# What to do with the WHO recommendations?

By: Frank Riezebos
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Contact via:
www.**Roon-Rice**.net

This concept paper was written at the request of:

Pisake Lumbiganon, MD, MS (Penn)
Professor of Ob & Gyn
President, The Royal Thai College of Obstetricians and Gynaecologists
Vice President, Asia Oceania Federation of Obstetrics and Gynecology
Convenor, Cochrane Thailand
Director, WHO Collaborating Centre for Research Synthesis in Reproductive Health
Faculty of Medicine, Khon Kaen University, Thailand 40002

# Preface.

**“In the beginning** there was birth!”
My inspiration concerning birth as a topic comes from many people, and I would like to thank a few in random order:
Dr. Pisake Lumbiganon (explaining me about the “comfort zone” of obstetricians), Dr. Ekachai Kovavisarach (pointing out the disadvantages of C-sections), Dr. Tanit Habanananda (referring to changing the status quo as pushing a stone uphill), Nurse Plernpit Promrak (continuously supporting my efforts), Nurse Sirinard Srikanjanapert (who is my inspiration concerning Active Birth (since 2007) and who unfortunately retired as she, like many others, felt it was probably to hard to push the stone uphill), Jon Jandai (for explaining the setting and the problems surrounding Mae&Dek hospitals and over medicalization of birth in general), Nurse Maneerat Pattarajinda (for her support and guidance), Larissa Barnett (British High Commission, Singapore: pointing out how insurance companies and caregivers join hands in an effort to take away ownership of the birth process from the pregnant woman), Annegien Verschoore de la Houssaye (for pointing out how PTSD can be directly related to a traumatic birth experience).

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# Introduction.

**Birth is Natural.** Presently, a growing number of birth practitioners believe that birth will have the best outcome if intervention is kept to a minimum. Freedom to move around during the birth process as well as the freedom to choose the position a pregnant woman is most comfortable with will also have a positive effect. A home like environment where the pregnant women is surrounded by loved ones and people she knows will increase her comfort. These factors combined will enhance the chances that birth is a positive experience to the pregnant woman.

**Medical intervention** combined with a caregiver’s approach is believed to disturb the natural process of giving birth and slowing it down, making it less efficient and increase the risk of complications, including the need for C-section. The “fear-tension-pain triangle” with known negative effects on the birth process can easily be activated if all involved in caregiving and support are unknown to the pregnant woman, and if she is unaware of how things will be done once in the LR and if a home-like environment is not recreated.
If the pregnant woman is given the choice, she will choose her own position at each moment in the birth process, including frequent vertical positions using gravity as an asset. In this position the gravity force of the fetus will enhance

dilation and will reduce the risk of supine hypotensive syndrome. In Asia the force of gravity of the fetus only (μ effectus gravitates) is estimated to be between 29 and 32 N.
Since birth is neither an illness nor a disease, a home-like environment is more suitable then a hospital-like environment. A hospital-like environment (strong lights, surrounded by sick or injured patients, high bureaucracy, stressed caregivers, strong disinfectant odors, crowded areas) can have a slowing down effect on the birth process and can turn a low-risk pregnancy into a high-risk pregnancy. In a home-like environment (that can very well be recreated in the hospitals, in the LR or in a pre-LR setting) the pregnant women would ideally be completely free to take all the time she wants/needs to concentrate on her work (i.e. labor): the act of giving birth. Interference (for example to sign papers of consent during contractions, or by inducing labor (Pitocin in IV to "speed things up") is thought to have a negative effect on the birth process and to provoke unnecessary pain.
For the woman, the act of giving birth can be an empowering experience, in which case her recovery will be speedy, her relationship with the newborn will be strong and there is no resentment of having more children in the future. This can have a positive effect on the relationship with her spouse. If birth however turns out to be a traumatic experience, the effect may be long lasting (Post Traumatic Stress Disorder) and have a negative impact on the bond with the child, and possibly spouse. The desire for a next pregnancy might be absent, and she may point at her husband and/or child as the guilty party for the trauma.

