

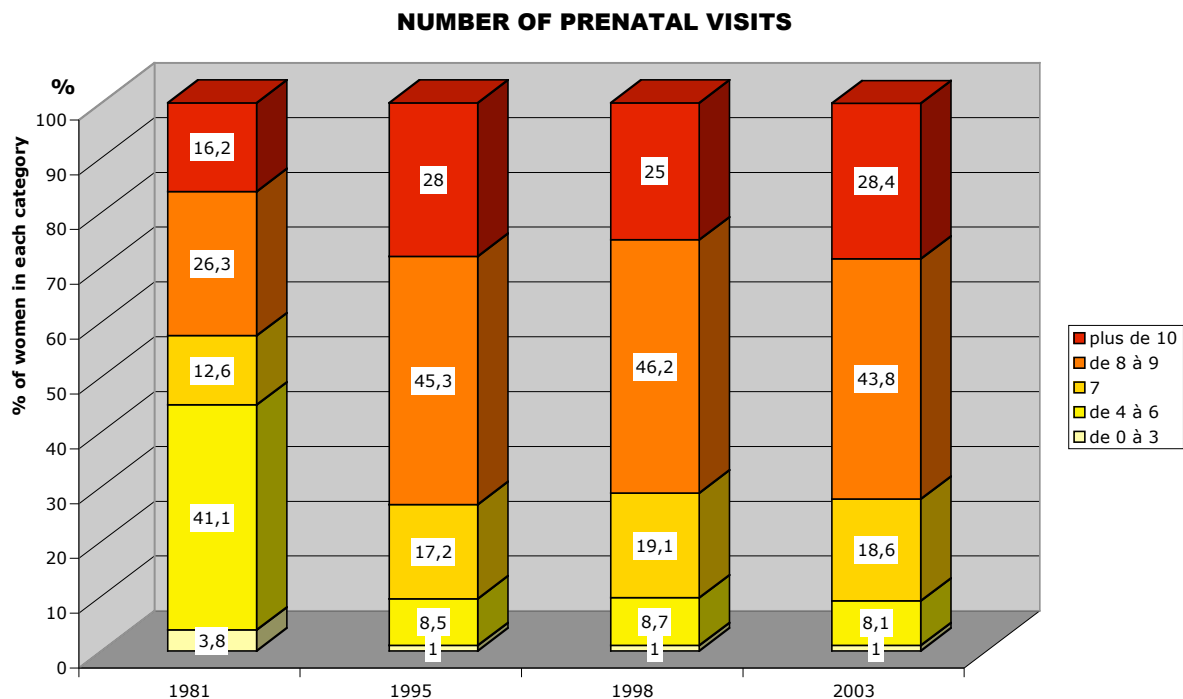
COUNTRY REPORT – FRANCE

THE EVOLUTION OF CHILDBIRTH IN FRANCE

As in many Western countries, childbirth in France has undergone massive upheavels since the early 1950s. While just after World War 2, nearly half of all births would take place at home, women quickly adopted the model of hospital birth. Today, less than 1% births take place outside hospitals. However, medicalisation — i.e. the use of technologies and the intervention of professional caregivers in the very process of childbirth — did not immediately follow. One the one hand, hospital birth produced visible effects such as the immobilization of parturients, a widespread adoption of the gynaecological position and a certain amount of discipline imposed on women with the help of pain reducing techniques. Yet, on the other hand, the use of instruments, drugs and 'routine' gestures only became common practice in the mid-1980s.

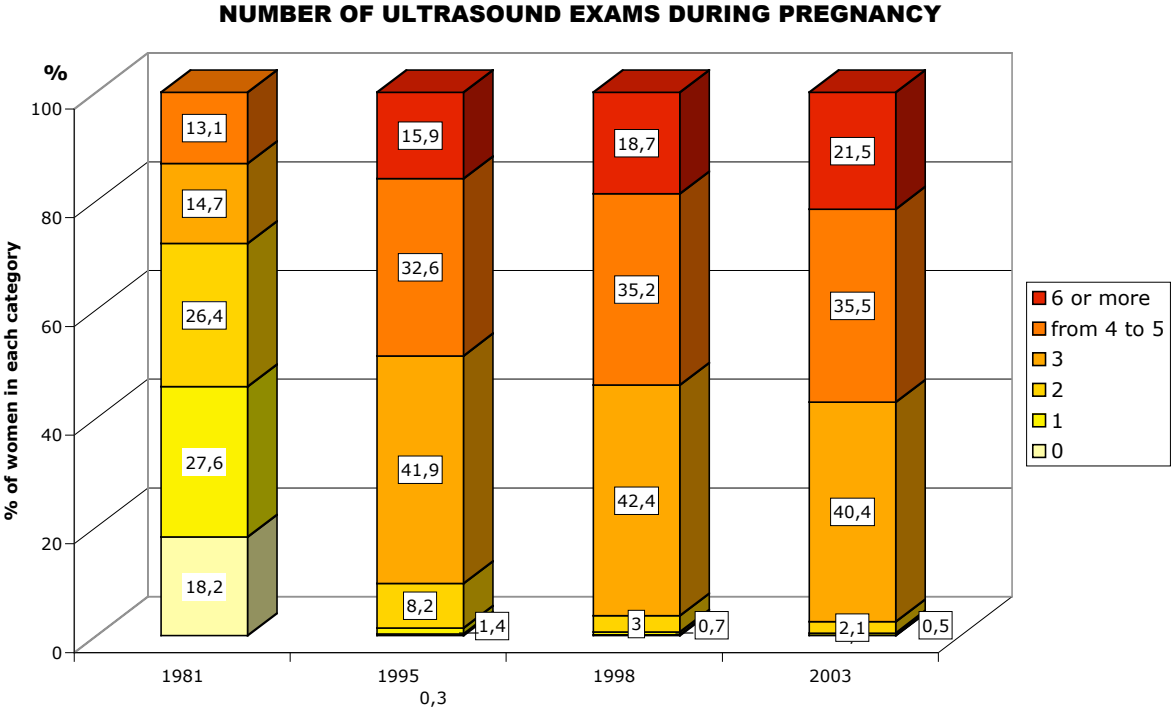
PREGNANCY

The medicalisation of childbirth paralleled systematic pregnancy monitoring as shown on the following graph:



While 45% women had 6 or fewer antenatal visits in 1981, in 2003 72% "benefitted" from 8 or more consultations during their pregnancy. This was already the case in the 1990s and has not significantly changed since this period.

