Health and care in pregnancy and beyond: putting women centre stage

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Global Health Histories
World Health Organisation
March 2011
• ‘the health, nutrition and life style of women and the quality of care during pregnancy and delivery establish a foundation of physical health and intellectual and social development for the next generation.’

World Health Organisation
Report of the Director General, March 1992
Health and care in pregnancy and beyond: putting women centre stage

• Background - key challenges
• Historical perspectives on care
• Lessons from history
• Balancing perspectives
Health and care in pregnancy and beyond: putting women centre stage

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Health and care in pregnancy

Key challenges 1

• All women need appropriate care in pregnancy and childbirth - not just those assessed as most at risk
• International attention focussed on preventing mortality - pregnancy care critically important for those who survive
• Women most in need least likely to access
• Care in pregnancy often divorced from other aspects
• Different professions, agencies have different perspectives
Health and care in pregnancy

Key challenges 2

- Predominant clinical focus, yet public health, education, preparation for birth, breastfeeding, parenthood essential
- Interventions that are essential for a few applied widely
- Evidence base lacking on what caregivers should actually do
- Gap between what is known and what actually happens
- Women not often involved in planning care they receive
Focus

• Draw mostly on UK/developed country perspectives, with implications for global perspectives, lessons for all settings
Range of settings

- Settings differ in range of dimensions, eg
  - High income vs low income
  - Equity vs inequity in income, access to care
  - Medicalised/highly interventive approach vs physiological/collaborative care
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Range of settings

- Women’s status varies widely – as does the status of those who care for them, especially if women themselves.
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Historical perspectives

pre-20th century

• Women cared for by other women, traditional midwives
  – Not necessarily respected, even seen as witches
  – Examples of excellent practice: Catherina Schrader
    • Memoirs of the Frisian Midwife Catharina Schrader, 1693-1740. (Marland H 1987) Roldopi, Amsterdam

• No systematic body of knowledge, no professional body

• Many customs and practices, eg
  – domestic customs, abdominal massage, bloodletting

• Still the situation in some countries

Historical perspectives
18th-19th century

- Increasing medical discourse 18th and 19th century, eg
  - Alexander Hamilton, Professor of Midwifery, University of Edinburgh, 1871:
    - 'Women when pregnant should lead a regular and temperate life carefully avoiding whatever is observed to disagree with the stomach; they should breathe free open air....their exercise should be moderate....'
  - Dr James Blondel, 1727
    - 'The child may receive some hurt by means of its mother....the prosperity of the fetus does depend on the welfare of the mother.....the child may also suffer by the affections of the mother’s mind..'
Historical perspectives
late 19th century

• Most care at home by midwives
  – Cost a few shillings to a few guineas

• Increasing use of physician-accoucheur at home
  – Cost from a few guineas to 100+ guineas

• Lying-in hospitals: charities for ill/poor women: mid 18th century onwards
  – Catastrophic mortality rates – sepsis
  – Semelweiss 1861

• 1890s: beginnings of ‘antenatal care’
  – French ‘receiving institutions’ to help ‘abandoned women’
Historical perspectives
early 20th century

• Boer War revealed ill health of young men
• Basic causes attributed to poor feeding in infancy and childhood
• Underlying cause identified as maternal ignorance and inadequate care
• Focussed state attention on health to make up for deficit
• Medical profession key to securing physical health of the nation
  – development of obstetrics
• Profession of midwifery regulated from 1902 (UK)
Historical perspectives
1900-1920s

- Educating women: seen as key strategy
  - Artificial feeding - more ‘scientific and accurate’
  - Classes in infant care, housewifery
  - Midwives need to be educated too (by medical men)

- Dr Ballantyne, University of Edinburgh
  - Assumed problems could be prevented, treated by scientific-technical advances
  - Not for women’s benefit, but for the fetus/child

- 1918: England - local authority antenatal clinics for ‘medical supervision’; similar developments in other countries: Australia, US
Historical perspectives
1915-1930s

• Counting deaths
  – 1917: Medical Research Committee
    • '52% infant deaths avoidable'
  – 1924: Maternal Mortality Report (Campbell)
    • Described maternal deaths: ‘burden of avoidable suffering’

• Institutionalised antenatal care seen as key solution

• Women’s groups saw it as a women’s cause
  – Even though pregnant women portrayed as deficient, neglectful

• Antenatal care as solution but no evidence for what it should comprise (it included X-ray pelvimetry by 1930s)
Historical perspectives
Maternal health and mortality

• No obvious impact of medicalised antenatal care on outcomes
  – eg eclampsia, sepsis
• Paradoxical increase in complications in women having most care in this system
• Little apparent improvement until mid-1930s
TRENDS IN MATERNAL MORTALITY OVER SEVENTY YEARS
1926-1996 Scotland

Maternal deaths per 100,000 live births

Source: From Registrar General Reports for Scotland
Professor Wendy Graham, University of Aberdeen
**Historical perspectives**

