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Full Text: SUMMARY REPORT The Regional Office for Europe and the Regional Office for the Americas of the World Health Organization held a joint Symposium attended by over 40 participants from North and South America and Europe, representing obstetricians, paediatricians, health administrators, sociologists, psychologists, economists, epidemiologists, medical journalists and service users. Certain rights are fundamental to attitudes and approaches in care following birth. For example, the right to: (a) choice of place of birth and primary birth attendant; (b) preservation of physical integrity and privacy for mother and child; (c) respect for birth as a highly personal, sexual and family experience; (d) warmth, food and shelter, especially during the first month after birth; (e) assurance of financial support adequate for the care of the family; (f) proper health care following birth; and (g) protection of children from abuse and neglect. Becoming a mother is a difficult life transition. The family and its support system of relatives and friends need to understand and be prepared for changes following birth. Health planners and workers must consider the woman's health as well as that of the baby. The Symposium formulated the following recommendations. Public policy 1. Poverty is the greatest threat to the health of the woman and the infant. In the absence of concerted measures to promote social equity, little improvement can be expected in maternal and infant mortality and morbidity. Mortality and morbidity rates are higher in socially disadvantaged communities, which may also receive much less in the way of formal health care. Thus (a) in the allocation of resources, nationally and locally, direct spending on health services may not be the highest priority; and (b) services for healthy women and babies should be organized so that those most in need have access to adequate care. 2. If the goal of health for all women and newborn infants is to be achieved, resources must be equitably reallocated from overall health care funds, making the care of this vulnerable group a priority. 3. The structure of health care systems and the way they operate are influenced by commercial interests and by the needs and perspectives of professionals and others who work in them. When such influences are strong, they need to be publicly recognized and, if necessary, controlled. 4. The improvement of care following birth must be a collaboration between: parents; health professionals; health planners; health care administrators; other related sectors; community groups; policy-makers and politicians. Policies and mechanisms should be developed which will guide decisions about the care of women and babies- for example, multidisciplinary committees on ethics and review boards for the assessment of the care of the newborn. Communities must examine how far their attitudes and practices support or obstruct the opportunity for women and babies to receive the best available care. 5. All countries need a systematic process of health planning, including resource allocation for the care of women and babies. This process would ideally be local and national, and it would reflect the views of a broad cross-section of professionals and interested groups in the community. Planning for the health of women and babies must go beyond an approach based on potential risks to the physical health of the woman, fetus and newborn infant; a positive effort is called for to involve the entire society in the promotion of health. 6. The allocation of health care resources to intensive life support systems for the newborn should be determined nationally. That decision must be informed by research findings, socioeconomic factors, and moral and ethical considerations. It should be based on consultation among care providers and representatives of parents and the community as a whole. It should include the establishment of minimum standards and requirements for staffing, equipment, and the siting of units for the newborn. 7. Mothers are the primary and continuing human resource available to sustain optimum infant development. They must be given general and specific practical support so that they can carry out this primary role. 8. Every woman in

employment should have an adequate period of paid maternity leave before and after childbirth. Social security systems should not penalize women for motherhood. Women should also be relieved of unpaid work after childbirth, and home help services should be available. After birth, paid leave should be provided for the father so that he can foster a relationship with the baby and support the mother. 9. Self-help groups should be promoted and funded in local communities to enable parents to meet the responsibilities of infant care. Professionals hate a duty to be knowledgeable about self-help groups in the community and they should inform parents about these groups. As one example, breastfeeding support groups in the community provide a valuable form of information exchange and support among women. 10. In any country or regi on existing cultural practices in the period following birth should be respected and maintained-unless they have been Woven harmful. Better communication between women and 1 health workers would improve opportunities to recognize strengths of local traditions, which could then be disseminated to other women. Health and medical services 11. For healthy women and babies, support equivalent to that provided in hospital should be made available to all mothers and babies at home. 12. If the mother desires breastfeeding, it should be initiated within the first hour after birth. Practices concerning breastfeeding should follow the resolutions adopted at the Thirtyfourth World Health Assembly in 1981. 