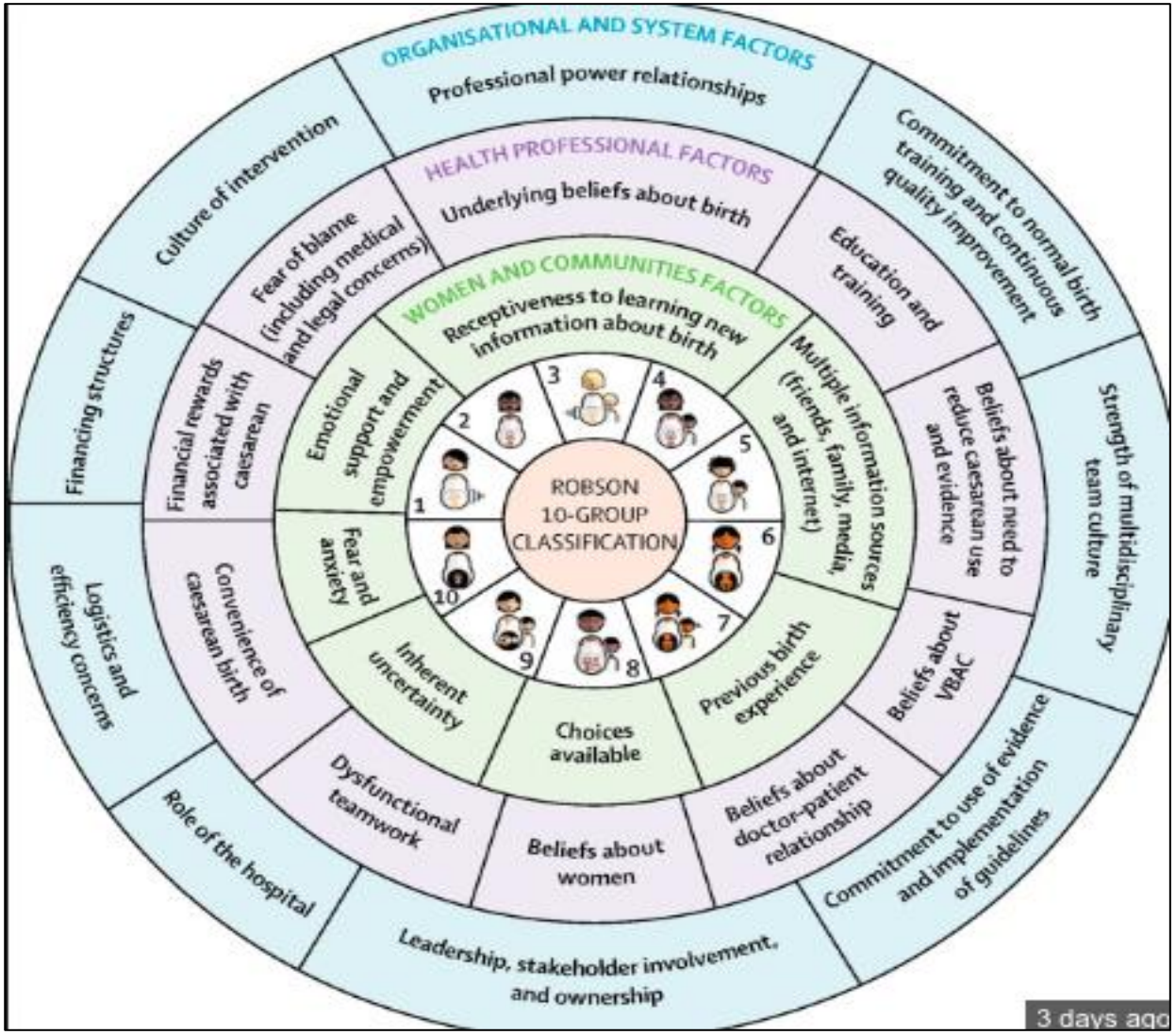
(Context-specific recommendation, low-certainty evidence)

Recommendation 3.2

For the sole purpose of reducing unnecessary caesarean sections, financial strategies (i.e. insurance reforms equalizing physician fees for vaginal births and caesarean sections) for health-care professionals or health-care organizations are recommended only in the context of rigorous research.

