Respectful childbirth

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Summary

- What is « respectful childbirth »?
  - « basic » respect
  - birth plans, shared decisions
  - complains and lawyers
- How to study « respectful childbirth »
- What is known
- The way forward

A sad story

- A woman, 37 years old, South American origin, 2nd pregancy
- Her first child died after delivery 20 years ago
- We tried to understand the story
  - she had prolonged labour, ending in a CS
  - after the delivery she never saw the baby
  - after several days, they told her that the baby has died
  - she never understood what happened

Lessons to be learned

- Keep the woman informed
- Being alone is suboptimal
- When things go wrong, do not be shy to discuss the problem
- Debriefing is important for the mourning process
- To show the neonate, whatever the condition, may be important
- and, obviously, avoid poor outcomesõ õ .

www.whiteribbonalliance.org/respectfulcare

Classification of mistreatments

- Physical, verbal, sexual abuse
- Stigma and discrimination
- Failure to meet standards of care
- Poor rapport between women and providers
- Health system conditions and constraints

Bohren MA, PLoS Medicine 2015

Quantitative review

- Prevalence depends on:

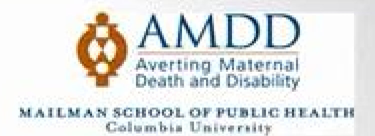
  . definition

  . questionnaire

  . context

  . population

- very few data



The Staha Project: Promoting Respectful and Attentive Care in Tanzania

Kate Ramsey, Wema Moyo, Stephanie Kujawski, Margaret Kruk, Godfrey Mbaruku, Lynn Freedman

