Putting an End to Women’s Global Slaughter

Bleeding to Death

by Michel Odent

Everyday events are rarely newsworthy. The media typically induces emotional reactions through constant reports of deaths related to disease, accidents, murders, human conflicts and natural disasters, which explains our widespread tendency to ignore the amplitude of chronic problems. Few people realize that, according to the most authoritative public health reports, more than half a million deaths related to pregnancy and birth occur every year. Bleeding is the single most common cause of maternal death worldwide. The WHO estimates that there are 14 million obstetric haemorrhages a year. (1)

These deaths are to a great extent preventable. Most of them will be avoided on the day when we have rediscovered the basic needs of women in labour and of newborn babies.

In the age of “evidence-based medicine,” it is becoming strange to refer to daily clinical lessons. However, I find it useful to summarize what I learned from decades of practice. We need this perspective because the results of the current randomized controlled trials are of limited use among those who have acquired a good understanding of birth physiology. In these trials, conducted in large conventional departments of obstetrics, the physiological processes are highly disturbed, both in the study groups and in the control groups. (2,3)

Learning from Clinical Observation

Over the years I have come to the conclusion that postpartum haemorrhages are almost always related to inappropriate interference. Postpartum haemorrhage would be extremely rare if a small number of simple rules was understood and observed. I am so convinced of the importance of these simple rules that I have twice agreed to attend a homebirth, although in each case I knew that the woman’s previous birth had been followed by a manual removal of the placenta and a blood transfusion. I take this opportunity to summarize my own attitude during the third stage of labour, in order to stress the differences between my experience and the “expectant” or so-called “physiological” management used in randomized studies. (4)

First, it is important to create the conditions for the “fetus ejection reflex,” which is a short series of irresistible contractions without any room for voluntary movements. (5) This means that the need for privacy and the need to feel secure are met. The opportunity for the fetus ejection reflex occurs when there is nobody around but an experienced, motherly, silent and low-profile midwife sitting in a corner and, for example, knitting (knitting or a similar repetitive task helps the midwife to maintain her own level of adrenaline as low as possible). (6)

When conditions are physiological, at the very moment of birth most women have a tendency to be upright (probably the effect of a transitory peak of adrenaline). (7) They may be on their knees or standing up, leaning on something. After an unmedicated delivery, it only takes a few seconds to hear and see that the baby is in good shape. Then, in most cases, my first preoccupation is to warm the room. In the French hospital where I used to work, we just had to pull a string to switch on heating lamps. In the case of a planned homebirth, instead of a written list of what to prepare, I focus on the need for a transportable heater that can be plugged in anywhere (including practical details, such as the need for an extension cord). When the heater is on it is possible, within a few seconds, to warm up blankets or towels and, if necessary, to cover the mother’s and the baby’s bodies. During the hour following birth women rarely complain that it is too hot. If the mother is shivering, it is not physiological: it means that the place is not warm enough.

From that time my main concern is that the mother is not distracted at all and does not feel observed. I want to make sure
that she feels free to hold her baby, to look into her or his eyes and to smell her or him. It is easier to avoid disturbances if the light is kept dimmed and the telephone unplugged. I often invite the baby’s father (or any other person who might be around) into another room to explain that this first interaction between mother and baby will never happen again and should not be disturbed. Many men have a tendency to break the sacredness of the atmosphere that ideally follows an undisturbed birth.

During the hour following birth, I remain as silent as possible and keep a low profile. I either sit down in a corner behind mother and baby or disappear, if there is an experienced doula present who has had a personal experience of this situation. Minutes after birth many mothers are no longer comfortable in an upright position. This is most likely the time when the level of adrenaline is decreasing and when the mother feels the contractions associated with the separation of the placenta. Then the birth attendant may have to hold the baby for some seconds, in order for the mother to find a comfortable position, almost always lying down on one side. After that there is no excuse to interfere with the interaction between mother and baby.

I don’t approach the cord and placenta for an hour. Clamping and cutting the cord before the delivery of the placenta is a dangerous distraction. Suggesting a position to the mother is another unneeded distraction. Her position is the consequence of her level of adrenaline. When the level of adrenaline is low and the mother feels the need to lie down, it would be unkind and unphysiological to suggest an upright position.

It is only when an hour has passed after the birth—if the placenta is not yet delivered—that I dare to disturb the mother in order to check that the placenta is at least separated from the uterus. With the mother on her back, I press the abdominal wall just above the pubic bone with my fingertips: if the cord does not move, it means the placenta has separated. In practice, the placenta is always either delivered or separated an hour after birth, and bleeding is minimal, if the third stage has not been “managed.” I have never had to inject a uterotonic drug to control the bleeding.