(Recommended, High-certainty evidence)

Summing up


ORGANISATIONAL AND SYSTEM FACTORS
Professional power relationships
HEALTH PROFESSIONAL FACTORS
Underlying beliefs about birth
WOMEN AND COMMUNITIES FACTORS
Receptiveness to learning new information about birth
ROBSON 10-GROUP CLASSIFICATION
1
2
3
4
5
6
7
8
9
10
Culture of intervention
Fear of blame (including medical and legal concerns)
Education and training
Commitment to normal birth training and continuous quality improvement
Financing structures
Financial rewards associated with caesarean
Emotional support and empowerment
Multiple information sources (friends, family, media, and internet)
Beliefs about need to reduce caesarean use and evidence
Strength of multidisciplinary team culture
Logistics and efficiency concerns
Convenience of caesarean birth
Fear and anxiety
Inherent uncertainty
Choices available
Previous birth experience
Beliefs about VBAC
Role of the hospital
Dysfunctional teamwork
Beliefs about women
Beliefs about doctor-patient relationship
Commitment to use of evidence and implementation of guidelines
Leadership, stakeholder involvement, and ownership
3 days ago

Implementation planning before guideline launch

Generic formative research phase protocol

Ana Pilar Betrán
Department of Reproductive Health and Research

World Health Organization

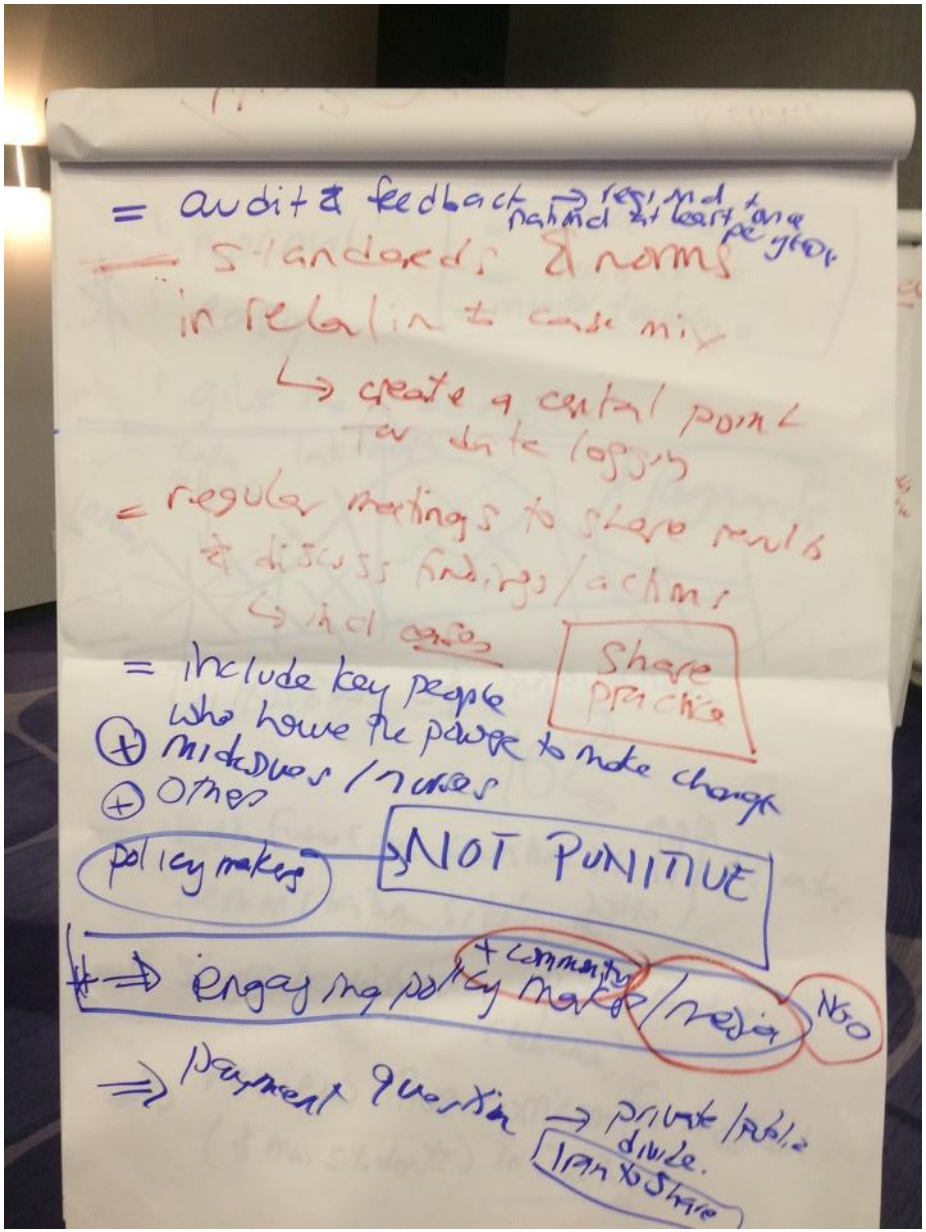
human reproduction programme hrp
research for impact
UNDP · UNFPA · UNICEF · WHO · THE WORLD BANK