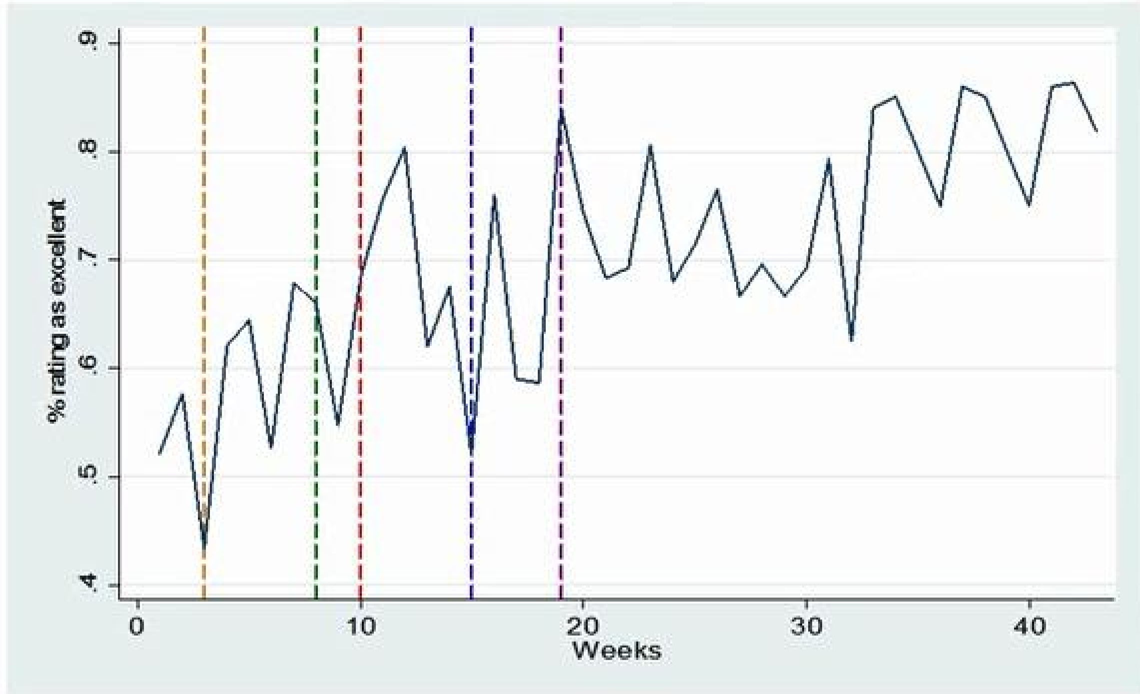
CHANGE Webinar

November 11, 2014

Quality Improvement Interventions

- Move admission and discharge to a private room
- Obtain/use curtains in the delivery room and screens in the maternity for privacy
- Pharmacy creates a stock out list each week to post in the maternity ward
- Recognize providers with tea, certificates, etc.
- Peer-to-peer learning with Bombo Hospital QI Team

Respect (N=1720)



Week 3: Admission/discharge moved
Week 8: Curtains for delivery cubicles
Week 10: Screens in maternity ward for exams
Week 15: Posting of supplies/drugs available
Week 19: Checklist of interventions

DIGNITY IN CHILDBIRTH: INTERVENTIONS AT FACILITY AND COMMUNITY LEVEL - HESHIMA PROJECT

Charlotte Warren, Lucy Kanya, Timothy Abuya, George Odhiambo, Alice Maranga and Charity Ndwiga

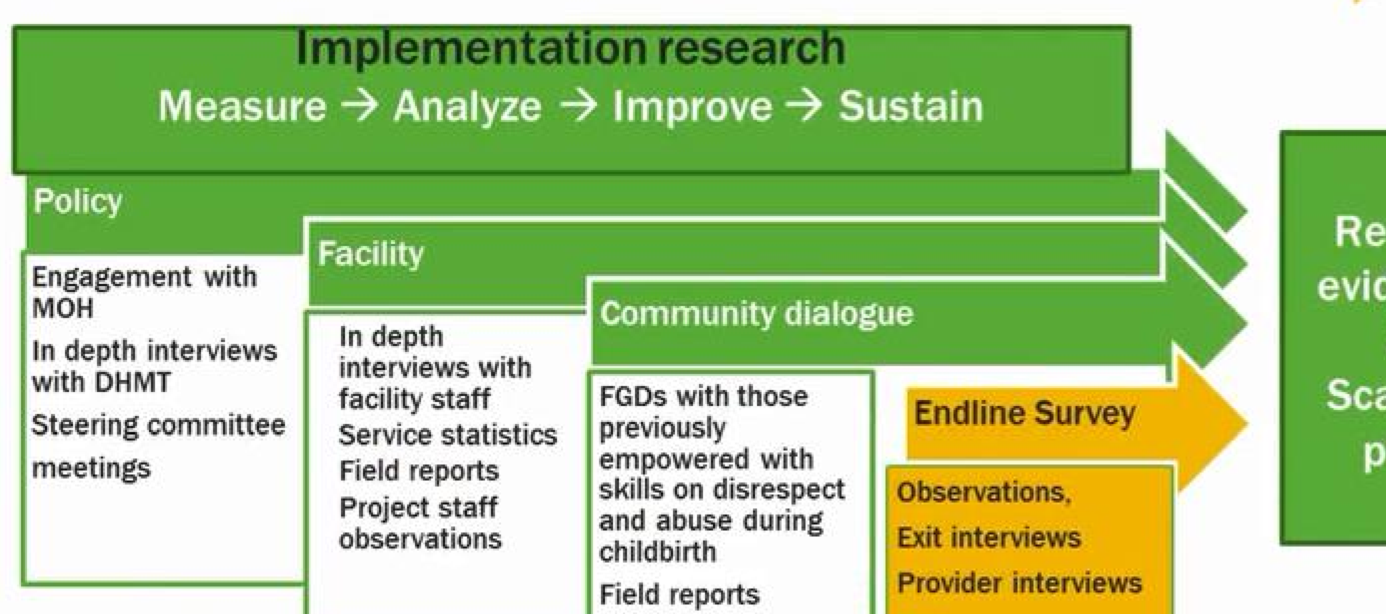
Webinar: Disrespect and Abuse during Childbirth: Emerging Evidence to inform Policy Advocacy