Such an attitude, based first on clinical observation, must be associated with physiological considerations. An easy delivery of the placenta with moderate blood loss implies that, immediately after the birth of the baby, a surge of oxytocin has been released. It is well-known that oxytocin release is highly dependant on environmental factors. It can be inhibited by adrenaline. This is more than empirical knowledge. A team from Sapporo (Japan) has studied the levels of adrenaline during the different phases of labour extensively by a noninvasive method (recording with a patch and analysing the skin micro-vibration pattern of the palmar side of the hand)(8) and confirmed the findings of a previous study in which adrenaline levels were measured through indwelling catheters.(9) The Japanese team clearly demonstrated that postpartum haemorrhages are associated with high levels of adrenaline.

The release of oxytocin can also be inhibited by the activity of the neocortex. After a birth under physiological conditions, the mother is still in a special state of consciousness, as if “on another planet.” Her neocortex is still more or less at rest. The advice is: “Don’t wake up the mother!”(10) Another opportunity to refer to privacy and silence.

Major Obstacles

I had the opportunity to explain these simple rules to intelligent teenagers who were free from preconceived ideas. They could easily understand the conflict between adrenaline (“the emergency hormone released when we

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are cold or scared”) and oxytocin (“the hormone necessary to contract the uterus”). They could also easily understand that when a mother is discovering her baby, she may have a tendency to forget the rest of the world: this is the wrong time to distract her.

While these simple rules are considered indisputable among the exceptionally rare mothers who have experienced an undisturbed third stage of labour, among birth attendants who have not been trained to “manage” and among those who think like physiologists, we must wonder why they are universally ignored. In other words we must wonder why all known societies disturb the physiological processes in the period surrounding birth.

Interference comes via birth attendants who are more often than not active—even invasive. Originally women probably gave birth close to their mother or another experienced mother in the family or the community. This is the root of midwifery. A midwife is fundamentally a mother figure. In an ideal world, one’s mother is the prototype of the person with whom one feels secure without feeling observed or judged. In many societies the birth attendant also became a guide and a helper.

The transmission of beliefs and rituals is the most powerful way to control the birth process, particularly the phase of labour between the birth of the baby and the delivery of the placenta. Let us first mention, as an example, the cross-cultural belief that colostrum is tainted or harmful—even a substance to be expressed and discarded. This negative misunderstanding of colostrum implies that, immediately after being born, the baby must be in the arms of a person other than the mother. This is the origin of the widespread, deep-rooted ritual, which is to rush to cut the cord. Space does not permit a comprehensive list of all known rituals and beliefs that disturb the physiological processes. Likewise, we cannot mention all the beliefs that reinforce the common repulsion toward colostrum. But as an example, there is a belief shared by several West African ethnic groups that on the first day the mother should not look at the newborn’s eyes, so that “the bad spirits cannot enter the baby’s body.” In the Dagara tribe in Burkina Faso, according to Sobonfu Somé, the “keeper of the rituals,” when a woman is in labour, the young children of the community are waiting nearby. As soon as they hear the first cry, they all rush to the place of birth shouting to “welcome” the baby. What a powerful way to inhibit the release of oxytocin and create conditions for a difficult and bloody delivery of the placenta!

We must realize that the 21st-century cultural milieu is transmitting its own beliefs, particularly via the natural childbirth movements. These beliefs are also often at odds with what we can learn from physiological perspectives. Let us just consider the vocabulary commonly used that gives an active role to the birth attendant: coaching, guiding, helping, supporting, etc.

In order to evaluate the evolutionary advantages of this multitude of beliefs and rituals, we must keep in mind that the basic strategy for survival of most human groups is to dominate Nature and other human groups; it is, therefore, an advantage to make human beings more aggressive and destructive. By the same token, it is an advantage to moderate the capacity to love, including love of Nature, that is to say the respect for Mother Earth. This explains the evolutionary advantages of disturbing the physiological processes in the period surrounding birth, particularly the third stage of labour, which is now considered critical in the development of the capacity to love. Over the millennia human groups have been selected according to their potential for aggression. We are all the fruit of such a selection.

These considerations must be explored within the context of the 21st century.

We are at a time when humanity must invent radically new strategies for survival. Today we are in the process of realising the limits of traditional strategies. We must raise new questions such as, “How do we develop a form of love which respects Mother Earth?” In order to stop destroying the planet we need a unification of the planetary village. We need, more than ever, the energies of Love. All the beliefs and rituals which challenge the maternal protective and aggressive instinct are losing their former evolutionarily advantages. We have new reasons to respect physiological processes as much as possible. We have a new impetus to rediscover the basic needs of labouring women and newborn babies. The first immediate reason is, of course, to put an end to the global slaughter of women.