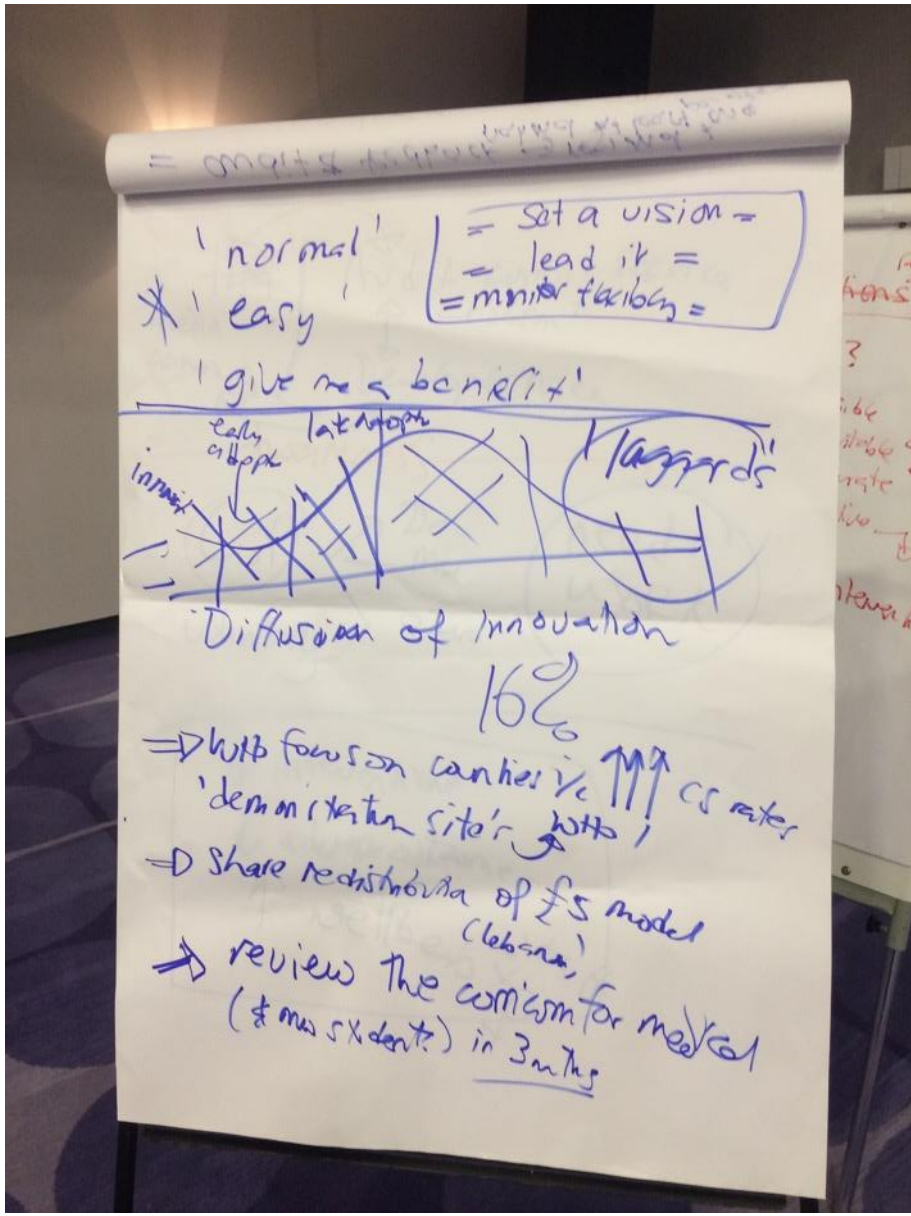
Creating the implementation protocol through formative research