November 12th 2014

Heshima Project

Planning and development

Landscape analysis → Definition of Disrespect and Abuse → Formative Research → Baseline Survey → Stakeholder Engagement → Intervention design



Prevalence of D&A during labour and delivery

Type of D&A	Baseline (n=641) % (n)	End line (n=728) % (n)	OR (95% CI) †	p-value††
Feeling humiliated or disrespected	20.1 (129)	13.2 (96)	0.58 (0.42 – 0.81)	0.004
Physical abuse	4.2 (27)	2.1 (15)	0.47 (0.23 – 0.95)	0.037
Privacy violated	7.4 (47)	5.7 (41)	0.69 (0.42 – 1.11)	0.115
Confidentiality violated¶	3.9 (25)	1.8 (13)	0.45 (0.23 – 0.89)	0.021
Verbal abuse	18.0 (115)	11.3 (82)	0.58 (0.41 – 0.83)	0.006
Detention	8.0 (51)	0.8 (6)	0.09 (0.03 – 0.25)	<0.001
Abandonment	12.7 (81)	16.9 (122)	1.28 (0.91 – 1.82)	0.145

* Missing values < 2%

† Endline vs. baseline; facility as a random effect to account for clustering

†† F test

¶ Facility not included as a random effect

We are all supposed to provide the best medical care

õ . but we are human

õ . circumstances may become difficult

How to be a good health care provider in obstetrics?

- Good basic knowledge
- Practical skills - Experience
- Observation - Preparedness
- Critical appraisal of the literature
- Good communication
- Take into account patient/client preferences

- Be nice !

Evidence based medicine: what it is

- Definition of «evidence-based medicine»:

it is the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients.

- This implies the integration in clinical practice:
  - personal clinical expertise
  - characteristics and preferences of the woman
  - knowledge and critical appraisal of up to date evidence from the literature

EBM: what it is **not**

- An automatic use of guidelines
- A practice guided only by results of randomised trials/meta-analysis without adjustment to the setting/context
- A battle: statistician vs clinician
- A practice without thinking

Example : breech delivery

- The fetus of the woman in front of me is presenting as breech :
  - . at term (38 weeks)
  - . conditions are favourables:
    - ˝ height: 170 cm
    - ˝ pelvis: seems normal
    - ˝ estimated weight: 3000g
    - ˝ etc...
- attempting at vaginal delivery ?
- elective caesarean section ?

Articles

Planned caesarean section versus planned vaginal birth for breech presentation at term: a randomised multicentre trial

*Mary E Hannah, Walter J Hannah, Sheila A Hewson, Ellen D Hodnett, Saroj Saigal, Andrew R Willan, for the Term Breech Trial Collaborative Group**

Summary

Background For 3–4% of pregnancies, the fetus will be in the breech presentation at term. For most of these women, the approach to delivery is controversial. We did a randomised trial to compare a policy of planned caesarean section with a policy of planned vaginal birth for selected breech-presentation pregnancies.

Introduction

About 3–4% of all pregnancies reach term with a fetus in the breech presentation.[1] Data from previously published cohort studies have shown that, in general, planned caesarean section is better than planned vaginal birth for the fetus that presents as a breech at term.[2,3] These studies are potentially biased, however, because women were not allocated to the different modes of delivery at random. Other concerns are that

women assigned planned caesarean section, 941 (90·4%) were delivered by caesarean section. Of the 1042 women assigned planned vaginal birth, 591 (56·7%) delivered vaginally. Perinatal mortality, neonatal mortality, or serious neonatal morbidity was significantly lower for the planned caesarean section group than for the planned vaginal birth group (17 of 1039 [1·6%] *vs* 52 of 1039 [5·0%]; relative risk 0·33 [95% CI 0·19–0·56]; p<0·0001). There were no differences between groups in terms of maternal mortality or serious maternal morbidity (41 of 1041 [3·9%] *vs* 33 of 1042 [3·2%]; 1·24 [0·79–1·95]; p=0·35).