The number of examinations also increased noticeably. The development of ultrasound screening is a striking example of this phenomenon. The proportion of women with 4 or more ultrasound exams during her pregnancy rose from 48.5% in 1995 to 57% in 2003.



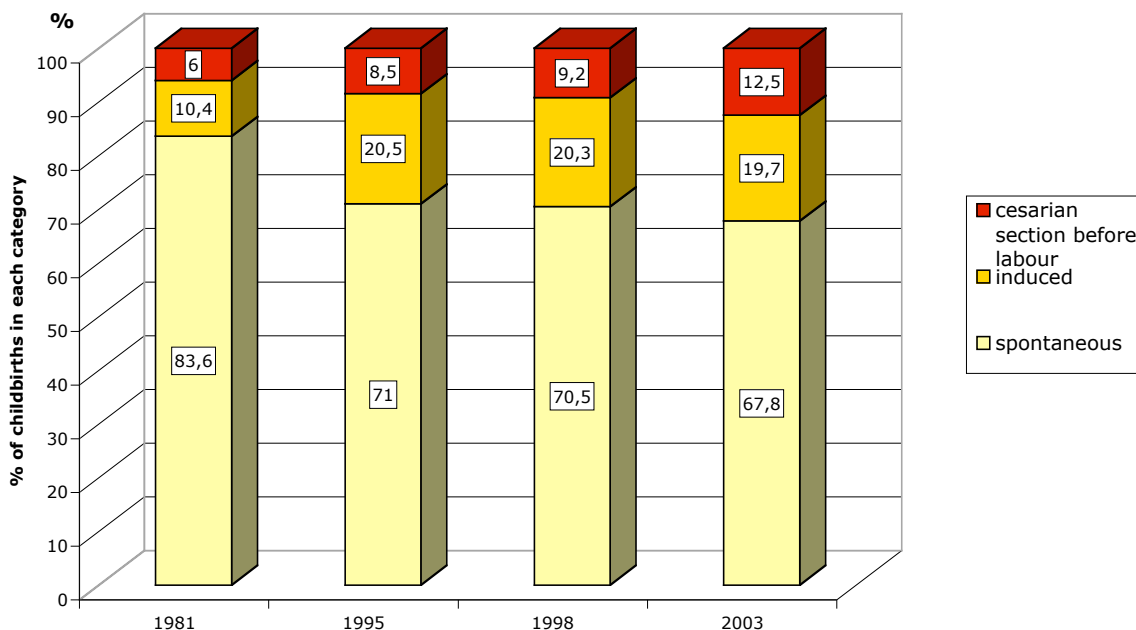
INTERVENTIONS DURING THE DELIVERY

Large-scale available statistics do not project a clear picture of the evolution of medical interventionism. However two significant events mark the stages of this process: continuous foetal monitoring was introduced in the 1980s and epidurals started around 1985; both techniques quickly became very popular.

The first form of intervention in childbirth : labour induction

Today, two thirds of childbirths begin without intervention, versus 83.6% in 1981. It seems that the ‘visible’ rate of labour induction — given that practice such as stripping the membranes is not recorded — has become stable around 20% over the past decade. However, the rate of caesarean sections before the onset labour have risen by almost 50% during the same period.

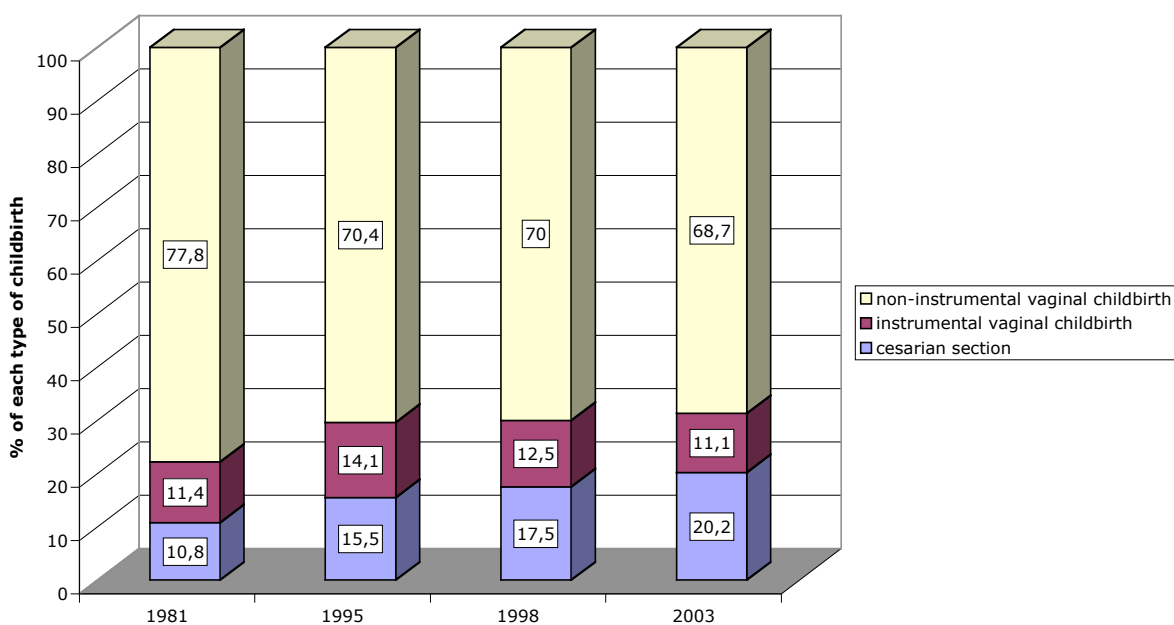
HOW DOES LABOUR START ?