In case of a high-risk pregnancies the goal changes from "accompanying a birth process" to "saving lives": It is clear that for high risk pregnancies other standards may apply.

**The partner** that has been involved in the birth process of his wife (ANC participation, presence during the birth process) is believed to be more supportive of his wife after birth, understanding better what she went through during delivery, and will be more supportive of the family nucleus in the long term as a result of this. As the family nucleus is the primary fabric of which society is made of, the way birth is dealt with will also deeply impact the society as a whole.

**King Louis 14** of France (1643-1715) is believed to have transformed the position in which birth was given. The position has always been vertical for as long as we can look back [2]. but King Louis 14 changed it from vertical to horizontal (supine). He enjoyed to watch the birth of his children, be it from his wife or one of his mistresses) and had a better view if the women were lying flat on a table. Mortality rates of King Louis' children are thought to be around 60% . As he had over 30 mistresses, it could be that high mortality rates were not his primary concern.

**The supine position** (used by Louis 14 and later adopted by hospitals) became the standard for centuries. However, some 50 years ago, the opinion in the West started to change. Janet Balaskas (UK), who was a pioneer concerning this change, wrote a book (1983) about Active Birth. This was a way of giving birth

where women are free to choose the position, and where the husband/partner is present and supportive during the whole birth process. Later, terms like Gentle Birth and Positive Pregnancy were also introduced. The supine position in all these views is believed to be counter-productive and complicating birth unnecessarily, but also many other practices presently still common in many LR's around the World. Many C-sections are a result of complications during deliveries. Evidence points to the fact that C-sections tend to enhance chronic diseases (Children delivered by cesarean delivery had significantly increased risk of asthma, systemic connective tissue disorders, juvenile arthritis, inflammatory bowel disease, immune deficiencies, and leukemia [1]) and increase the risk of ASD. Moving away from the supine position may very well be instrumental in significantly reducing C-sections. This may however imply that caregivers will have to give up some space in their comfort zone.

# World Health Organization.

**The World Health Organization** produces regular reports on Health issues including topics related to birth. In these reports, recent research findings are included. The recommendations in these reports are based on up to date evidence. However, the recommendations are for the World, and therefore do not necessarily apply to a specific country. The country of focus in this paper is Thailand. Possibly, Laos and Cambodia that share languages with a part of the Thai population could be included, making it more a regional study.

The following reports by the WHO about childbirth are considered relevant in the case of Thailand (and possibly Laos and Cambodia).

2018: WHO recommendations: intrapartum care for a positive childbirth experience.
Presently, childbirth in the World is not considered to be a positive childbirth experience by the WHO, justifying the need for this report. Implementing these recommendations could very well transform childbirth to become a positive experience.

2018: WHO recommendations: non-clinical interventions to reduce unnecessary caesarean sections.
The number of C-sections is above 40% in Thailand, and very much on the rise in countries surrounding it. More information to pregnant women on the pro's en con's of C-sections, as well as respecting recommendations could reduce C-sections to a minimum.

The WHO also points out to a specific situation regarding HIV: Elective C-section should not be routinely recommended to women living with HIV.

# Implementation?

**Recommendations** could be implemented…or not. This depends on many things: the value a nation gives to the WHO findings and studies, the ability of a nation to implement changes, the different parties involved and how they work together, priorities, etc. The first question should be: Why should WHO recommendations be implemented? The next question then could be: How should the WHO recommendations be implemented?

**Why** recommendations should be implemented is a decision following a national debate. This will be different for every country. Factors influencing this decision may be: Declining birth rates, high level of chronic diseases, high cost of healthcare, etc.

**How to** implement the WHO recommendations:

There are many approaches to be considered but the writer of this paper (who would offer to be a facilitator) would like to suggest the following actions:

Define the participants to be involved where both birth practitioners and postpartum women would be equally represented as participants. Have a baseline established by participants comparing the 2018 WHO recommendations with the current practices. Participants will draft this baseline, but facilitators will ensure that all participants have a voice.

Do this exercise for 2 groups:

1. Postpartum women
2. Birth practitioners (nurses / obstetricians / others)

The output of such an exercise would divide the present birth practices in 2 groups and 2 lists can be made:

List A: Birth related practices that are recommended by the WHO but that are presently not in place.