13. All parents and newborn infants have the right to be in close contact from the time of birth. Closeness between mother and infant should be promoted in all circumstances, including the period after Caesarian birth or other medical interventions affecting the woman or infant. Women and babies should not be separated and should be together as much as the mother wishes. Rooming-in should be promoted; and thought should be given to abandoning central nurseries for normal babies. Furthermore, involvement of parents in the care of the unhealthy newborn should be promoted, including the actual care of the unhealthy infant and participation in decisions about treatment. 14. Mothers and babies should not be kept in hospital beyond the time when they can benefit from further hospital diagnostic or therapeutic measures. If rest or social or educational support are needed, they should be provided in the home. 15. Health care personnel should support efficacious and safe technologies, but they should not impose them on women and families. When the desire of parents is judged to go against the good of the infant, then a formal advisory system for solving these problems must be implemented in each health care facility. 16. Iatrogenesis (harm to the woman or her infant by diagnostic or therapeutic measures) should be avoided, for example harm from treatment of jaundice in the newborn. Jaundice affects many full-term newborn infants, but the vast majority of them are healthy and do not need diagnostic investigation or treatment. 17. Since hospital-acquired infections are a major threat to women and infants, hospitals should monitor their infection rates and introduce programmes for the prevention of such infections. Rooming-in rather than a central nursery can be an important part of such a programme. Early discharge of women and infants would also be part of such programmes. 18. Every baby should have its own record from the moment of birth, which may include data about pregnancy and birth. This record, or at least a copy of it, should be kept at home by the woman. It would include data about growth, development, nutrition, immunization and medical history. It can form a basis for communication among givers of health care and with the woman. The woman should also have her own health record in her home. Confidentiality of these records must be protected. 19. Resources should be allocated, both in hospital and in the community, to the follow-up of the health of the newborn infant and the woman. Ideally, personnel involved in the birth and in hospital aftercare would make the first home contact with the woman and family to enquire about their wellbeing. Every woman and baby should have the opportunity to receive community-based health care. Home-based care givers should encourage the promotion of health in the woman and her baby. 20. Home-based alternative technologies for women and babies, such as portable phototherapy for neonatal jaundice, should be developed to allow expansion of coverage to the population that lacks access to hospital care. Such innovations should be evaluated just as rigorously as complex hospital technology. Prevention and screening 21. All women and newborn infants should receive immunization and screening tests in accordance with the recommendations of their own countries, whether at home, in a clinic or in a hospital. Before screening

of women or babies is contemplated, it must be evaluated by random controlled trials, examining not only efficacy and safety but also psychosocial costs and benefits. Each country should evaluate the relevance of particular screening procedures to its own particular needs or resources. The means of administration of vitamin K and the type of eye prophylaxis in the newborn infant need further evaluation. When indicated, immunization with anti-D is recommended for the woman. 22. The period following birth may be an important time for making family planning advice and services available to both parents. The person giving such information to women should be someone in whom they have confidence. In many contexts, the best person will be a nurse or midwife. Information should be given on a variety of contraceptive techniques, so that women can make informed choices. 23. The eradication of neonatal tetanus is a high priority. 24. Low birth weight, which correlates strongly with both perinatal mortality and morbidity, should receive high priority for research into causes and prevention. Meanwhile, however, some actions seem to reduce the incidence of low birth weight and other causes of perinatal mortality and morbidity. Services should be developed with such actions in mind and the public should be fully informed of the reasons for and importance of these actions, which include: family planning (to avoid a large number of children and too short intervals between children): prenatal care to identify possible risks to the fetus and woman and to treat any diseases or conditions developing during pregnancy; nutritional and social support during pregnancy; avoidance of cigarettes, alcohol and drugs during pregnancy; and appropriate care during labour and delivery. Routine care 25. Every woman and infant should have access to a basic level of care regardless of whether the birth takes place at home or in a primary or secondary health care setting. At every birth, wherever it takes place, one attendant should take overall responsibility for the woman and infant. 