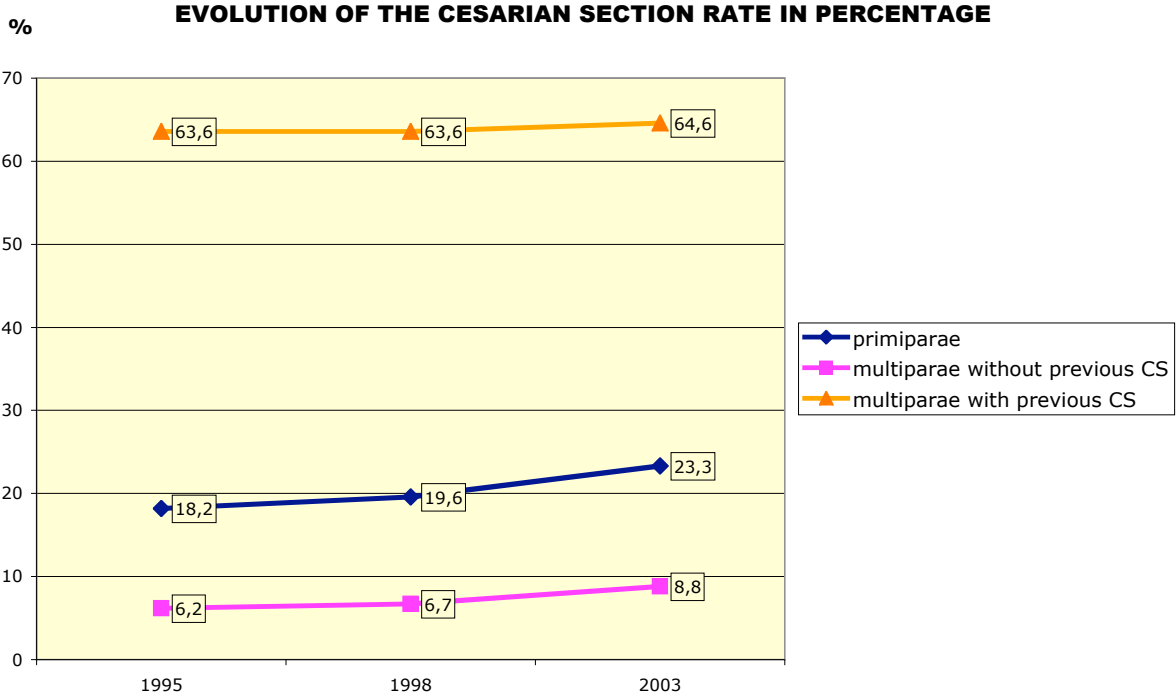
Instrumental extractions and cesarian sections

Non-instrumental vaginal deliveries represent about two thirds of births, i.e. 11% less than in 1981. There has been a relative stability of this percentage since 1995. However, with respect to other types of delivery, a trend is becoming evident: the sharp increase in caesarean sections during the past 8 years (15.5% to 20.2%, which means a near-doubling since 1981) and a significant decrease of instrumental extractions (forceps, spatulas, ventouse) back to their 1981 level in 2003.

CHILDBIRTH EVOLUTION

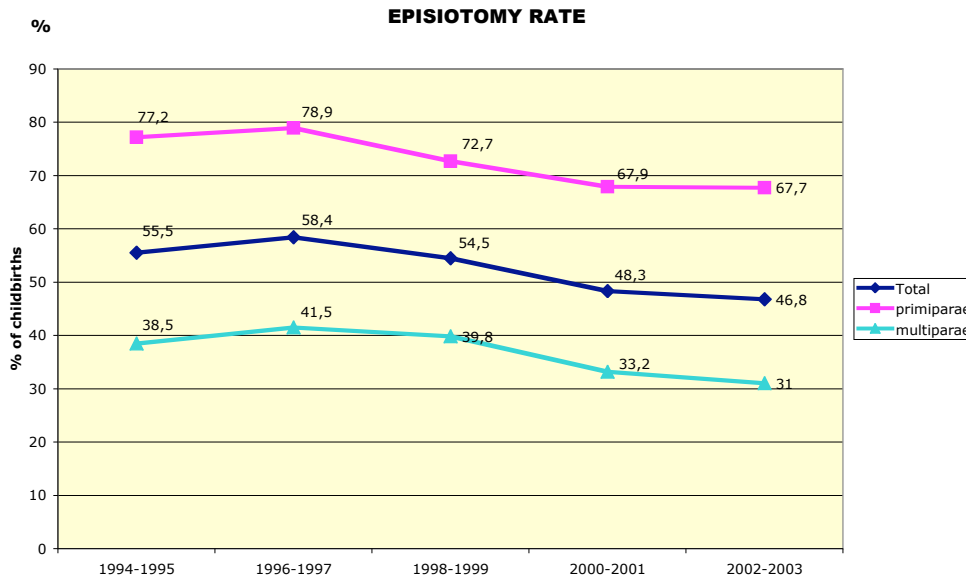


The steady rise of c-section rate is visible on the graph. It is especially noticeable for primiparous, raising from 18.2% to 23.3% between 1995 and 2003. It mechanically implies a growth of the global rate over several years: with a birth rate of two children per woman, and given that two thirds of women with a first caesarean section will have one for the following births, any increase of 1% in the rate of c-sections for primiparous women results in an additional increase of 0.6% for the global rate in the following years.



