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Towards women-centered care in Slovenia

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Global evolution of maternity care

Before two hundred years ago all birth care was humanized as it was attended by midwives, kept the birthing woman in the center and, in general, respected nature and culture.

After second world war came the technological age. If we can put a man on the moon, surely we can have perfect childbirth. Childbirth was moved to the hospital with doctors and machines and drugs. Doctors were in the center and in control, midwives were marginalized, there was no role for the woman or her family – medicalized birth.

The 1980s & 1990s saw a reaction against this medicalized birth and the beginning of a move to humanized birth. Humanized birth means putting the woman giving birth to the center and in control so that she and not the doctors or anyone else makes all the decisions about what will happen. Humanized birth means understanding that the focus of the maternity services which are based on good scientific evidence including evidence based use of technology and drugs.

The past fifteen years has seen a struggle between the medicalized and humanized approaches to maternity care which has become intense and global. Today there are three kinds of maternity care: the highly medicalized, »high tech«, doctor centered, midwife marginalized care found, for example, in the USA, Ireland, Russian, Slovenia, Poland, Czech Republic, France, Belgium, urban Brazil; the humanized approach with strong, more autonomous midwives and much lower intervention rates found, for example, in the Netherlands, New Zealand and the Scandinavian countries; a mixture of both approaches found, for example, in Britain, Canada, Germany, Japan, Australia.

Evolution of maternity care in Slovenia

Slovenia completely medicalized birth as it happened in lots of countries in Europe, and especially countries from the East Europe which were much under the influence of the former Soviet Union. There was no movement to humanize childbirth in Slovenia until late eighties although some changes happened even before that. Since then in Slovenia some gynecologists and other physicians, midwives, public health specialist, social scientist and interested women have worked to begin the process of demedicalizing and humanizing childbirth.

As part of the effort to humanize birth in Slovenia, a survey of hospital birth practices was developed, project "Maternity Hospitals for Today", and we already have data from it. Results of the survey show that slowly progress is being made to humanize birth. The most progress has been made in the social and educational aspect of childbirth – for example including a family member at the birth, keeping the baby with the mother after the birth, etc.

But the doctors still assist at births, control midwives and the midwives are still marginalized and as yet there are no out-of-hospital birth centers. In 1990 there were three free standing in Germany and now there are over 100 and many midwives have left the hospital and are attending births in birth centers or at home. Many doctors in Slovenia still believe home birth is dangerous in spite of excellent research which proves conclusively that planned home birth is absolutely safe for low-risk women.[1] In Slovenia, medicalized birth in hospitals still results in a big gap between the excessive use of dangerous, invasive procedures and what the scientific evidence says should be used. (see table 1)

[1] K. Johnson and B. Daviss, "A Prospective Study of Planned Home Births by Certified Professional Midwives in North America," *British Medical Journal* 330, no. 7505 (2005): 1416.

Table 1: Is maternity care in Slovenia based on good scientific evidence?

Procedure	Practice*	Evidence
Prenatal care only by midwives	**almost never**	**always**
Low risk birth with midwife only	**almost never**	**always**
Same midwife for pregnancy & birth	**never**	**always**
Continuous care same midwife at birth	**almost never**	**always**
Companion present during labor	**88 %**	**always**
Companion must have cetificate	**sometimes**	**never**
Companion must pay extra	**sometimes**	**never**
Enema on admission	**72 %**	**never**
Pubic shaving on admission	**87 %**	**never**
Routine continuous CTG	**67 %**	**never**
Lithotomy position, first stage	**80 %**	**never**
Lithotomy position, second stage	**79 %**	**never**
Routine withhold fluids	**58 %**	**never**
Routine withhold food	**always**	**never**
Routine intravenous catheter	**70 %**	**never**
Spontaneous labor & birth, no drugs	**31 %**	**> 90 %**
Induction of labor with drugs	**30 %**	**< 10 %**
Augmentation of labor with drugs	**43 %**	**< 10 %**
epidural block	**6.6 %**	**< 10 %**
vakuum extraction	**4 %**	**< 10 %**
forceps delivery	**0.4 %**	**< 10 %**
episiotomy	**54 %**	**< 10 %**
fundal pressure, second stage	**60 %**	**never**
cesarean section	**13,7%**	**10 – 15 %**
rooming in (24 h)	**72 %**	**always**
baby friendy hospitals	**86 %**	**100 %**