26. Government agencies should support the provision of health care by alternative providers, such as empirical midwives. The role and efficacy of these alternative providers should be systematically evaluated. 27. Every woman should receive basic care immediately following birth. In those parts of the world where haemorrhage, infection and pregnancy-induced hypertension are important causes of maternal mortality and morbidity, every effort should be made to provide effective treatment and to prevent long-term sequelae. An effective referral system is necessary for the woman when complications arise during pregnancy, birth, or the period following birth. Such a system must include free transport where necessary. 28. A first priority is that every newborn baby, whether born at home or in hospital, should be assessed for breathing difficulties and be given the necessary support to initiate and sustain respiration. Every birth attendant should be trained in and equipped to deal with immediate care and resuscitation of the newborn, including identification of the need for consultation or referral to more specialized care. 29. Every newborn baby should be evaluated initially for vital signs and gross congenital abnormalities. Evaluations should take place next to the mother if possible, in a room at the right temperature and without hazard to baby or woman. 30. Discharge from hospital should depend on the wellbeing of the mother and infant, the wishes of the parents, and the availability of home support. In particular, discharge policies should not be based on the single criterion of weight and should concentrate on earliest possible discharge. Unhealthy infants 31. Staff in every special care unit for the newborn must be aware of the wishes and attitudes of the community it serves. Communicationwith the community is vital. Policies of special care units must be consistent with the community's values. 32.Parents have the right to early active involvement in the care of their unhealthy infant: early and free visits to the special infant care unit; encouragement of feeding and skin-to-skin contact, whether or not the infant is connected to monitoring systems; facilities where parents can live while the infant is in special care; and participation in decisions regarding diagnosis and treatment. 33. Low birth weight is both a risk factor and a social indicator. A decision to refer a low birth weight infant for care in another unit should take account not only of the infant's condition and the ability to care for him or her locally, but also the need to avoid separation of families. 34. A woman who becomes seriously ill during pregnancy or labour or whose fetus is endangered should be provided with an appropriate level of care, ideally before birth. Transport must also be available for every unhealthy infant who needs care elsewhere. Vehicles for the transport of infants should be equipped with

the basic means of maintaining body temperature and supporting respiration. If she wishes, the woman should be able to accompany her infant. A referral network must be established and understood by all concerned. The infant should be accompanied by the record prepared by the primary care provider. Communication between the different levels of care is important. 35. All countries should develop criteria by which to determine whether or not certain treatments for the newborn should be regarded as experimental. Examples of "experimental" treatment, in present circumstances, include the management of extremely premature infants and serious congenital defects. Guidelines should be formulated for the selection of infants for whom maximum intensive care and surgery are justified. The possibility of short- and long-term negative consequences of such treatment should be fully communicated to the parents. 36. Ideally, unhealthy infants requiring intensive care should receive it in special units within maternity hospitals. In these units, paediatric and specialized nursing staff should be on duty 24 hours a day. The minimum acceptable facilities for life support, including biochemical tests and radiology, should be available. No institution providing tertiary care should be permitted to refuse to accept a case presenting at their facility, at least for assessment, stabilization and referral. Research 37. Most research on women following birth and on infants has focused on clinical management. Priority should now be given to research on: the organization and overall content of services; preventive services; assessing the appropriate use of technologies; and the long-term future of women and infants. This research should include surveys of the views of parents and the community. 38. Any technology used in care following birth should undergo evaluation before its introduction for general use. Such evaluation should include efficacy and safety, economic implications, and cultural acceptability. The results of technology assessment should be widely disseminated to professionals and the general public. WHO should continue to promote and expand a network of technology assessment centres to assist countries in selecting new technologies and assessing them. This network will constitute a focal point for the dissemination of information. 