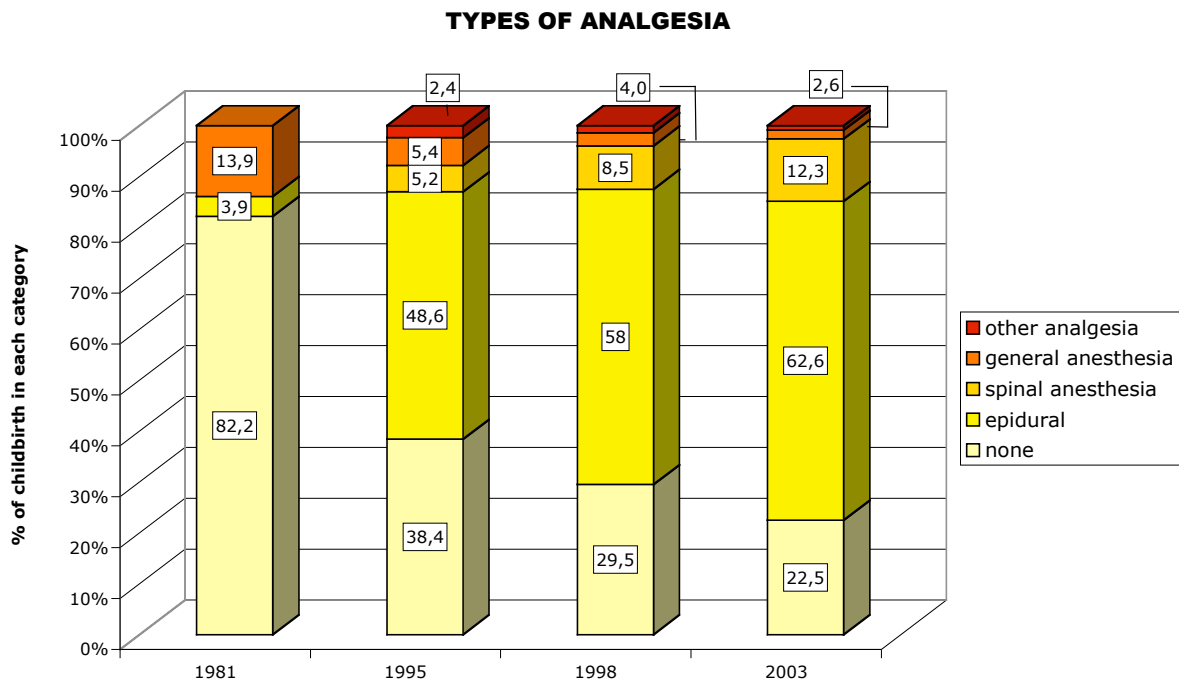
Episiotomy

In contrast with c-section, episiotomy seems to begin a slow decline. Note that large national perinatal inquiries which were the source of statistics presented here are not interested in the question of episiotomy which was considered a “non-issue” until the recent period. The following graph is therefore derived from queries in the AUDIPOG database collecting data from volunteer hospitals.



Analgesia

The practice of epidural analgesia which initiated its expansion around 1985 has continued to rise in the following years:



Its development — from 3.9% in 1981 to 48.6% in 1995 and 62.6% in 2003 — was accompanied by a near-disappearance of general anesthesia. Also note the development of spinal analgesia in recent years. In 2003, only 22.5% deliveries took place without analgesia.

‘EFFICACY’ OF THE SYSTEM

The question worth raising at the sight of this massive technological development is whether it is accompanied by an increase in the ‘efficacy’ of the organisation of obstetrical care.

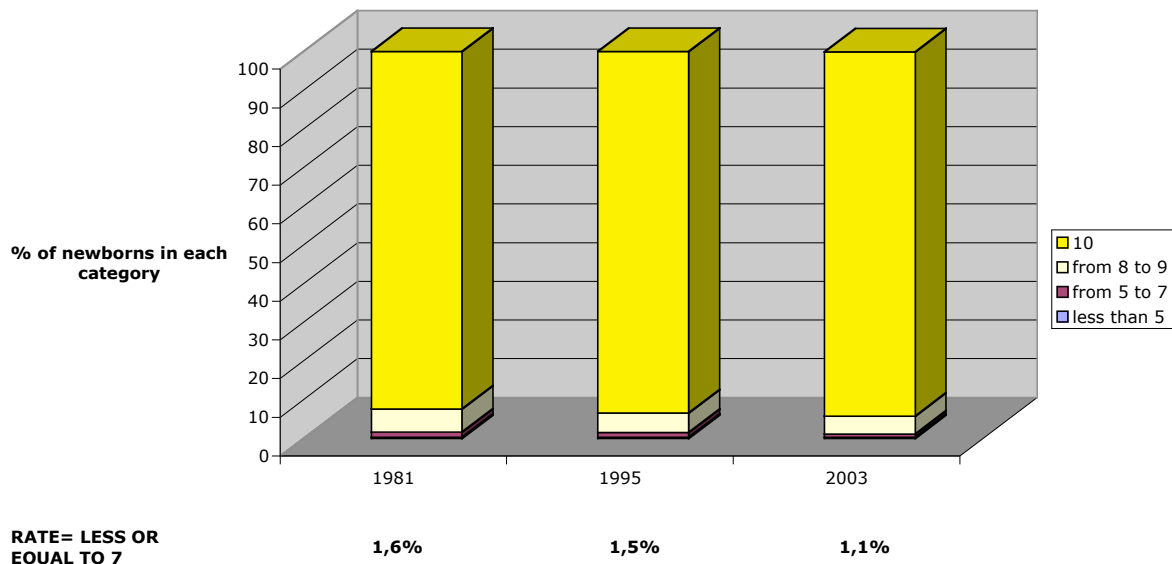
First note that this efficacy is generally assessed on the sole basis of mortality and morbidity rates. So far, no large-scale investigation has been attempted to take into consideration the satisfaction and experience of women and children, nor the long-term impact of obstetrical/neonate interventions on their healths.