Prenatal care for low-risk women (with no serious medical problems) should always be only with midwives but is almost always the doctor who is taking care. Prenatal care for low-risk women (no serious medical problems) should always be only with midwives but is almost always with doctors. Low risk births (80-90% of all births) should be attended only by midwives but it is almost always doctor who is in control over the birth and gives orders to the midwife. This is distressing, since many studies have shown that one-on-one, continuous care by the same person throughout labor means a shorter labor, less pain, fewer complications, and better safety for mother and baby.[2] A companion should always be permitted to be present without need for certification not payment. We even know of some hospitals where there more than one companion is not allowed. This is against the best evidence which support the presence of the partner of the women and the doula at the same time, per example. There should be a continuous care from the same midwife during pregnancy and throughout the labor and birth and in the post-partum period, too.

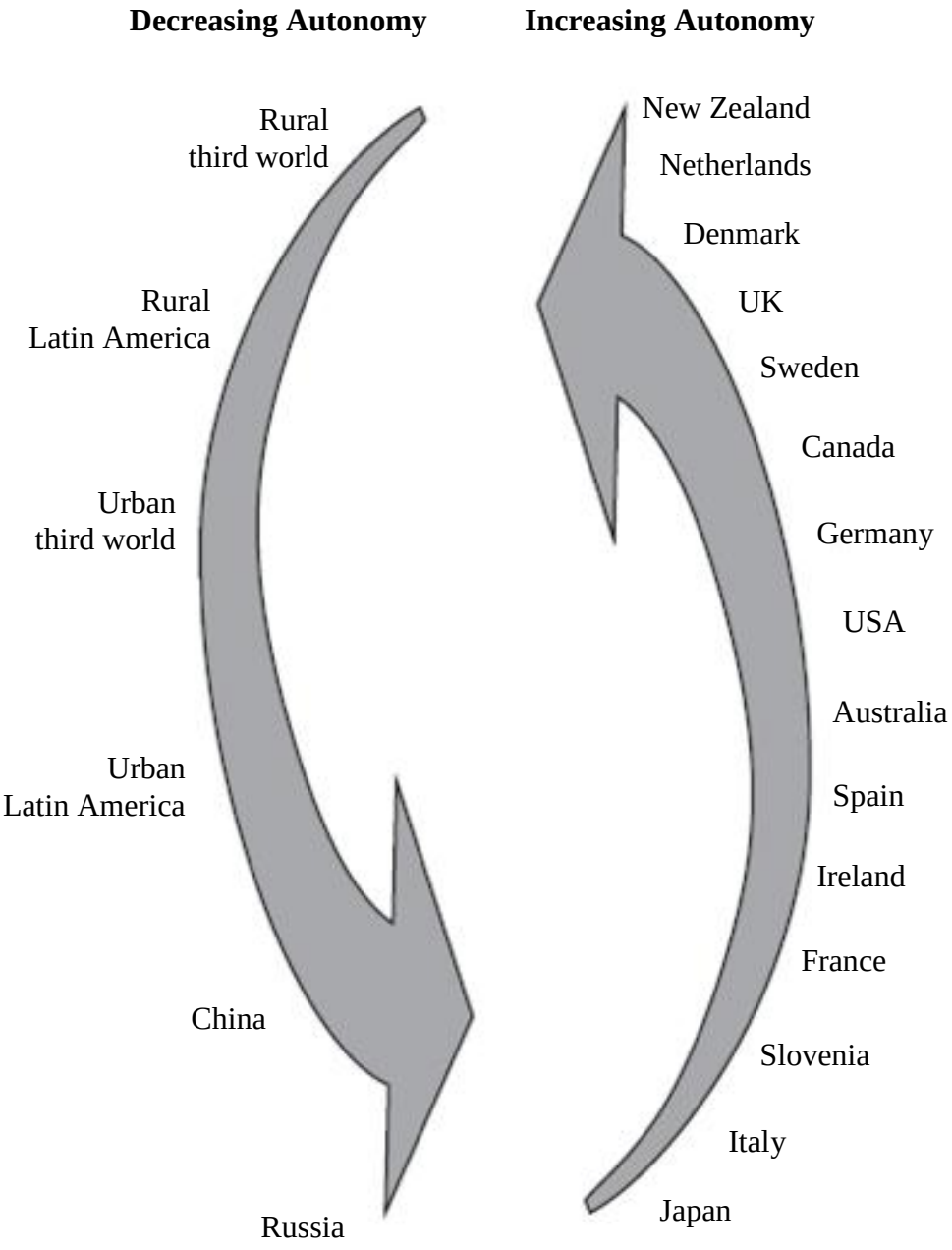
There should never be enema or pubic shaving or withholding of fluids or food nor routine intravenous catheter nor routine CTG during labor. Lithotomy position (flat on back) should not be used during first nor second stage of labor. Uterine stimulant drugs to induce or augment labor should never be used in over 10% of cases – the very high rate of using such drugs (70%) may be a cause for the apparent increasing rate of maternal deaths in Slovenia. Episiotomy is necessary, according to the scientific evidence, in at most 10% of cases but, according to the survey, is used in 54% of births – this is genital mutilation of thousands of women in Slovenia. Fundal pressure during the second stage should never be used and yet is used in 60% of births – this is abuse of Slovenian women and their babies. Research show that if the births are attended by midwives, there is much less such unnecessary use of procedures.