- ✓ To identify the local reasons for increasing CS rates
- ✓ To understand women's and providers' viewpoints and opinions on why CS are increasing and on interventions
- ✓ To design and implement locally feasible and acceptable interventions to reduce CS

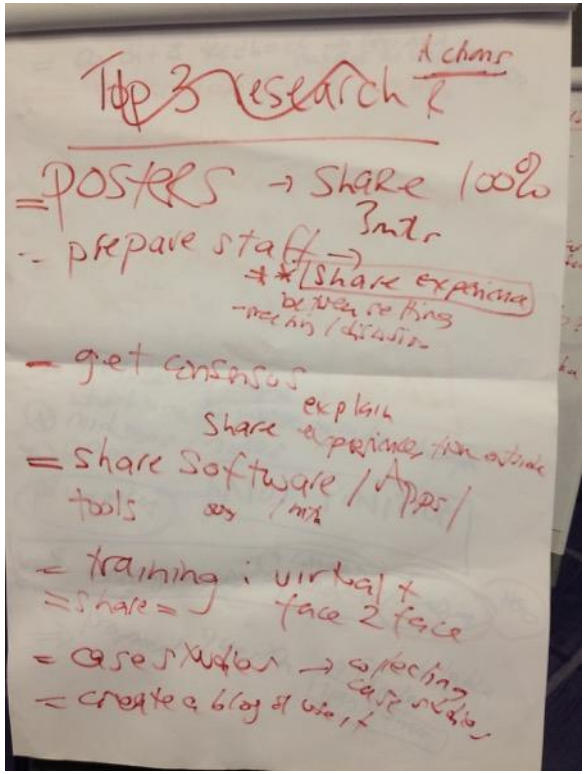
Meeting of Gulf State maternity care providers, Beirut September 2018

Issues raised

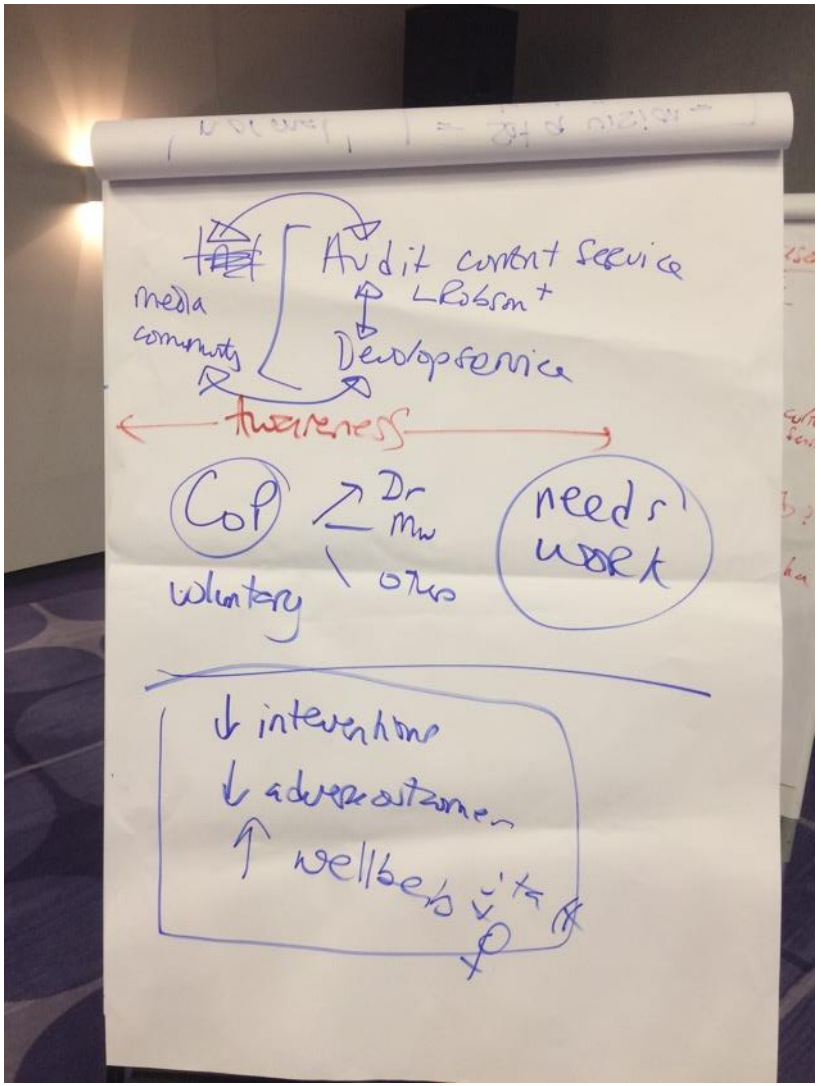




Solutions (expected and unexpected)