It is as if the only relevant objective for the whole system were to prevent dramatic events, indeed a laudable objective but not the only one worth pursuing. This is even more illusory in the absence of strong evidence for positive correlations between technology-oriented practice and better mortality/morbidity rates in developed countries.

First indicator: the state at birth measured by the Apgar score at 5 minutes.

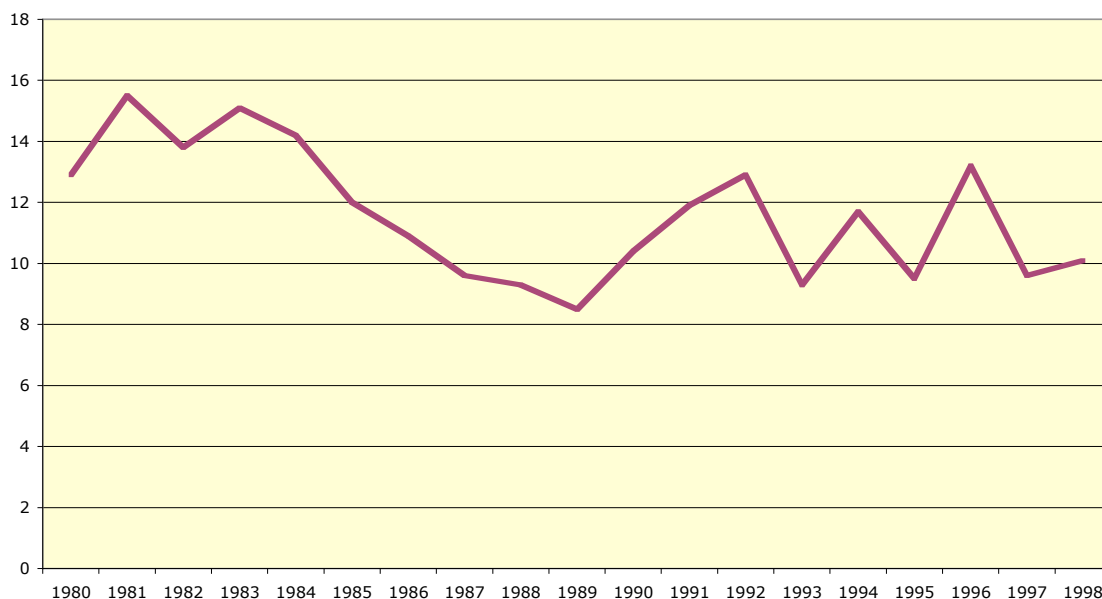
In recent years there has been a decrease of scores less than or equal to 7. The fact that no change has been recorded between 1981 and 1995 should be questioned, since most of today’s technologies were already implemented in 1995.

AGPAR SCORES (5MN)



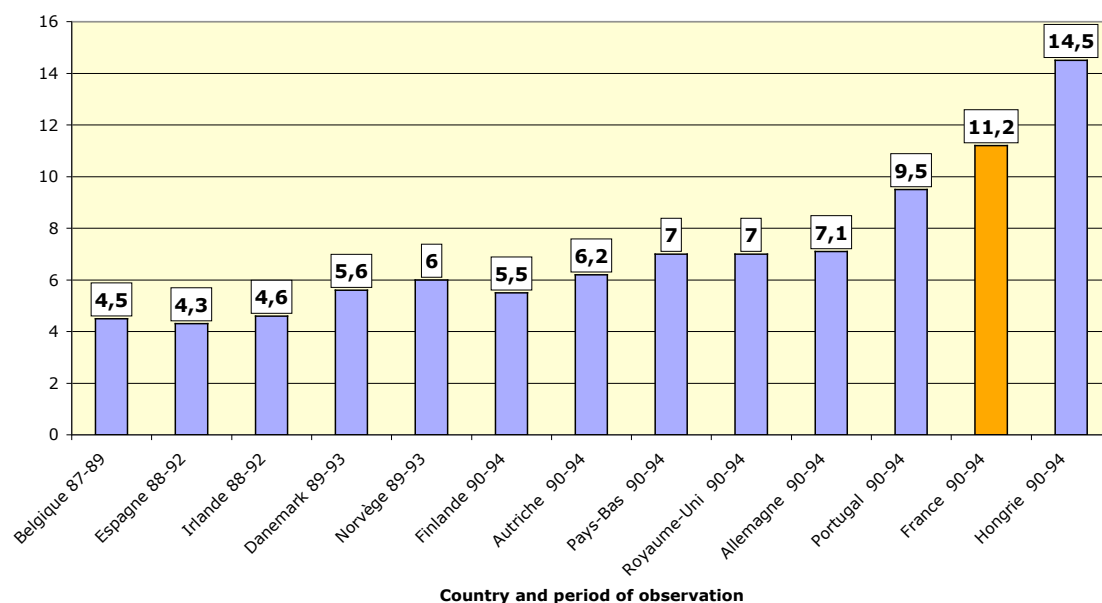
Second indicator: maternal mortality

EVOLUTION OF MATERNAL DEATHS FOR 100000 BIRTHS



It seems that maternal mortality slightly decreased after the 1980s, though this change might not be significant given the low probability of this event. The question remains to situate French performance in this domain. There is no evident answer to this question because of variations of the census method from one country to another. In addition, available comparative studies appear to be quite old. With all these precautions, however, it appears that France is not in the leading group.