**Maternal health and mortality**

- Associated with rise in economic conditions, improved nutrition, free midwifery care
- Growing awareness of impact of socio-economic inequalities
- **Cause and effect dilemma** – what impact did formal antenatal care have?
  - did women come for care because they were better educated, nourished, housed, care easier to access?
  - or did care actually make a difference?
  - if so, what was making the difference?
Historical perspectives
Maternal health and mortality: 1930s onwards

- Growing scepticism about benefits of antenatal care
  - ‘We are now faced with the fact, if we take maternal mortality as a test, that antenatal care has not done what we were told it could do…it is no good concentrating on antenatal care unless we give attention to other matters. In our zeal….let us not forget the mother’ Lancet 1934
  - We unhesitatingly accept that..antenatal care is a means of reducing perinatal and neonatal mortality, although what exactly it consists of and how it works has been less clear to us’ Report of Social Services Committee 1980

- But ‘speaking against the advancing tide’
Historical perspectives
Embedded interventions: 1950s-1980s

- Attention turned from maternal health to perinatal mortality and morbidity
- Interventions developing fast, (some) improving
  - technology enabled visualisation of the fetus: fetal medicine developed
  - antibiotics, blood transfusion, elective delivery techniques, screening techniques

- But a 'growing tendency to apply to all women measures which are of unquestionable benefit to only a minority'
Historical perspectives
Fragmentation: 1950s-1980s

• Between disciplines
  – Obstetrics, paediatrics, general practice, midwifery, health visiting....

• Between stages of the childbearing cycle
  – Pregnancy, labour and birth, postnatal, infancy, feeding

• Between hospital and community

• Between programmes
  – Maternal, infant, public health, nutrition, family planning, immunisation.....
Historical perspectives
Embedded interventions: 1950s-1970s

- Routine antenatal care and birth in hospital
  - Large clinics, long waiting times, duplication of care by midwives and doctors
- Routine antenatal education
  - Large antenatal classes, teaching by rote
- Routine interventions embedded
  - Frequent vaginal exams in pregnancy and labour
  - Bed rest in pregnancy
  - Induction of labour
  - Enemas, pubic shaves
  - Restriction of movement
  - Restriction of food and fluids
  - Pharmacological pain relief
  - Episiotomy
  - Separation of mothers and babies
  - Routine artificial feeding, breastfeeding measured and timed

- 1979: Cochrane awarded obstetrics the ‘wooden spoon’
Global impact of maternity care practices
19th-20th century

• Colonialism, benevolence, missionary work
  – Doctors and midwives from developed countries worked internationally
  – Hierarchical - army, medical model - doctors know best
  – Exported attitudes and routine practices across the world
    • Myles textbook in over 50 languages

• International aid agencies scaled up these practices and attitudes (WHO formed 1948)
• Longstanding impact - consequences mixed, depending on setting
Historical perspectives
Womens’, midwives’ voices raised: 1970s-1990s

- **UK, Australia, some western European countries**
  - reaction by midwives and women’s groups

- **US: very few midwives, lack of coordinated women’s groups, medically-led health care system - medicalised care increased, despite**
  - evidence of importance of support
    - eg Klaus and Kennell 1984
    - midwifery care tackling maternal mortality in low income areas
      - Breckenridge. Frontier Midwifery Service, Kentucky

- **Resulted in substantive differences in perspectives between US and countries with midwifery**
  - and the countries and agencies they influenced
Historical perspectives

Contribution of research: 1970s-90s

- Research predominantly biomedical, focus on fetus, clinical outcomes; technology driven
- Studies started to challenge routine practices, demonstrated many ineffective, harmful
- RCTs of routine interventions, eg
  - EFM, episiotomy, schedule of visits, midwifery-led care
- Most of which demonstrated that avoiding routine interventions, physiological, collaborative approach improved outcomes
- Systematic reviews, Cochrane Collaboration, EBM
- Surveys and qualitative studies of women’s views and experiences
  - Oakley, Graham, Kitzinger, Garcia, Green, Lumley
Historical perspectives
Midwives in research: 1970s-90s

- Midwives conducting and collaborating in research
- Strong developments in UK, Scandinavia, US - took time for other countries to start to develop research capacity
- Broadened the range of research questions asked
- Started to have an impact: practice and policy
- Struggle to be recognised as academic equals, find funding support, support for capacity building
Historical perspectives
Project-based implementation: 1970s-90s

- Improving access, reducing maternal mortality, adverse outcomes, interventions and improving maternal satisfaction
  - community-based care in low-income communities
    - Sighthill Maternity Team. 1982. Scottish Med 185-189
  - midwifery service in low-income communities
Project-based implementation - current

- **Rwanda**: local midwifery care - educated, supported by Edge Hill University, UK
  - impact on maternal mortality

- **China**: research collaboration with clinical midwives, increasing normal birth, women supporting women, midwifery training
  - Prof Feng Cheung, Hangzhou Normal University
    - supported by University of Edinburgh, UCLAN
Historical perspectives
Shifting policy, UK: 1980s onwards

- Combination of research evidence, advocacy by women’s groups, midwives, and others resulted in policy shift to woman-centred care, midwife-led care
- Women’s views seen as key
- Minimising interventions, continuity of care, reaching vulnerable groups