- 'Happy births'
- Strategies to address the lawyers…



Implementation programme for ALL contexts

Document review

Readiness assessment

Primary qualitative research with women, providers and administrators

Where to begin?

Scenario 1

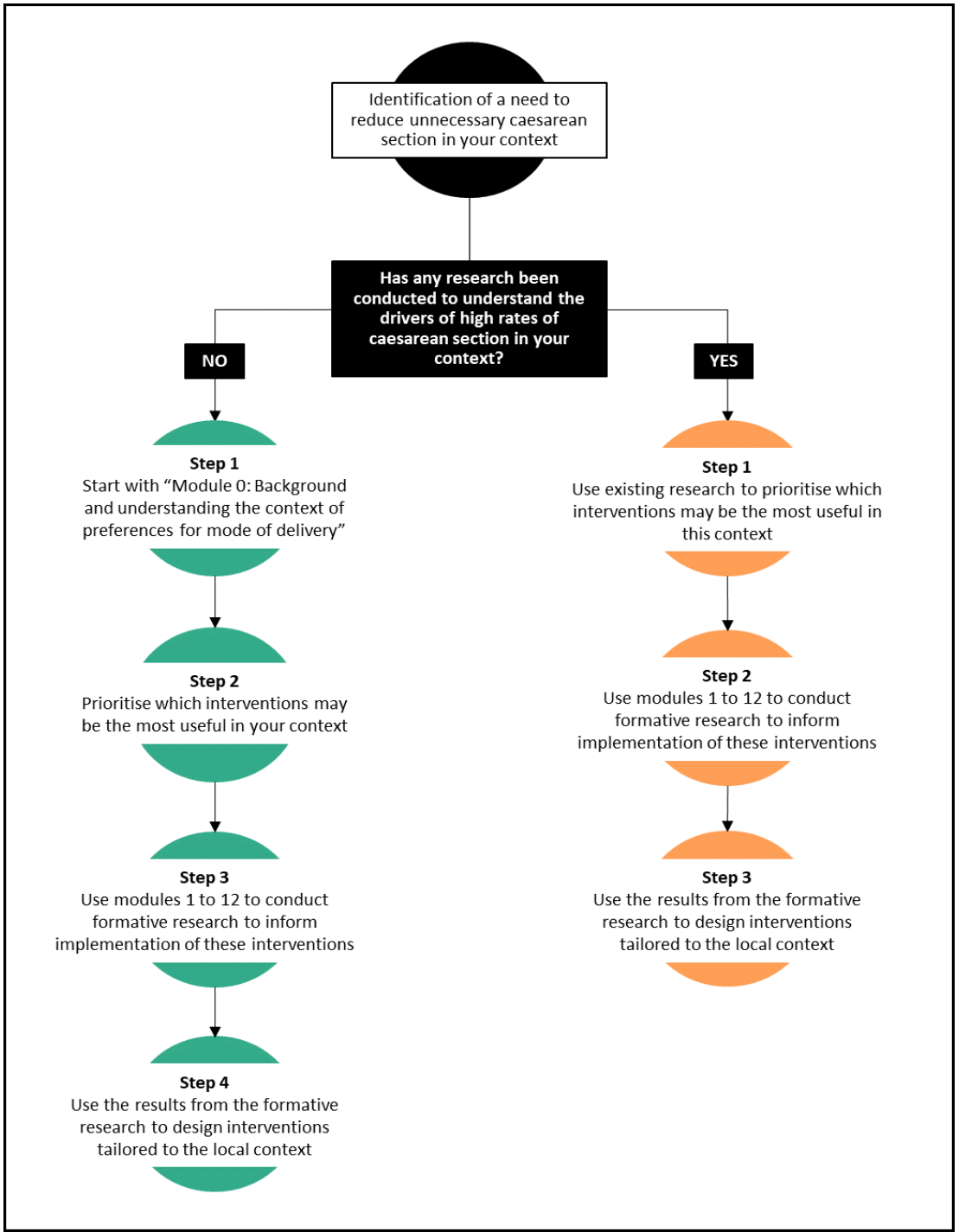
Contexts where high or rising CS rates are acknowledged as a problem, but research has not been conducted to understand the drivers of high rates (e.g.: women's or providers' preferences for mode of childbirth, individual and health-system factors contributing to caesarean section).