How to make progress

It helps to view changes in maternity care from a global and historical perspective, paying particular attention to how services tend to improve or evolve. In the chart "Global evolution of birthing practices" I've focused on the autonomy of birthing women and midwives because I see that as the key variable for determining where a country or region is in the evolutionary process. In countries at the top of the chart, women and midwives have a high degree of autonomy; in countries at the bottom, they have little or no autonomy. The chart illustrates where countries lie at this time. I've put them in these positions based on the knowledge of their maternity care systems I've gleaned from personal visits as well as from published reports, World Health Organization reports in particular. Of course the placement is a bit arbitrary – the evolution of maternity care is by no means static and one might argue that the Netherlands should be higher on the chart than New Zealand, for example – but the overall pattern is certainly valid.

[2] Enkin, M. et al. *A Guide to Effective Care in Pregnancy and Childbirth*, Oxford University Press, New York 2000, pp. 247-254.

Table 2: Global evolution of birthing practices



Until around three hundred years ago, all countries in the world were at the top of the circle, with almost all birthing women having control over their own childbirth. Midwives were autonomous care providers who assisted women during childbirth. Essentially, the woman and midwife worked together without outside interference because of the nearly universal cultural taboo against men getting involved in women's reproductive activities. Just as in the past menstruating women had been isolated, birthing women were isolated with no men allowed nearby.

With the gradual introduction of men and "barber-surgeons" (precursors of today's medical surgeons) into maternity care, both birthing women and today's medical surgeons) into maternity care, both birthing women and midwives gradually lost their autonomy in childbirth, and as childbirth became less woman-centered, countries slowly moved down the left side of the cycle. Their urban areas are "modernizing" maternity care by bringing in obstetricians and hospitals, while the women in rural areas still use indigenous midwives.

Eventually, a country reaches the bottom of the circle, where the global goal of "development" has penetrated and the government and the population are eager to be "modern" China, Russia, and much of Latin America serve as examples here. Birthing women in these countries are no longer allowed to decide what happens during their pregnancy and birth, and midwives are nothing more than slaves to doctors.

Then something happens in the countries at the bottom of the chart. It varies from country to country, but whatever it is, when things get really bad and women's reproductive freedom is abused severely enough, some precipitating factor or series of events finally brings women's attention to the power doctors hold over their reproductive lives. This leads to women's disillusionment, anger, and resentment and a call to action. This reaction may go more quickly in developed countries, where there is at least some degree of freedom and women's rights in place, but it can also be the start of these rights and freedoms.

Although midwives in countries at the bottom of the chart tend to be divided into those who accept the status quo and those who want to change it, this precipitating factor angers the midwives as well. They join with the angry women (often forming coalitions that also include scientists, journalist, some politicians, and some doctors and nurses) to start the long, difficult process of regaining their autonomy to childbirth and reproduction, moving the country up the right side of the circle.

