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Resistance and Possibility: The Struggle to Preserve Normal Birth

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Dr. Najmeh Maharlouei must be congratulated for initiating the publication of this quarterly journal, Women's Health Bulletin. The bulletin will provide a forum for an exploration of significant issues relating to women's health, offer a further venue for academic publications on the subject, and encourage healthy debate, reflection and discussion. The Third International Iranian Conference on Women's Health was held this May in the beautiful and historic city of Shiraz. The conference brought together many clinicians, academics and health policy experts for meaningful dialogue about health issues that Iranian women face. I laud the conference organizers for their vision and the execution of a very successful conference. The quality of much of the research presented was impressive and the earnest desire of the speakers to make a difference for Iranian women was evident.

One of the salient issues explored during the conference was the rising incidence of cesarean births in Iran and throughout the developed world. One is grateful for cesarean birth capability when there is a clear clinical need. Recommendations from the World Health Organization in 1985 suggested that in order to reduce mortality and severe morbidity in parturient women and their infants, rates should be between 10% and 15% (1). The optimal cesarean birth percentage is currently unknown, yet some would suggest that rates much above the WHO parameters appear to do more harm than good. In 2008, cesarean birth rates of up to 46% were reported in some countries; current rates may well be higher (2).

Although helpful when necessary, a cesarean birth is a major abdominal operation that bears with it the risk of anesthetic and surgical error, infection, increased blood loss, and greater risks in ensuing pregnancies (3). In the near future, the advance of antibiotic-resistant superbugs may make any unnecessary surgical procedure exceedingly ill-advised (4). Recovery time for the mother is prolonged following a cesarean birth and the delay can interfere with the normal progression of mother-infant connections, breastfeeding and parenting activities.

A potent disincentive for normal vaginal birth is the agreement between some women and their obstetrical caregivers that cesarean birth is a less painful, safer and more desirable mode of delivery; a mode that is convenient, predictable, quicker, and can preserve vaginal integrity and reduce potential sequelae such as urinary incontinence and complications in labour. Many women are fearful of the process of labour and birth and this fear can be exacerbated by maternity caregivers and family members who have little exposure to normal unmediated birth (5). The advantages of normal vaginal birth are multiple. There is increasing evidence that navigating the birth canal can support the infant's respiratory function and that the baby's exposure to the vast array of normal bacteria in the mother's vaginal microbiome can support the infant's ability throughout life to resist infection, allergies and even obesity (6).

Strategies to reduce cesarean births may require complex and multifactorial approaches. What may be needed is a significant paradigm shift in attitudes towards birth, the woman's body and issues of risk. The current management of vaginal birth and labour in many settings contributes to making vaginal birth an undesirable experience. It is important to resist what is seen worldwide: the homogenizing and institutionalization of the complex and personal nature of birth, whereby women wear standard hospital gowns and labour in public settings along with many other women, without the personalized one-on-one care of known midwives or the presence of family

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 birth 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.

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