CIANE Charter for the Designation « Respected Childbirth »

Charter of the *Collectif interassociatif autour de la naissance (CIANE)*

The aim of this initiative is to promote birthsites where women, men and their babies, are respected, as well as their physiological and emotional needs and their philosophical convictions. Besides basic physical security, psychic and emotional security is the other essential condition for ensuring that childbirth remains a physiological and non-medical act, thus preserving for us and our children its intimate and civil aspects. Psychic and emotional insecurity in the mother can disturb the physiological process of birth for the same biological reasons that stress and anxiety can disturb digestion, breathing, perspiration, lactation and sleep.

Emphasizing positive aspects means **recognizing** the deserving attitudes and behavior of caregiving teams in these birthsites and **promoting** their good practices through objective information that is as widely **publicized** as possible. It also means supporting them in their work, helping them to perpetuate it, and allowing as many women, fathers and babies as possible to benefit from such a context.

The CIANE initiative for birthsites to be designated as "**Respected Childbirth**" takes its inspiration from the MFCI (Mother-Friendly Childbirth Initiative) designation, a project of the **Coalition for Improving Maternity Services** whose head office is in Florida, USA (1).

To receive the "**Respected Childbirth**" designation, the sites and persons ensuring childbirth care must respect the civil and deontological principles expressed in the 11 steps of the CIANE Charter and commit themselves to promote them.

This Charter has a European vocation and has been enacted with the participation of health professionals (midwives, gynecologists, pediatricians, epidemiologists, sociologists and health economists) whom we thank for their contributions.

Assessment of the childbirth sites appears on a separate document and comprises 96 questions on the criteria defined by the 11 steps mentioned in this document.

Remembering the CIANE mission

CIANE is a collective made up of national associations. Its action, based on civil values and respect of the law, has no links with any political party, union, philosophical theory, religious or sectarian group. It endeavors to promote the responsibilities and rights of the perinatal system's beneficiaries. The Collective's mission is to promote attitudes and practices related to maternity care that are based on physiology and respect of human beings. As a result, the birthing process takes place in more favourable conditions, the mother-father-child attachment is established and iatrogenic effects and their related costs are substantially reduced. The model we advocate focuses on the mother, baby and family and is primarily concerned with their well-being and the quality of care they receive. It is founded on evidence-based practices and maintains that personalized follow-up, prevention, awareness of responsibility and well-being are valuable alternatives to extensive and costly programs of screening, diagnosis and treatment applied systematically and without specific necessity, thus entailing waste, complications and anxiety.

PREAMBLE:

Whereas :

• In spite of very high and constantly rising health costs per capita (2) and even though women and their newborn babies are assured safety of childbirth, morbidity and mortality rates in France are too high compared to those of most industrialized and neighbouring countries;

• Midwives attend the vast majority of births in these industrialized countries with the best perinatal outcomes, whereas in France midwives are the principal attendants at the time of expulsion of the baby in less than one birth out of every two births;

• Obstetrical practices that contribute to rising costs and inferior outcomes in maternal and perinatal statistics include not only the inappropriate use of technologies and routine procedures not based on scientific evidence (4), but also inappropriate use of the competencies of caregivers : an obstetrician is trained at high costs to treat pathologies and not to routinely take charge of normal pregnancies and births. Studies have brought out the fact that when an obstetrician attends a woman giving birth vaginally, there is a marked increase of untimely interventions with a high iatrogenic potential.

• Preventive interventions and increased dependency on technology have diminished women's confidence in their innate capacities to give birth physiologically without interventions (5);

• The establishment and integrity of the mother-father-child relationship, which begins during pregnancy, is compromised by the separate obstetrical treatment of mothers and babies as if they were two distinct units with conflicting needs;

• In spite of the fact that breastfeeding offers undeniable health, nutritional and developmental benefits for babies, only a small fraction of French mothers are fully breastfeeding their babies by the age of six weeks. This is due to lack of support for breastfeeding;

• The perinatal system, with services concentrated in a few establishments, and the current networking of maternity centers no longer guarantee access to resources and care to which women are entitled by right.

We, member associations of CIANE, **have therefore decided to acknowledge and promote the services of birthsites that respect the following principles**:

PRINCIPLES:

We believe that the values and cornerstones of attitudes and practices during pregnancy and the birthing process are as follows:

1 – Normalcy of the birthing process:

• Birthing is a private and intimate act. It is a normal and healthy process and never a potential pathology;

• Women and babies have the wisdom necessary to, respectively, give birth and be born;

• Except in confirmed cases of pathology, it is vital to respect the baby's decision to be born naturally when he or she is physiologically ready to do so;

• At birth, babies are human beings with full rights. They are alert and sensitive and in particular very sensitive to pain, to restraint of movement and to manipulations to which their bodies can be subjected. They must therefore be acknowledged as human beings and treated as such (6).