Interpretation Planned caesarean section is better than planned vaginal birth for the term fetus in the breech presentation; serious maternal complications are similar between the groups.

Lancet 2000; **356:** 1375–83
See Commentary page 1368

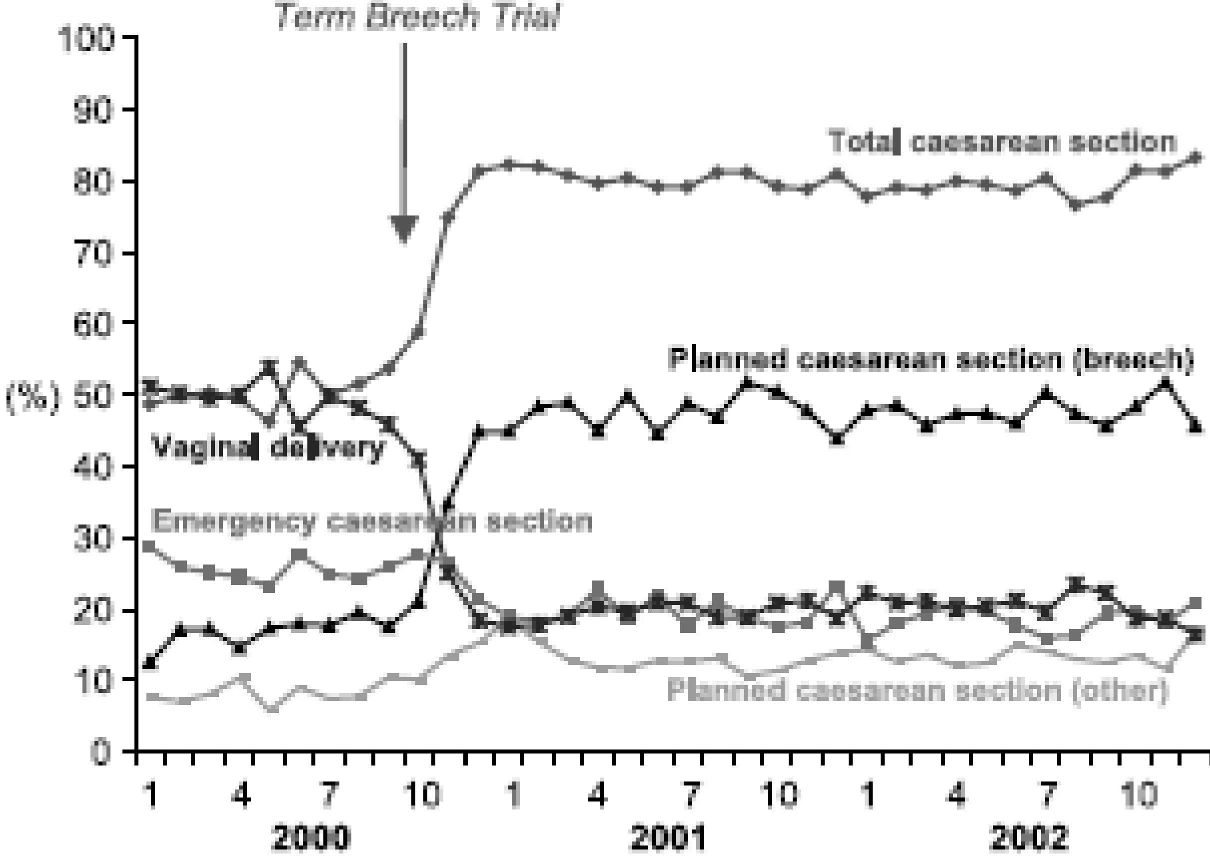


Fig. 2. Percentages of different modes of delivery in women with an infant in breech presentation at term preceding and following the publication of the Term Breech Trial in October 2000.