MATERNAL DEATHS FOR 100 000 BIRTHS

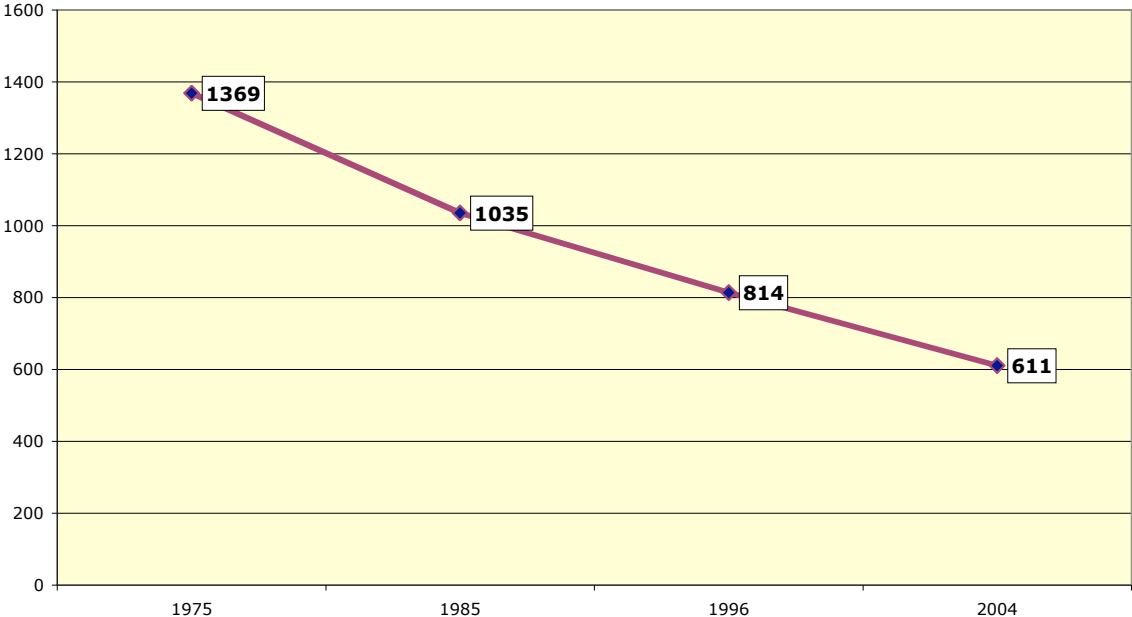


In brief, the massive transformation of childbirth conditions over the past 25 years does not seem to result in a disruption of mortality/morbidity indicators. In addition, an important matter of concern for us is that the impact of these widespread practices on women and their newborns is not really taken into account.

TRANSFORMATIONS OF THE CARE SYSTEM

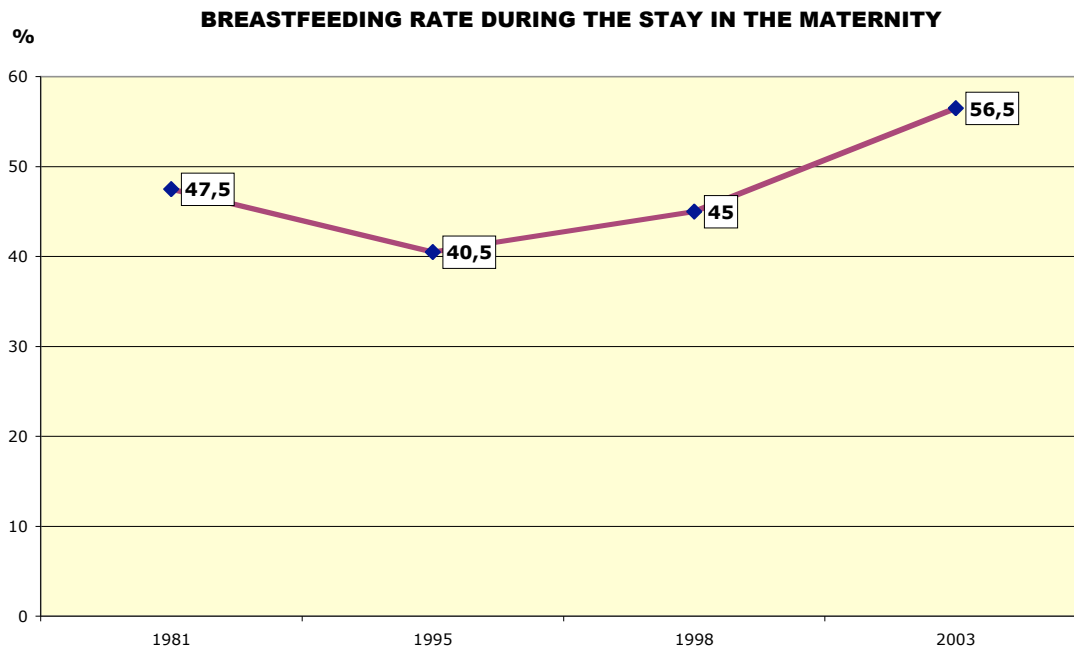
The development of this "management" of deliveries has been paralleled by a concentration of births in a decreasing number of hospitals. This trend is going on today. Even though a few large structures are trying to slightly 'de-medicalize' childbirth, at least for parents who ask for it, it seems that the major incentive for implementing techniques like continuous foetal monitoring and epidural has been to increase the number of deliveries in the same maternity.

NUMBER OF MATERNITIES IN FRANCE



Breastfeeding

After a period of dramatic decline, it seems that the breastfeeding rate — measured during postpartum days in the maternity — is again progressing. We notice an increasing awareness of this issue among professional caregivers, and noteworthy efforts have been done to support women.



THE ROLE AND SITUATION OF CONSUMERS IN PERINATAL CARE

As shown above, France has been for many years in the trend of overmedicalizing and technicizing childbirth, apparently with no hope of backtracking this tendency. Nonetheless, several important institutional changes occurred during the past five years, owing to which consumers have been assigned roles in defining health policies. These should be instrumental in triggering a long-wished transformation of the system.

