Resistance and Possibility: The Struggle to Preserve Normal Birth

Mary Josephine Donovan Sharpe 1,*

1Midwifery Education Program, Ryerson University, Toronto, Canada
*Corresponding author: Mary Josephine Donovan Sharpe, Midwifery Education Program, Ryerson University, Toronto, Canada. Tel: +416-9795000; ext. 7980, Fax: +416-9795271, E-mail: msharpe@ryerson.ca
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Implication for health policy/practice/research/medical education:
Lowering high cesarean birth rates in favour of normal vaginal birth has a number of implications for health policy, practice and maternity caregiver education. For instance: investing resources for settings which encourage normal birth; developing structures for auditing unnecessary cesarean births and finally, bolstering the role of the registered midwife as the known primary caregiver for all low risk births.

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members. Labour is often unnecessarily induced before 41 weeks or artificially augmented. Women can be placed on continuous fetal monitors in spite of the evidence to show that their routine use does not improve outcomes for the baby (7). Women are provided with either nitrous oxide or epidurals to help with labour pain but not with birthing pools, massage, or the assistance of a known continuous trained caregiver or supportive loved ones (8). Women routinely labour in bed and give birth with their legs in stirrups. Cesarean births cost health care systems much money; however, resources are also needed to adequately support normal birth in hospital, home or birth centers. I offer the following suggestions that have been associated with lower cesarean rates.

- Prioritize the development of models of maternity care that buttress the woman’s choices, autonomy and empowerment. Offer her maximum education about the pregnancy, birth and post partum periods and the evidence of research related to the risks and benefits of any procedure.

- Offer a known registered midwife for each woman to provide primary continuous individualized and responsive care throughout pregnancy, labour, birth and the post partum period. Worldwide, midwives are the expected primary caregivers for normal birth. In many countries, increasing numbers of new obstetricians have displaced the expert primary care role of the midwife, who would refer to specialists only if necessary (8).

- Create attractive settings for birth that support normal birth; settings that acknowledge the family and other supporters; settings that women will want to use and offer these free of charge. Institute settings where normal birth is expected and supported and where there is the possibility for the woman to eat and drink, walk freely, take a variety of positions during labour–lying, sitting, standing, in water– and the privacy to vocalize and communicate with others; settings where she can birth standing, on a birthing stool, or on her side (9).

- Attend to the hormonal bases of labour. It is the release of oxytocin that gives the contractions their strength and supports the normal and effective progression of labour; however, this hormone is susceptible to disturbance and its release can be interrupted by fear, anxiety, and lack of privacy. The work of labour gives rise to powerful endorphins that sustain and support the woman’s efforts and her initial connection with her baby.

- Provide settings where the woman feels safe and where her birth can be acknowledged as a highly significant event in her life rather than something to be endured. The particularity of each woman’s experience—the creative, unusual, and unique unfolding of the process of labour and birth—makes birthing an adventure for the woman, her family and her caregivers.

- Create an enthusiasm for normal unmedicated births; propagate positive images by sharing culturally appropriate films, and testimonies from parents, models and champions of normal birth. Draw on research that emphasizes the benefits of normal vaginal birth and unmedicated birth.

- Invest in a universal health care system that does not privilege the wealthy over the poor and which refuses to tolerate unnecessary surgical procedures. Institute an auditing board for every cesarean to investigate its necessity (9).

Normal birth requires patience, space, time and a tolerance for uncertainty. It is unpredictable, surprising, individual, particular and unique. Unmedicated birth requires a wide capacity for understanding, compassion and support on the part of a known caregiver and recognition that birth has a wide range of personal meanings for women. Some may say that maternal choice for cesarean birth is the principal reason for its increase. Research has suggested that practitioner preference and financial considerations may be more responsible (10). Nonetheless, one needs to address the basic question: What are the rights of women related to elective cesarean birth when there are no medical indications? It would appear that we need to support patient autonomy and choice; however, only after informed choice has been given following a detailed exploration of all the risks and benefits and the provision of powerful, positive and attractive opportunities for physiological birth instead of an operative birth.

In Iran, the establishment of many Baby Friendly Hospitals that support breastfeeding has been remarkable and very impressive. Could it be possible to establish “Normal Birthing Friendly Hospitals” or Birth Centers which champion normal unmedicated vaginal birth? The exploration of the issue of cesarean birth rates done by academics such as Dr. Maharlouei et al. (11, 12) an important beginning to a paradigm shift that could benefit women and babies in Iran and beyond.

References