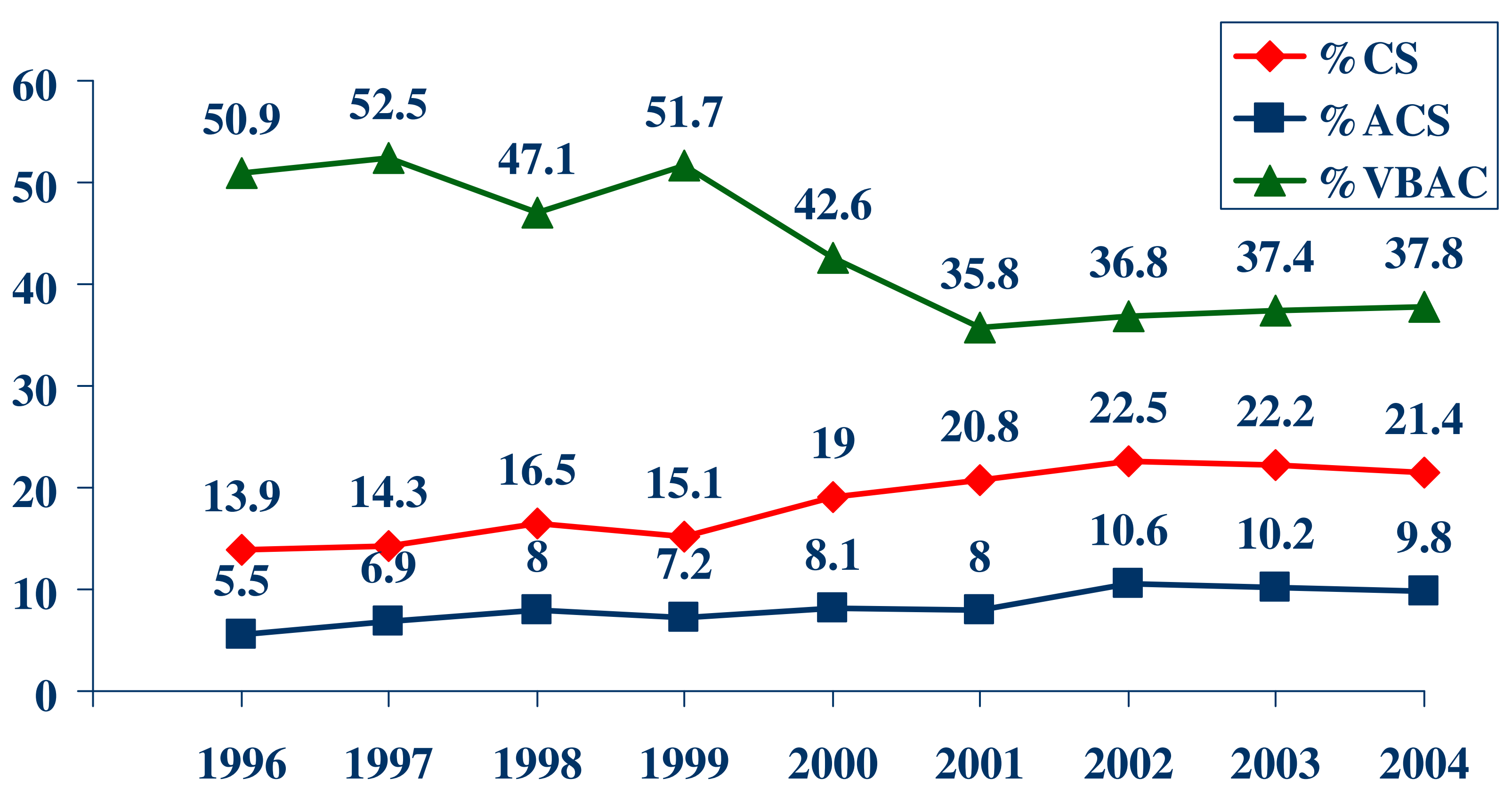
Whatqs next in the decision making process?