NON-PROFIT SOCIETIES IN THE FRENCH SYSTEM

Till recent times the management of the French health system has been mainly in the hands of health professionals and bureaucrats. However, a number of citizens' movements — notably AIDS activism that played a prominent role — gradually established the legitimacy of consumer/patient representation. This representation was regulated by Kouchner's law on patients' rights (4 March 2002). Law reasserted individual rights, among which the obligation for practitioners to seek informed consent, and it raised the amounts of financial compensation in case of medical failure. Further it made it obligatory to formally provide space for the representation of consumers at all levels of health policy making, from hospitals to the regional and national bodies. Recently an accreditation procedure has been enforced, mainly to make sure that groups claiming to be coopted by consumers are not controlled by professional lobbies or the pharma industry.

THE FOUNDATION AND MANAGEMENT OF CIANE

CIANE (*Collectif Interassociatif autour de la Naissance*) has become the privileged contact of health authorities at the national level. This coalition of non-profit societies was founded in 2003. From the start it brought together a large number (up to 140) of societies involved in improvement of perinatal care. Their sizes and impact were extremely diverse, ranging from that of *La Leche League* boasting several thousand members to local societies whose membership may be as small as a dozen. In addition, CIANE benefited from cumulated expertise in 'virtual communities', basically Internet discussion groups.

This growing mobilisation benefitted from the use of new communication tools: websites, discussion lists, forums and cooperative knowledge engineering such as Wikipedia and Ekopedia. Electronic communication made it possible for isolated parents to exchange views and know-how; it fostered the creation of mutual help or militancy societies gathered around CIANE; it created public space for citizens' debate (such as the *Re-Co-Naissances* discussion list) and it allowed the flowering of spaces for exchanging testimonies and practical information.

The CIANE collective worked informally during its first four years. This management proved efficient: the ease of exchange, the speed of reactions, the possibility of truly collective work have been essential ingredients of its success. However, in 2007 CIANE decided to register as a formal non-profit society and apply for its accreditation in order to carry on its representation in professional and administrative bodies. A great care has been taken in preserving its informal/consensual processes of decision making from the authoritarianism and bureaucratic rigidity that might emerge from its institutionalisation.

DEFINING A BIRTH POLICY

From the start, CIANE elaborated a platform of proposals for the improvement of pregnancy, childbirth and newborn care which worked as a landmark for bringing together activist groups and claiming to embrace the largest view of consumers' expectations. This platform has been updated after *États généraux de la naissance* at the end of 2006.

États généraux de la naissance (EGN 2006) brought together more than 400 participants among whom one half were professionals of perinatal care. A few workshops campaigned against the (wrong) security-obsessed trend of medicine towards "more technology", partly resulting from a bad coupling between the sanitary organisation and medical practice: allowing more and more births in a decreasing number of maternities implies an increasingly rigid and "industrial" management of care. In this way, parents and newborns are often subjected to acts and speech in contradiction with the respect they are entitled to. This lack of respect is a source of stress, sometimes suffering that may have a dramatic effect on the relationship between parents and their newborn children. The increasing interference of medicine in childbirth yields more harmful effects: parents feel less safe, if not incompetent; they end up surrendering to professional practitioners and loose confidence in their own capacity to take care of their child.

Following EGN 2006, a platform of concrete proposals was published by CIANE in early 2007. It was granted support by several professional groups. Three major themes underly this platform:

- The diversification of offer, in particular towards the creation of “physiological channels” working on the “one woman/one midwife” basic principle, which includes free-standing birthing centres and homebirth;
- The setting up of medical practice respectful of women, newborns, fathers and relatives at large;
- The setting up of information systems projecting a consumer-friendly picture of the health-care system. In this respect, CIANE elaborated a project for a quality label inspired by the *Mother-Baby-Friendly Initiative* of CIMS (Coalition for the Improvement of Maternity Services).

Promoting practice more respectful of parents, newborns and their relatives is therefore one of CIANE’s priorities. This implies working at several levels: suggesting landmarks for guiding practice, working on tools such as the birth project that facilitating the dialogue between parents and caregivers while boosting the former’s responsibility, and finally rethink the price setting system so that perinatal care will be done in better conditions.

PARTICIPATING IN POLICY MAKING

Today CIANE is an obligatory partner (though sometimes a trouble-maker) of professional and administrative bodies. Its delegates are taking part in the High authority on health (*Haute autorité de santé*, HAS) for the publication of recommendations for clinical practice (RPC) aiming at changing the system “from the top”. Even though the use of RPC in court cases is subject to controversy, they are very useful for elaborating birth projects. (We deliberately use the word ‘project’ rather than ‘plan’ to distinguish this approach from birth plans à l’anglaise.)

CIANE participates in the National commission on birth (*Commission nationale de la naissance*, CNN) and a few committees organised by the Health ministry. However this buzzing activity should not project the false hope of “changing the world” by a handful of experts and ferocious activists working at the highest level. There are 850 000 births taking place every year over the whole territory and the practice of every hospital or clinic is strongly dependent on local conditions. Concretely, perinatal care policies are decided by Regional commissions on birth (*Commissions régionales de la naissance*, CRN) and Networks of perinatal care whose principal task is “to facilitate [...] professional collaborations thanks to a better coordination of all actors in which attention will be paid to respecting consumers’ choice.” Since health regulations (the ‘Kouchner law’ of March 2002) have placed patients/consumers at the centre of the healthcare system, delegates of consumer groups should be sitting in all bodies (whether consultative or decisional) of the healthcare system. In addition, each public or private institution should sort out disputes with its consumers via a committee for regulating issues with clients and the quality of caretaking (*Commission des relations avec les usagers et de la qualité de la prise en charge*, CRUQ) in which representatives of accredited societies are sitting.

