20073-27-045

THE LANCET, AUGUST 24, 1985

World Health Organisation

APPROPRIATE TECHNOLOGY FOR BIRTH

In April, the European regional office of the World Health Organisation, the Pan American Health Organisation, and the WHO regional office of the Americas held a conference on appropriate technology for birth. The conference, held in Fortaleza, Brazil, was attended by over 50 participants representing midwifery, obstetrics, paediatrics, epidemiology, sociology, psychology, economics, health administration, and mothers. Careful review of the knowledge of birth technology led to unanimous adoption of the recommendations which follow. WHO believes these recommendations to be relevant to perinatal services worldwide.

Every woman has the right to proper prenatal care and she has a central role in all aspects of this care, including participation in the planning, carrying out, and evaluation of the care. Social, emotional, and psychological factors are fundamental in understanding how to provide proper perinatal care. Birth is a natural and normal process, but even "no risk pregnancies" can give rise to complications. Sometimes intervention is required to obtain the best result. In order for the following recommendations to be viable, a thorough transformation of the structure of health services is required together with modification of staff attitudes and the redistribution of human and physical resources.

GENERAL RECOMMENDATIONS

Health ministries should establish specific policies regarding appropriate birth technology for the private and nationalised health services.

Countries should carry out joint surveys to evaluate birth care technologies.

The whole community should be informed of the various procedures in birth care, so as to enable each woman to choose the type of birth care she prefers.

The mother and her family should be encouraged to practise self-care in the perinatal period and develop the understanding of when and what help is required to improve the conditions of pregnancy, birth, and afterwards.

Women's mutual aid groups offer valuable social support and a unique opportunity to share information about birth.

The health team must foster coherent attitudes to ensure continuity in the monitoring of birth and the perinatal team should share a common work philosophy in order to ensure that staff changes do not jeopardise continuity of care.

Informal perinatal care systems (including traditional birth attendants) must coexist with the official system and a collaborative approach must be maintained for the benefit of the mother. Such relations, when established in parallel, can be highly effective.

Professional training should pass on new knowledge of the social, cultural, anthropological, and ethical aspects of birth.

The perinatal team should be jointly motivated to enhance relationships between mother, child, and family. The work of the team can be affected by interdisciplinary conflicts, which should be systematically explored.

The training of health professionals should include communication techniques in order to promote sensitive exchange of information between members of the health team and the pregnant woman and her family.

The training of professional midwives or birth attendants should be encouraged. Care during normal pregnancy, birth, and afterwards should be the duty of this profession.

Technology assessment should involve all those using the technology, epidemiologists, social scientists, health authorities, and the women on whom the technology is used.

Information on birth practices in different hospitals, such as rates of caesarean section, should be available to the public.

Research on the structure and numbers of the team attending at birth should be conducted, at regional, national, and international levels, consistent with maximising access to appropriate primary care and maximising normal birth outcomes and improving perinatal health, cost effectiveness, and the needs and desires of the community.

SPECIFIC RECOMMENDATIONS

The wellbeing of the new mother must be ensured through free access of a chosen member of her family during birth and throughout the postnatal period. In addition, the health team must provide emotional support.

Women who give birth in an institution must retain their right to decide about clothing (hers and her baby's), food, disposal of the placenta, and other culturally significant practices.

The healthy newborn must remain with the mother whenever possible. Observation of the healthy newborn does not justify separation from the mother.

Immediate breastfeeding should be encouraged even before the mother leaves the delivery room.

Countries with some of the lowest perinatal mortality rates in the world have caesarean section rates of less than 10%. There is no justification for any region to have a rate higher than 10–15%.

There is no evidence that caesarean section is required after a previous caesarean section birth. Vaginal deliveries after a caesarean should normally be encouraged wherever emergency surgical intervention is available.

Ligation of the fallopian tubes is not an indication for caesarean section. There are simpler and safer methods for tubal sterilisation.

There is no evidence that routine fetal monitoring has a positive effect on the outcome of pregnancy. Electronic fetal monitoring should be carried out only in carefully selected cases related to high perinatal mortality rates and where labour is induced. Research should investigate the selection of women who might benefit from fetal monitoring. Meanwhile, national health services should abstain from purchasing new equipment.

It is recommended that the fetal heart rate be monitored through auscultation during the first stage of labour, and more frequently during expulsion.

There is no indication for shaving pubic hair nor for an enema before delivery.

It is not recommended that the pregnant woman be placed in a dorsal lithotomy position during labour and delivery. Walking should be encouraged during labour and each woman must freely decide which position to adopt during delivery.

The perineum should be protected wherever possible. Systematic use of episiotomy is not justified.

The induction of labour should be reserved for specific medical indications. No region should have rates of induced labour higher than 10%.

During delivery, the routine administration of analgesic or anaesthetic drugs (not specifically required to correct or prevent any complication) should be avoided.

Artificial early rupture of membranes, as a routine process, is not justifiable.

Further investigation should evaluate the minimum special clothing required for those attending birth and the newborn.

IMPLEMENTATION OF RECOMMENDATIONS

The above recommendations acknowledge differences between various regions and countries. Implementation must be adapted to these special situations.

Governments should determine which departments should coordinate the assessment of appropriate birth technology.

Universities, scientific societies, and research groups should all participate in the assessment of technology.

Financial regulations should discourage indiscriminate use of technologies.

Obstetric care that criticises technological birth care and respects the emotional, psychological, and social aspects of birth should be encouraged.

Government agencies, universities, scientific societies, and other interested groups should be able to influence the excessive and unjustified use of caesarean section by exploring and publicising its negative effects on mother and infant.

WHO and PAHO should promote a network of evaluation groups to assist countries in adopting new technologies developed by more advanced countries. This network will in turn constitute a focal point for the dissemination of information.

The results of technology assessment should be widely disseminated in order to change the behaviour of professionals and the attitudes of the general public.

Governments should consider the development of regulations to permit the use of new birth technologies only after adequate evaluation.

National and regional conferences on birth, to include health providers, health authorities, users, women's groups, and the media should be promoted.

WHO and PAHO should designate a year during which attention is focused on promoting better birth.