Looking at how this played out in particular countries can provide important lessons for Slovenia in how to go about getting to where it needs to be. In Canada, per example, an arrest of a home birth midwife in Toronto led to a coroner's inquest, which led ultimately to the government legalizing midwifery.

Germany is another good example of the struggle to regain autonomy. In the 1980s, the national organization of German obstetricians went to the federal government and demanded that all out-of-hospital births be forbidden by law. Suddenly, German midwives woke up, German women's organizations woke up; they formed coalitions and worked together to plan an opposition strategy. They collected ammunition in the form of scientific data and policy documents from other countries and from WHO and descended on their legislators and the media. It was a battle, but in the end they were successful. Out-

of-hospital birth was not outlawed in Germany, and the is now a strong, wide-awake lobby of German women and midwives who stand ready to oppose any further attempts on the part of German obstetricians to take away birth options.

As a result of this struggle, a large number of German midwives have since left hospitals to become community midwives attending birth at home and at out-of-hospital birth centers. Today, approximately one-quarter of the midwives in Germany are working primarily outside of hospitals, and the number of out-of-hospital alternative birth centers (ABCs) has increased from one in 1990 to more than seventy in 2003.(3) This happened despite fierce resistance from the German obstetric establishment, which repeatedly told women that out-of hospital birth would put their babies in jeopardy. Germany demonstrates that it is possible to change a maternity care system without the blessing of the obstetricians, an important lesson for countries in the bottom of the cycle. It seems there is at least one thin more powerful than the medical establishment: women, when they are angry and get organized.

Around the same time, there was a similar angry reaction among women in New Zealand. A professor of obstetric at the university hospital conducted an experimental, randomized trial to try to further confirm if a particular screening test for cervical cancer worked: the Pap test, named after the doctor who first described it, Sr. Papanicoleau.(4) The study looked at women who had positive pap test. The group with positive screening tests was divided in half: one half received follow-up and treatment for cancer, and the other half received no treatment. Over time, an increasing number of women in the group that received no treatment died from cervical cancer – but the experiment continued. Then a journalist got wind of the situation and wrote a bout the study. Women in New Zealand were outraged. The country's entire obstetric profession lost credibility.

At the same time, midwives in New Zealand were trying to improve the country's maternity care and to resist the extreme medicalization of birth going on in other countries. When New Zealand women became disillusioned with obstetricians, many turned to midwives to assist their births, and New Zealand legislators began paying more attention to what midwives and women wanted. They created a new system of maternity care, and now every woman having a low-risk pregnancy in New Zealand can choose her own midwife or family physician for prenatal and birth care (leaving the obstetricians to care for women with high-risk pregnancies), and she can choose where to give birth as well. All maternity care is covered by the national health service in New Zealand, and all providers, whether doctors of midwives, receive the same flat fee for providing pregnancy care and attending birth of low-risk women. New Zealand now has rates of unnecessary obstetric interventions that are among the lowest in the world, with a national C-section rate close to 10 percent. And it has lower perinatal and maternal mortality rates than Slovenia. (5)
Through precipitating events vary in countries where a shift in maternity care has taken place, it's possible to see common themes and draw some conclusions. I believe there are lessons those who want to bring about change in the Slovenia can learn from this evolutionary process.

First, it appears that the medicalization of maternity care and the loss of women's and midwives' autonomy must become extreme for a reaction to set in. It is only when women's reproductive freedom is being severely abused in one way or another that women and midwives get sufficiently angry to take action. There is no doubt that at

present in the Slovenia certain aspects of maternity care are getting very medicalized – as evidenced by the rate of labour induction and augmentation and false information given to women about the risk of using them; high episiotomy rate, and false information about the risk and benefits of using it; continuous use of CTG during normal labour, birth position of the woman in the first and second stage of labour (lying in the bed), and by shaving and enema, a practices which should be abandoned from contemporary childbirth completely.

Autonomy of the women, autonomy of the midwives

Another feature of this circle of evolution of birthing practices is the interrelationship between autonomy of women and the autonomy of midwives. Simply put, if women in a country do not have the power to make their own birth decisions, there will be no autonomy for midwives, and if midwives do not have the authority to practice independently, the autonomy of women is much more difficult to achieve. Women understand that their feeling of strength and freedom are closely tied to having control of their bodies, including control of their reproduction and childbirth. And midwives know that they will never have autonomy without the full support of the women in society. This is why the quality of maternity care in any country is closely tied to the level of autonomy of women and midwives and why I used autonomy as the critical factor when placing countries on the circle of evolution of maternity care in the chart.