MAKING MOBILISATION POSSIBLE

Beyond its participation in these groups, CIANE invests a great deal of energy in bringing to light questions pertaining to perinatal care, encouraging debate on these questions and promoting a broader understanding of these issues.

EGN 2006 have already been mentioned; this should be completed with participation in many colloquiums, professional and/or general audience conferences, the publication of papers in several journals, a committed response to the requests of journalists and media etc. All these actions are in the same time opportunities to increase the level of expertise which is capitalised on the CianeWiki website, thereby giving the largest public access to knowledge, data, and the viewpoints of CIANE and its affiliated societies.

WHAT TO CONCLUDE ?

We share mixed feelings about the outcome of birth activism in France, ranging from anger, frustration, loss of confidence to pleasure contemplating a few successful stories.

LIMITED PROGRESS...

We feel that things are moving — yet arguably too slow for making sure that progress is irreversible. Among positive changes we may cite the broader acceptance of birth projects. In the early 2000s the idea of birth project/plan would prompt outraged reactions among professional caregivers. Today, thanks to CIANE's participation in a work group of the Health ministry, it is explicitly mentioned in the new version of the Maternity record (*Carnet de maternité*) handed over to every pregnant woman. The birth project will be further discussed in the framework of the new national perinatal enquiry scheduled in 2009.

Even though we regret that the Gyn-obs college's (CNGOF) recommendations on episiotomy are ridiculous (suggesting a decrease of the national rate to 30%), we notice that the status of episiotomy drifted from that on a 'non-act' to that of a 'problem' whose reminder deeply irritates professional caregivers, for which it deserves being precisely taken into account in the next national enquiry.

We also feel satisfied with the new recommendations of the High authority on health (HAS) moderately aiming at the right directions:

- 1) *Labour induction* has been officially recognised as a potentially harmful intervention that should be restricted to a few specific medical situations;
- 2) The HAS promoted a change in the *antenatal screening for Down syndrome* based on a technique combining ultrasound screening with blood test in a manner significantly reducing the need for amniocentesis (a source of miscarriage) and providing results at an earlier stage of pregnancy.
- 3) Recommendations were published for the banning of *fundal pressure* on the basis of evidence found in the scientific literature.

CIANE not only took part in work groups for these recommendations; it initiated the process by submitting a request to the HAS along with previews of the EBM literature on these topics.

At the regional level, a few non-profit societies affiliated to CIANE have accomplished considerable work for improvement. In Burgundy, for instance, a society was granted funding for conducting a survey of newborn care in regional maternities, after which a common action of consumers and caregivers has been set up in a few pilot maternities. Around Lyon, three societies joined the 'Aurore' regional perinatal health network (*Réseau de santé périnatale*) in 2005. They quickly were able to take part in practical tasks: a redesign of the network's information flyer, the writing down of specifications for the training of professionals in early

pregnancy medical interviews, and regular interventions in this training on the topic of birth project... They also questioned caregivers on the conditions of Down syndrome antenatal screening (work group in progress) and pre-/post-labour transfers. In addition, thanks to their initiative, a work group studied follow-up care for pregnant women planning homebirths. This cooperation between consumers and caregivers proved beneficial for a constructive dialogue and the recognition of the role of parents representatives in professional bodies. Working on the birth project certainly was instrumental in a gradual improvement of birth practices. It remains that the network does not bear authority on all practitioners in its geographical area; therefore activists are still facing a resistance in the organisation of obstetrical teams that is slowing down the process.

... AND REASONS FOR WORRYING

Other processes at work are much less encouraging:

- The closure of small maternities is going on, leading to low quality/security standards in low-populated areas; women are given less and less choice for the place of birth.
- The gyn-obs College (CNGOF) published a recommendation advocating the use of continuous foetal heart-rate monitoring during labour despite the evidence of its inefficiency in preventing foetal distress. CNGOF's argument is based on the work load in hospitals and a presumed litigation risk!
- The new price setting system in public hospitals has serious detrimental effects. Nowadays financial support is only granted on the basis of medical acts, an incentive for more interventionism in situations that require "care rather than cure".
- Homebirth remains the *bête noire* of professional caregivers and bureaucrats. Public demand is increasing and nothing is done to allow for a reasonable growth of its practice: midwives no longer have access to insurance, hospital transfers often turn dramatic, and townhall officers may reject birth declarations by fathers since the common practice is that these declarations are done by a hospital employee.
- The « *Maisons de naissance* » (free-standing birth centres) file is still at a standstill. After ten years of working in many committees, the Health ministry managed to write down specifications for experimental centres that is meeting unanimous rejection. Many professional caregivers who are against the idea of birthing centres estimate that the proposal is unacceptable since all they want to support is the creation of physiological units inside existing maternities. Consumers and a few professionals supportive of free-standing birth centres point at shortcomings of the proposal, such as the clause that these should be built on the hospital premises for the sake of 'secure transfer'; in addition, no solution has been suggested as to midwives' insurance, and the financial set up is unlikely to allow for a real autonomy. In brief, the only effect of the time and energy spent over a decade will be the promotion of physiological units, an idea that was unknown in earlier times.

WHICH STRATEGY FOR THE FUTURE?

Given the slow progress we are often questioning strategies. Is it proper to continue a patient dialogue and collaboration with bureaucrats and professional circles? Or should we bang the

table and refuse to support a less than half-hearted policy? This question has no evident answer.

We note the emergence of recent individual initiatives tackling the problem from another angle: humour, derision, denunciation and straight attacks of “the enemy”. These actions may contribute to social mobilisation if they have more impact on mass media.

Should we adopt a strategy of “working around through Europe” that would consist of getting consumers’ expectations accepted by European Union bodies, thus forcing national bodies to take action? The question remains open.