List B: Birth related practices that are not recommended by the WHO but currently do occur.

In list A, and list B, a priority order as well as a feasibility order should be established by participants. Some things are seen as more important then others, and some practices may not be changeable, for various reasons.

This will indicate what to implement and what to de-implement.

**The first group, the postpartum women**, would be interviewed in focus groups concerning their experiences and the care they received during birth. The

interviews would take place in a village environment and not in hospitals. A random selection of lists of postpartum women could be taken from lists provided by the city hall (or Tesaban) of women that gave birth recently. This seems to be a better way of getting names and data then getting this information from hospitals, that may tend to filter out problem cases, and may be biased. Also, geographic locations could in this way be grouped in order to make interviews more efficient. In the second part of the interview these women would be asked to give scores on the urgency or importance of change.

**The second group, the birth practitioners**, would meet in workshops where they can review the recommendations and identify those not in place but recommended and those in place but not recommended. This would be done in various hospitals around the country in Thailand, and in various countries if this were to become a Thai/Lao/Cambodia implementation effort. (The sharing, comparing, learning and exchanging between countries could have enhancing effect)

The recommendations (or a selection of these recommendations depending on feasibility, acceptance and readiness of implementation) to implement or de-implement will be made by the project team, the chief obstetricians, the chief nurses and postpartum women representatives. An action plan will be specifically defined for each selected recommendation.

This action will be implemented 2 ways, namely to the birth practitioners, but also to women who intend to become pregnant, or are pregnant already.

**To the birth practitioners**: The action plan can result in workshops, in information leaflets, in review of government policies, hospital policies in various sections (A/N, LR, P/N). A strategy could be developed with the assistance of facilitators. In certain cases implementation could also mean the reversal of certain policies: For example, at some point in time in Thailand it was decided that birth delivery should not take place in the famous "mother & child" hospitals any more. This has been regarded by many caregivers, but also many mothers who have given birth there, as a step back in time.

**To the women** who intend to become pregnant or who are pregnant already: The implementation will be informative but also empowering. The choice of concrete actions will depend on budget and will make use of strategic information diffusion theories, where it would only be fair for both budgets (the one for birth practitioners and the one for women) to be equal. There would be a significant effort to explain the birth process in more detail (including at schools) by translating existing youtube presentations (presently in English mostly) in relevant languages (Thai, Lao, Khmer, Puthai, So, and other national languages or dialects), by making new youtube presentations and by making them fun to watch en entertaining.

**The facilitators** will ensure that the implementation of the action plans will take innovative and up to date approaches resulting in maximum impact. The details

on how the facilitators would propose to operate reaches beyond the scope of this concept paper, but have already been worked out to some extent.

**Conclusion**: What to do with the WHO recommendations is a matter of national debate. The first question should be: **why** implement the WHO recommendations? The second question could be: **how to implement** the WHO recommendations? How to implement would be done by first setting up a list of birth practices that need implementation, and a second list of birth practices that would need to be de-implemented. If implementation efforts are honest and effective, using up to date media with also pregnant women empowering as a goal, the effect could be considerable:
1. Reduction in non-elective C-sections.
2. Reduction in complications during childbirth that do not require C-sections.
3. Reduction in elective C-sections (by informing woman correctly about the health risks for them and their child).
4. Reduction in PDSD cases by reducing traumatic birth experiences.
5. An increase in birth-rates.
6. Reduction in health cost believed to be in the order of X,XXX million Baht (facilitator's estimation that would require a relatively simple cost-benefit analysis to be confirmed).

**About the author:** Frank Riezebos (55 yrs), MSc. Development Sociology 1992, Wageningen University & Research, Wageningen, The Netherlands.
Some 30 years experience in Thailand (mostly Isarn), fluent in languages Thai, Lao, French, Dutch, English, Portuguese. Presently working with the ROON & RICE NGI (www.Roon-Rice.net), living part time in Thailand and part time in The Netherlands / Portugal.

**Contact via:** www.**Roon-Rice.**net

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