39. All research should use the strongest possible design. In the assessment of any technology, this design is a randomized controlled trial, probably a multi-centre collaborative trial that can achieve adequate sample size. Community-based research, organized by community groups and assisted by relevant experts, should be encouraged. 40. In improving care following birth research on the services themselves, including relevant social science research, can help to change both individual practices and policy. This type of research lacks funding and institutional support now enjoyed by biomedical research. Health workers should be encouraged to enquire into their own performance with the support of a competent team with expertise in study design, analysis of data, and dissemination of results. 41. Two areas of research needing high priority are: fetal growth and its retardation and the prevention of low birth weight infants; and health problems in the woman following birth, including postpartum depression. 42. Care following birth should be evaluated on a population as well as in an institution. The basic requirements are knowledge of: the population for whom care is being provided; the services available for unhealthy women and unhealthy newborn infants; which women and which infants receive what kinds of service and their outcomes, including mortality and short- and long-term morbidity; the satisfaction of the parents with the service and the satisfaction of those who work in the services; and financial costs. This evaluation should be done in the context of overall evaluation of perinatal care. 43. All governments should appoint a broad-based representative committee, including health care providers and the users of health care, to establish guidelines and recommendations for the care of mothers and infants. These guidelines should be based on a continuing evaluation system and should be widely distributed and frequently revised. Such guidelines should include minimum standards for equipment and care practices following birth. 44. All countries should make an effort to improve perinatal records. Birth and death certificates should include birth weight, and they should be linked whenever possible. A good statistical system is essential, beginning with registration of all births and deaths. Permanent perinatal surveillance systems are needed at the national level. Education and training 45. For staff working in hospitals or home health services, initial and inservice training should be based on the needs of women and babies and be linked to local services, so that training is realistic and relevant. Training should

include the ability to conduct research and/or interpret research findings. All professionals should receive the lists of relevant random controlled studies. Training of all health care staff should make them aware of the stresses and anxieties that both care receivers and givers may undergo. 46. Those working in special care units face infants with severe illness, handicap, and often death, so they must be oriented to the implications of such stresses and how to cope with them, and they should receive emotional support. Regarding breast-feeding, special attention must be given to the training and practices of health professionals who come in contact with women in the postpartum period. Contradictory advice must be avoided. The practice of giving food other than milk during the first months is to be discouraged. 47. WHO should be active in ensuring that appropriate courses in public health, with special emphasis on maternal and child health, are taught at universities and schools of medicine, nursing and midwifery. Public information and the media 48. In societies where young people have little opportunity to learn about childbirth, infant care and the responsibilities of parenthood, education is needed to prepare them for these experiences. 49. Information about the period following birth which is accurate, clear, attractively presented, of high quality and consistent should be disseminated widely to parents, schoolchildren, teachers, health professionals and politicians. 50. WHO and its regional offices should institute a regular programme of meetings with journalists, media and public relations leaders, and editors of professional journals to familiarize them with the recommendations of WHO meetings and other issues affecting maternal and child health. WHO should promote the implementation of the recommendations of the Trieste meeting and the two earlier meetings. From the EURO/PAHO Symposium on Appropriate Technology following Birth. Trieste, 7-11 October 1986 Sharing Space: WHO Reports SUMMARY REPORT The Regional Office for Europe and the Regional Office for the Americas of the World Health Organization held a joint Conference that was attended by over 60 participants from north and south America and Europe, representing midwives, obstetricians, pediatricians, health administrators, sociologists, psychologists, economists, and service users. The Conference made a number of recommendations based on the principle that each woman has a fundamental right to receive proper prenatal care; that the woman has a central role in all aspects of this care, including participation in the planning, carrying out and evaluation of the care; and that social, emotional and psychological factors are decisive in the understanding and implementation of proper prenatal care. General recommendations 1. Health ministries should establish specific policies about the incorporation of technology into commercial markets and health services. 2. Countries should develop the potential to carry out cooperative surveys to evaluate birth care technology. 