As women and midwives struggle up the right side of the circle of evolution of birthing practices and regain autonomy, maternity care simultaneously becomes more women-centered, more humanized, and more evidence-based. Western European countries serve as an excellent example of the relationship between autonomy for women and midwives and healthful birthing practices. In Western Europe, there is a gradient in the equality and independence of women in general from north to south, with women in northern countries such as Denmark having a lot of rights and independence and women in southern countries such as Italy having far less. There is similar north – south gradient in the authority and independence of midwives in these countries, and the quality of maternity care follows. For example, episiotomy rate is less then 10% in Scandinavia, around 30% in Italy and still 50% or even more in Slovenia.

To Slovenian who are used to thinking that their country in obstetric is among the best in the world, the position of the Slovenia in the circle of evolution of birthing practices often comes as a surprise. Although women in the Slovenia have made enormous strides in their place in society, when it comes to maternity services, Slovenian women have made too little progress, there is no question that the women's movement in Slovenia has neglected issues of maternity care. As a result, today in Slovenia women are still willing to put themselves in a doctor's hands and say: "Take care of me." Birthing women in Slovenia have limited valid information, limited true choices base on full disclosure of risks, high rates of unnecessary and risky interventions such as pharmacological induction of labor, unfavourable rates of mortality for pregnant and birthing women and serious lack of transparency, accountability, monitoring, and regulation of obstetric practices – hence Slovenia's ranking on the circle of evolution. One of the main reasons that obstetrics in Slovenia is out of control is because obstetricians do not have the restraining influence of a larger, strong midwifery profession and larger, strong women's groups focus on maternity issues as do obstetricians in some other industrialized countries.

Perhaps most promising at all, more women in the USA and European countries, among them in Slovenia, too, are coming to see the crisis in maternity care as a women's issue. It's about a woman's rights to control what happens to her body and to have access to the best health care options available. For some time women have lobbied for the right to prevent – or end – an unwanted pregnancy, but a woman's right to control a wanted pregnancy and birth has received less attention. Now women's groups are taking on a wide range of issues related to maternity care, such as the need for transparency and accountability.

With Slovenia's entrance into the European Union, the role of midwives will change dramatically. In Western Europe midwives provide prenatal care, attend the 70 to 80% of births which are low risk and most women never see a doctor during pregnancy and birth.

This is what needs to happen in Slovenia. It will be a difficult struggle but if midwives, women's groups and others work together, it can happen. Slovenia has Germany, the Netherlands, Great Britain and the Scandinavian countries as fairly close neighbors and these countries can serve as important models.

In the US, for example, the movement for demedicalizing and humanizing birth is gaining momentum. *The Coalition for Improving Maternity Services (CIMS)* has taken the lead and now has more then fifty member organizations and more than ninety thousand individual members. Their mission: "to promote a wellness model of maternity care that will improve birth outcomes."[3] These are principles underlying this model:
- Normalcy: treat birth as a natural, healthy process.
- Empowerment: provide the birthing woman and her family with supportive, sensitive, and respectful care.
- Autonomy: enable women to make decisions base on accurate information and provide access to the full range of options for care.
- First, do no harm: avoid the routine use of tests, procedures, drugs, and restrictions.
- Responsibility: give evidence-based care solely for the needs and in the interests of mothers and infants.[4]

It's hard to find fault with these simple but profound concepts, yet they stand in sharp contrasts with the reality thousand of women in modern world experience each year. If these principles were in place, women and families would be free to have the childbirth of their choice. The key issue is who is in control, most of the present care system for birthing women in Slovenia is designed not to assist the mother but rather to control her. Physicians, hospitals, electronic fetal monitors, and drugs do not have babies – only the mother of the child can do that. To give birth, a woman must open up her body, wide. This profound social and biological act requires everything a woman has and is. All maternity services should reflect this fundamental fact and should be designed to assist and support the woman.

[3] For further information on the *Coalition for Improving Maternity Services* and its mission, see www.motherfriendly.org
[4] www.motherfriendly.org

Sources of data on practices

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