Enormous Disparities

While postpartum haemorrhage is a common complication on all five continents, there is an enormous disparity regarding the burden of maternal death. This disparity is impressive when considering the maternal mortality ratios in 170 countries, as they were displayed in a table published in the “Human Development Report” in 1995. These ratios express the “number of deaths from pregnancy-related causes per 100,000 live births.” They can be as high as 2,300 (Rwanda) and as low as 6 (Australia, Canada, Finland). The worldwide ratio is in the region of 400. It is around 10 in wealthy countries. It is striking that more than half the maternal deaths occur in Africa. Among the 23 countries with a ratio above 1,000 per 100,000, 22 are African (the other one is Haiti). This intriguing fact needs to be interpreted (we must acknowledge that malaria increases the risk of maternal death).

The first and obvious explanation is that most African countries have a very low standard of living. This implies that all health criteria are low and that most haemorrhages are not effectively treated in well-equipped and well-organized hospitals. However, certain African countries have a high maternal death ratio compared with their gross income per capita. For example, the maternal mortality ratio of 1,400 in Equatorial Guinea is high compared with the gross income per capita ($5,640). In Bulgaria, for example, where the gross income per capita is also below $6,000, the maternal mortality ratio is 23, according to the same source.

I suggest an additional reason why it is so common to bleed after giving birth in Africa and why so many young African mothers die. It is precisely on that continent that the most powerful and invasive perinatal beliefs and rituals exist and are transmitted from generation to generation. India, where childbirth is also highly ritualised, has a maternal mortality ratio estimated at 560 per 100,000 live births, and postpartum haemorrhage accounts for 35–56% of these deaths.

Postpartum haemorrhage is, to a certain extent, a complication of the socialisation of childbirth.

Meanwhile

After thousands of years of culturally-controlled childbirth, it would not be realistic to try to reduce overnight the rates of
maternal death simply by promoting privacy and undisturbed first contact between mother and newborn baby in a warm place. Would this be acceptable since it would shake the very foundations of our civilisations? We have come to rely on pharmacological agents.

In September 2003, at its triennial meeting in Santiago, Chile, the International Confederation of Obstetrics and Gynecology (FIGO) recommended active management during the third stage of labour, with uterotonic drugs, cord traction and fundal massage as the optimum ways to reduce postpartum haemorrhage. The International Confederation of Midwives (ICM) established similar protocols at its conference in Trinidad. In wealthy countries, synthetic oxytocin is the most commonly used uterotoninc agent. It is given via injection, either in isolation (“Pitocin,” “Syntocinon”) or associated with ergometrine (“Syntometrin”).

For many reasons synthetic oxytocin cannot be widely used in those parts of the world where the largest number of deaths from postpartum haemorrhage occur (cost, administration by injection, thermolability and so on). This is why misoprostol is appropriate. It is an E1 prostaglandin analogue that stimulates uterine contractions, rapidly and powerfully. It has an excellent safety profile, is heat-stable, low-cost and has been identified as an important technology for reducing maternal mortality in homebirth. In Tanzania, traditional midwives are using 1000µg misoprostol rectally to treat postpartum haemorrhage; in the Gambia, women are given 600µg orally to prevent haemorrhage; and in an innovative study in Indonesia, women self-administered misoprostol as soon as the baby was born. Generic misoprostol is now manufactured in China, Taiwan, India, Egypt, Colombia and Brazil. The hope induced by countless studies of misoprostol in third stage of labour was the reason for recent public health meetings in Kampala, Uganda, and Nairobi, Kenya. (16)

All over the world active management of the third stage is now the recommended protocol. It is undoubtedly the best way to reduce the global burden of maternal death in the near future. From a long-term perspective we must wonder what the effects will be on the evolution of our civilizations of routinely substituting drugs for the main natural “hormone of love” at a critical time for mother-child attachment. But while it will take only a few minutes to learn how to use synthetic oxytocin or misoprostol, it will take decades to understand the meaning of privacy.

Michel Odent, MD, is familiarly known as the obstetrician who introduced birthing pools and home-like birthing rooms. With six midwives, he was in charge of about one thousand births a year at Pithiviers Hospital in France in the 1960s and 1970s and achieved excellent statistics, with low rates of intervention. Odent is a contributing editor to Midwifery Today and author of The Scientificatation of Love, The Farmer and the Obstetrician and The Caesarean.

References:


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Leslie Barclay, Fulisia Aiavao, Jennifer Fenwick, and Kaisarina Tooloa Papua

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