3. The whole community should be informed about the various procedures in birth care, to enable each woman to choose the type of birth care she prefers. 4. Women's mutual aid groups have an intrinsic value as mechanisms for social support and the transfer of knowledge, especially with relation to birth. 5. Informal perinatal care systems (including traditional birth attendants), where they exist, must coexist with the official birth care system and collaboration between them must be maintained for the benefit of the mother. Such relations, when established in parallel with no concept of superiority of one system over the other, can be highly effective. 6. The training of people in birth care should aim to improve their knowledge of its social, cultural, anthropological and ethical aspects. 7. The training of professional midwives or birth attendants should be promoted. Care during normal pregnancy and birth, and following birth should be the duty of this profession. 8. Technology assessment should be multidisciplinary and involve all types of providers who use the technology, epidemiologists, social scientists, and health authorities. The women on whom the technology is used should be involved in planning the assessment as well as evaluating and disseminating the results. The results of the assessment should be fed back to all those involved in the research as well as to the communities where the research was conducted. 9. Information about birth practices in hospitals (rates of Caesarean section, etc.) should be given to the public served by the hospitals. 10. The psychological wellbeing of the new mother must be ensured not only through free access to a relation of her choice during birth but also through easy visiting during the postnatal period. 11. The healthy newborn must remain with the mother, whenever both their conditions permit it. No process of observation of the healthy newborn justifies a separation

from the mother. 12. The immediate beginning of breastfeeding should be promoted, even before the mother leaves the delivery room. 13. Countries with some of the lowest perinatal mortality rates in the world have caesarean section rates under 10%. Clearly there is no justification in any specific geographic region to have more than 10-15% caesarean section births. 14. There is no evidence that a caesarean section is required after a previous transverse low segment caesarean section birth. Vaginal deliveries after a caesarean should normally be encouraged wherever emergency surgical capacity is available. 15. There is no evidence that routine intrapartum electronic fetal monitoring has a positive effect on the outcome of pregnancy. Electronic fetal monitoring should be carried out only in carefully selected medical cases (related to high perinatal mortality rates) and in induced labour. Countries where electronic fetal monitors and qualified staff are available should carry out investigations to select specific groups of pregnant women who might benefit from electronic fetal monitoring. Until such time as results are known, national health care services should abstain from purchasing new monitoring equipment. 16. There is no indication for pubic shaving or a predelivery enema. 17. Pregnant women should not be put in a lithotomy position during labour or delivery. They should be encouraged to walk about during labour and each woman must freely decide which position to adopt during delivery. 18. The systematic use of episiotomy is not justified. The protection of the perineum through alternative methods should be evaluated and adopted. 19. Birth should not be induced for convenience, and the induction of labour should be reserved for specific medical indications. No geographic region should have rates of induced labour over 10%. 20. During delivery, the routine administration of analgesic or anaesthetic drugs, that are not specifically required to correct or prevent a complication in delivery, should be avoided. 21. Normally rupture of the membranes is not required until a fairly late stage in the delivery. Artificial early rupture of the membranes, as a routine process, is not scientifically justified. Implementation of recommendations 1. Governments should identify, within the structures of their health ministries, units or departments to take charge of promoting and coordinating the assessment of appropriate technology. 2. Funding agencies should use financial regulations to discourage the indiscriminate use of technology. 3. Obstetric care services that have critical attitudes towards technology and that have adopted an attitude of respect for the emotional, psychological and social aspects of birth care should be identified. Such services should be encouraged and the processes that have led them to their position must be studied so that they can be used as models to foster similar attitudes in other centres and to influence obstetrical views nationwide. 4. The results of the assessment of technology used in birth care should be widely disseminated, to change the behaviour of professionals and give a basis to the decisions of users and the general public. 5. Governments should consider developing regulations to permit the use of new birth technology only after adequate evaluation. 6. National and local birth conferences that include relevant health providers, health authorities, users, women's groups and the media should be promoted. From the Joint Interregional Conference on Appropriate Technology for Birth, Fortaleza, Brazil, 22-26 April 1985

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