- But not welcomed by all – ongoing division of opinion and approach
- Implementation inconsistent, ineffective
Historical perspectives
Ongoing medicalisation of pregnancy and birth up to present day

- Continuation of institutionalised, one-size-fits all antenatal care – resistant to research evidence and policy directions
- Rapid development of screening tests
- Spiralling intervention rates
  - caesarean section rates
    - Brazil 35% to >80%
    - China circa 50%
    - US >30%
  - episiotomy, restrictive practices

- Loss of clinical skills in normal birth
Historical perspectives
Evidence base incomplete: women’s health missing up to present day

• Systematic review of interventions aimed to improve maternal nutritional intake

• Women from disadvantaged groups from developed countries
  • D’Souza, Renfrew, McCormick 2006
    http://www.nice.org.uk/nicemedia/pdf/food_summary_v4_FINAL.pdf

• None of the studies measured outcomes in subsequent pregnancies, maternal health outcomes after the end of participation, or women’s own wellbeing, particularly tiredness, exhaustion, mental health
### Historical perspectives

Evidence base incomplete: women’s health missing

<table>
<thead>
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<th>Studies of HIV/AIDS, infant feeding and health</th>
<th>Feeding patterns reported</th>
<th>Infant health and wellbeing reported</th>
<th>Maternal health and wellbeing reported</th>
<th>Breast health, breastfeeding problems reported</th>
<th>Total studies</th>
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<td>Co-morbidity</td>
<td>Mortality</td>
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Historical perspectives
Evidence base incomplete - one size does not fit all up to present day

- Interventions work differently for different population groups
  - women with complex obstetric problems, illness, HIV/AIDS
  - young, poor, homeless, marginalised
  - needs specific studies, inequalities lens, culturally appropriate care

- Historical and cultural differences between studies, settings, health systems, make findings hard to generalise - information on these very limited
Historical perspectives
Key positive developments: 1980s onwards

- Improved medical procedures, interventions
- Women-centred care that respects physiology, normality: strengthening midwifery
- *Growing awareness of socio-economic inequality*
  - tackling the structural determinants, lifecycle approach
- Public health approaches
  - improving nutrition, smoking cessation, tackling domestic violence
- Human rights-based approaches
  - non-discrimination, focus on vulnerable groups, women’s empowerment, right to life, accountability
- Community-based approaches
  - based in women’s own localities, social and cultural norms; engaging families, community leaders in solving problems
- Partnerships between national and international agencies, NGOs
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Lessons from history 1
Remove ineffective or harmful developments

• Over-medicalisation
• Fragmentation of care and programmes between disciplines, across childbearing cycle
• Reliance on technology and institutional, one-size-fits all care
• Losing focus on women's own abilities; disempowering women

• Care with taking models of care, interventions, to scale
Medicalised antenatal care

• Institutionalised, hierarchical organisation
• Focus only on clinical outcomes
• Woman separated from context - family, community
• One size fits all
  – routine practices
  – hospital-based
• Education
  – clinical aspects
  – preparation for birth
  – class teaching
• Benevolence rather than rights
Collaborative, normality focussed, more effective

• Respects her autonomy, rights
• Respects normality, physiology
• Good quality care when needed
• Tailored to her needs
• Based in her own community
• Caregivers she knows and trusts
  – support, reassurance, praise
• Who understand diverse needs
• Information and education about
  – birth, feeding, parenthood
  – her own health and wellbeing
• Not interfering with her own support networks
Lessons from history 2
Broaden the research lens

• Collaborative, multidisciplinary studies - capacity building needed

• Range of research approaches

• Full range of relevant outcomes

• Incorporate women’s views

• Inequalities lens
Broaden the research lens
Add midwives to the research endeavour

• Research development strengthens midwifery practice and maternity policy
  • UK, US, African Midwives Research Network
  • ICM Research Standing Committee

• Ongoing struggle to be recognised as academic equals

• Strengthening midwifery programmes – national, international, to include capacity building for research
Lessons from history 3
Foster collaborative developments

• Focus on implementing evidence-based policy

• Across all disciplines, communities, programmes

• Integrate programmes to avoid fragmentation, make it easier for women, improve cost-effectiveness
Lessons from history 4
Tackle the power imbalance

• Whether related to gender, discipline, country, size of programme budget

• Avoid distortion of part of the picture
Medical procedures, interventions

- Community-based approaches
- Cross-sectoral partnerships, alliances
- Human rights based approaches
- Public health approaches
- Women-centred care that respects normality, physiology
- Tackling socio-economic inequality
Lessons from history 5
Keep women centre stage

• Litmus test, key principle – are women’s needs and rights core to planning and service delivery?
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Medical procedures, interventions

Women-centred care that respects normality, physiology
Medical procedures, interventions

Women-centred care that respects normality, physiology

Tackling socio-economic inequality
Balancing perspectives

- Research
- Programme planning – global, regional, national
- Service delivery
- Health worker education
Putting women centre stage?
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March 8th – International Women’s Day
100 year anniversary

White Ribbon Alliance
Atlas of Birth

www.whiteribbonalliance.org
Mother and Infant Research Unit

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