- If you tell the woman that delivery is safer by elective caesarean section ?
- If you take into account your experience and ask for her preferences ?
- If you take into account future pregnancies ?

Importance for the future pregnancies

- Risk difference is small for this delivery
- If we do an elective caesarean section for this delivery, then for the next:
  - attempt at VBAC, risk of uterine rupture
  - or a second caesarean section
- Several caesareans increase the risk of:
  - placenta praevia (prematurity)
  - placenta accreta

Effet sur les grossesses suivantes: % d'antécédents de césarienne et % de voie basse après césarienne



Royal College of Obstetricians and Gynaecologists

Setting standards to improve women's health

4.1 What information ***about the baby*** *should be given to women with breech presentation regarding mode of delivery?*

Women should be informed that planned caesarean section carries a reduced perinatal mortality and early neonatal morbidity for babies with a breech presentation at term compared with planned vaginal birth.

Women should be informed that there is no evidence that the long term health of babies with a breech presentation delivered at term is influenced by how the baby is born.

2. *Individualise Management*

While it is true that women with breech presentation at term will most often be delivered by caesarean section, management should be individualised. The term breech trial did not have the statistical power to meaningfully analyse subgroups, some of which are likely to be pregnancies that do extremely well with breech vaginal delivery.

3. *Factors that may favour a planned vaginal delivery*

a. Reduced fetal risk from planned vaginal delivery:

Continuous fetal heart monitoring in antenatal labour is required.

Immediate availability of caesarean facilities if necessary.

Availability of a suitably experienced obstetrician.

Presume favourable fetal circumstances, eg small or average size, no placental insufficiency, frank breech, appropriate gestational age, documented head flexion.

Favourable maternal circumstances, eg adequate pelvis, maternal co-operation with pushing, multiparity.

b. Increased risk from planned caesarean section:

In particular, this would include women planning a large family where a scar on the uterus may have particular serious morbidity in association with placenta praevia accreta in subsequent pregnancies. (Silver et al, 2006).

c. Strong particular maternal preference for vaginal delivery.

Counselling the patient about the risks and benefits of planned vaginal breech delivery should be undertaken wherever possible.

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The Royal Australian
and New Zealand
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What if the situation is more complex ?

- Before term
- Small or big baby
- Clinician with limited experience in breech delivery

> need for a good discussion and shared decision making

And sometimes the situation changes in the processõ .

- We decided to attempt at VD :
  - . CTG is not reassuring
  - . labour progress is poor
  - . there is an indication for induction of labour
  - . õ õ
- We decided to do a caesarean, but :
  - . the woman is admitted in advanced labour
  - . the onset of labour is spontaneous at 37 weeks, then the fetal weight is lesser
  - . õ õ

Conclusion

- It is important to provide high quality counselling to the woman
- It is important to take into account women's characteristics, preferences and the context

- Mais, ce type de discussion est longue, difficile et troublante pour les couples (et les soignants)
- La signature d'un consentement ne remplace pas la discussion et la prise de risque (consentis par les deux parties)

Respect of health care providers by the clients/lawyers

Consequence

- Frequent excuse to perform unnecessary interventions
  - high percentage of CS, inductions, etcõ
  - not necessary, then harmful
- High cost
  - insurance for practitioners
  - compensations go to lawyers rather than really compensate families
  - many tests and interventions

As a general conclusion

- *Be nice with the health personnel and they will be nice with the patients*
- Mutual trust
- Commitment with a goal:
  - deliver the best patient-centered care
  - avoid unnecessary tests/interventions
  - be nice
  - and when things go wrong, explain why it happened