Research teams that fall into this category may find it useful to start with *Module 0*: to better understand the drivers of high rates of CS. They may use the results from Module 0 to prioritise which interventions may be most useful in their context; then use Modules 1-12 to conduct formative research to inform implementation of these interventions.

Scenario 2

Contexts where high or rising CS rates are acknowledged as a problem, and research has been conducted to understand the drivers of high rates.

Research teams that fall into this category may already have ideas or preferences about which interventions may be the most useful in their context. They may select the most appropriate interventions, then use Modules 1-12 to conduct formative research to inform implementation of these interventions.


Identification of a need to reduce unnecessary caesarean section in your context
Has any research been conducted to understand the drivers of high rates of caesarean section in your context?
NO
YES
Step 1
Start with "Module 0: Background and understanding the context of preferences for mode of delivery"
Step 2
Prioritise which interventions may be the most useful in your context
Step 3
Use modules 1 to 12 to conduct formative research to inform implementation of these interventions
Step 4
Use the results from the formative research to design interventions tailored to the local context
Step 1
Use existing research to prioritise which interventions may be the most useful in this context
Step 2
Use modules 1 to 12 to conduct formative research to inform implementation of these interventions
Step 3
Use the results from the formative research to design interventions tailored to the local context

Filename

Type of participants included in each module

MODULE	Women	Providers
Prenatal education	✓	✓
Decision aids for mode of delivery	✓	✓
Labour companionship	✓	✓
Group therapy for women with fear of childbirth	✓	✓
Public dissemination of caesarean section rates	✓	✓
Mandatory second opinion	✓	✓
Audit and feedback		✓
Continuous training and implementation of clinical protocols		✓
Equalising physician pay for vaginal and caesarean birth		✓
Opinion leader education		✓
Goal setting at a hospital level		✓
Policies that limit legal liability and malpractice lawsuits		✓

Making guidelines work (3)

Wisdom

The expert translation of population level knowledge for each unique individual

Evidence-based medicine (EBM) is the integration of best research evidence with clinical expertise and patient value… when these three elements are integrated, clinicians and patients form (an)…alliance which optimises clinical outcomes and quality of life…'

Sackett et al 2000

From knowledge to wisdom

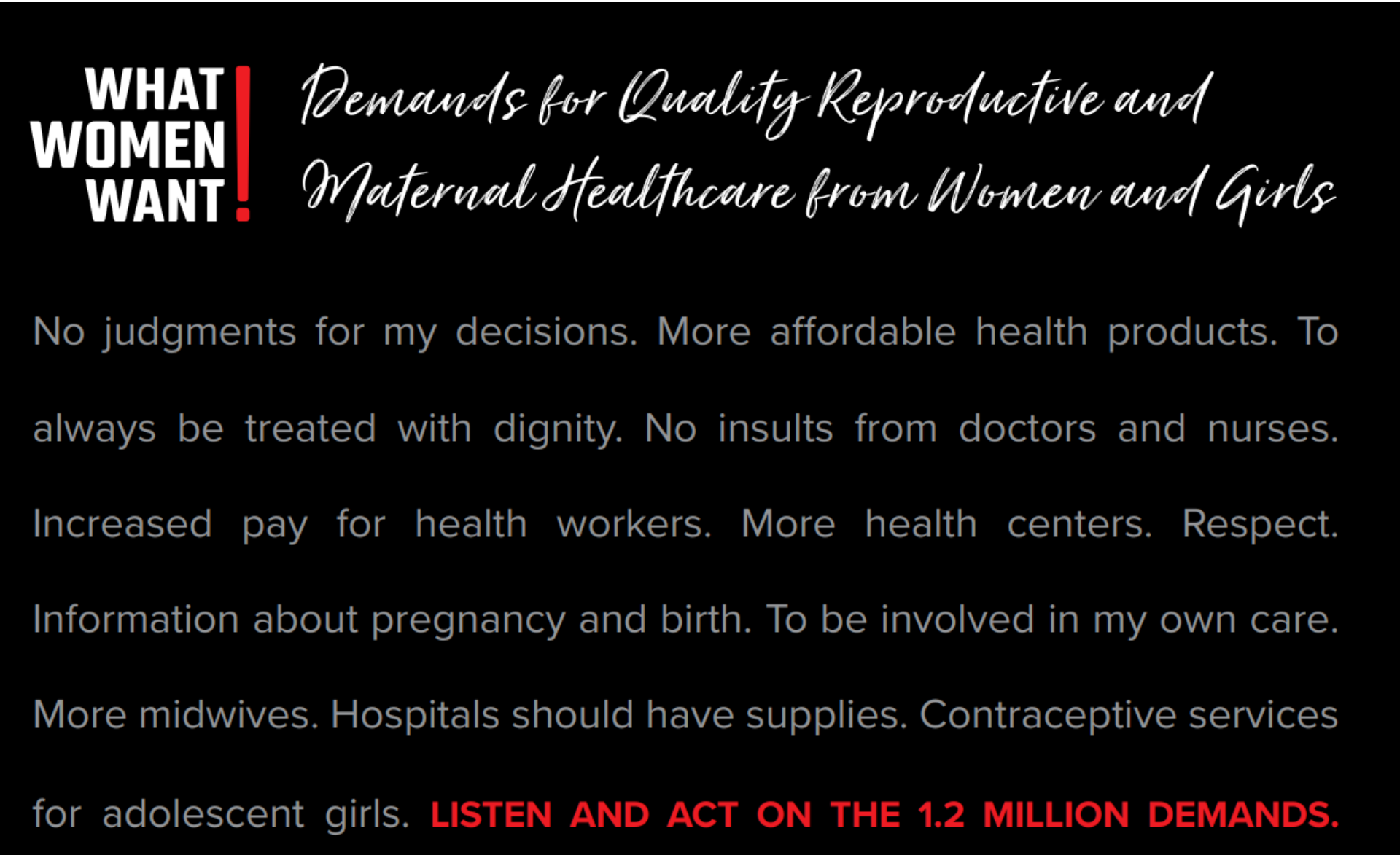
- Asking the right questions
- Using the right design
- Valuing the whole spectrum of information and expertise, tailored to the individual

Integrating science and story

The definition of the expert *(Benner 1984)*

- no longer relies on an analytic principle (rule, guideline, maxim)
- intuitive grasp of each situation - zeroes in on the accurate region of the problem without wasteful consideration of a large range of unfruitful, alternative diagnoses and solutions.
- deep understanding of the total situation.
- performance fluid, flexible and highly proficient.
- Uses analytic problem solving where necessary.

What women say: in 2019



Right Care
through courage (not recklessness)

How can I make sure this design/technique/organisation/ system/guideline etc is only adopted if it acts as an agent to improve overall, holistic, long term wellbeing of mothers, babies, families, and staff

I urge midwives to stop being well behaved and to take on their duty to advocate for women's rights to a good birth

Listening to women is a radical act.

But acting on what we hear is revolutionary.

Right Care through relationship: being-with not doing-to

Constantly be alert to and challenge the corruption of what actually works by the dominant dialogue of what is assumed to work.

Getting it right…
For all?

"Mother and baby are doing incredibly well. It's been the most amazing experience I could ever have possibly imagined. How any woman does what they do is beyond comprehension….It's been amazing, so we just wanted to share this with everybody."

…It was amazing, absolutely incredible, and…Im so incredibly proud of my wife…

Describing what it was like to be present at the birth, Harry said: "This is definitely my first birth. It was amazing, absolutely incredible, and, as I said, I'm so incredibly proud of my wife.

▲ Prince Harry after Meghan gives birth to boy: 'Absolutely over the moon' – video

"As every father and parent will ever say, you know, your baby is absolutely amazing, but this little thing is absolutely to die for, so I'm just over the moon."

Measuring, listening, and doing what counts for BOTH/AND

Love and compassion are necessities, not luxuries. Without them humanity cannot survive

Dalai Lama

With thanks to all those who made all this possible…
these and many others!