• Breastfeeding provides the best nourishment for ensuring optimal development of newborns and infants (8).

• Thanks to good care during pregnancy, competent advice and well organized management of emergencies, births can safely take place in hospitals, birth centers or the parents' home, depending on circumstances or free choices.

• The perception that midwives – guardians of the normalcy of birth - have of childbirth and their training in maternity care are the most appropriate for the majority of pregnant women who give birth.

2 - Empowerment

• A woman's confidence in her ability to give birth and care for her baby can be enhanced or on the contrary diminished by the attitude, behavior, facial expressions and remarks of any person at her side, as well as by the setting, atmosphere and organization of the place where she gives birth. Loss and/or destruction of this confidence can be the source of multiple problems during the birthing process, breastfeeding and for establishing the mother/child attachment;

• The mother, the father and their baby are distinct but interdependent persons during pregnancy, birth and infancy. Their relation and interconnectedness are vital and must be respected;

• Pregnancy, birth and the postpartum period are milestone events in the course of life. These experiences profoundly affect women, babies, fathers and families, and have important and long-lasting effects on society.

3 – Autonomy

Every woman should have the opportunity to :

• Experience birth as an important, healthy and positive event for herself and her family, regardless of her age or the circumstances surrounding the birth;

• Express her feelings without fear and be at ease to say that the experience was painful and traumatic without being the object of reprimands or criticism on the part of caregivers;

• Give birth as she wishes in an environment that ensures emotional security, that is a setting in which she feels supported and safe and in which her emotional well-being, her privacy and personal preferences are respected;

• Have access to objective information on pregnancy, birth and baby care, as well as to complete documentation on all the birthsites, different types of professionals offering services and current practices;

• Have access to accurate, objective and up-to-date information on the benefits and risks of all interventions, drugs and tests offered to her during pregnancy, birth and the postpartum period, information to be followed with the right to informed consent or refusal (7);

• Receive any support or advice from exterior sources so as to be able to make truly informed choices and to decide with her partner what is best for herself and her baby, based on respect of individual and ethnic values and beliefs (7).

4 - Abstaining from doing harm

• Interventions should never be applied routinely during pregnancy, birth or the postpartum period. Many tests, procedures, medical technologies and drugs entail risks for the mother and baby and they should be applied only with the informed consent of the woman concerned and if there is specific and verified scientific evidence that they are beneficial.

• If complications arise during pregnancy, birth or the postpartum period, the medical treatments proposed should be evidence-based.

• Except in case of explicit refusal on the part of the person concerned, giving the latter complete and objective information partakes of her fundamental right to have her dignity respected (6).

• No act liable to augment the mother's pain or that of the baby should be performed systematically if it is not linked with an existing pathology. In case of necessary painful interventions, analgesia or anesthesia must systematically be offered but only after clear and accurate information has been given to the mother on the levels of pain that may be induced. These interventions primarily concern induction and speeding up of labor (by artificial rupture of membranes or administration of oxytocin), assisted extractions (fundal pressure, vacuum, forceps), manual exploration of the uterus, suture of an episiotomy or a tear. Not treating the pain resulting from these interventions constitutes a malpractice act.

• A woman in labor should not be immobilized, especially in the lithotomy position. Freedom of movement and position help to reduce the mother's pain and is necessary for the baby's progress.

5 – Responsibility:

• Each caregiver is responsible for the quality of care he or she provides;

• Maternity care during childbirth should not be based on the needs of the caregivers or providers of services but solely on those of the mother and her baby;

• Each birthsite is responsible for periodic review and evaluation, according to current scientific evidence, of the effectiveness, risks and rates of the medical interventions practiced on women and babies in accordance with protocols.

• Governments and public health institutions are responsible for offering sufficient maternity care services to meet the demand, for making it possible for all women to have free choice of birthsites and for ensuring the quality of the care that the latter dispense;

• Women must feel free to exercise their right to informed choices and assume responsibility for the health care they and their babies receive;

6 - Transparency

• Any birthsite must be transparent about its activities and their outcomes. It is the staff's responsibility to ensure this transparency. This is achieved through the publication of a periodic report on the activities of the birthsite and by putting at the public's disposal any important information concerning these activities and their outcomes.

7 – Respect of the law:

• No one is above the law;

• Protocols and regulations in care establishments must respect the law and cannot be challenged by a third party;

• Informed consent must be obtained prior to any medical act and it can be withdrawn anytime (7);

• The unborn foetus is an integral part of the mother and any damage to its integrity affects the emotional and physical integrity of the mother;

• In addition to being subject to the ethical and deontological regulations of professionals, the medical act is a remunerated act which cannot be imposed without the consent of the mother. Therefore, the caregiver's will cannot prevail over that of the mother for she possesses, like her companion, values of altruism, unselfishness and love for her child.

*These principles support the following eleven steps that define and promote birthsite services under the designation "**Respected Childbirth.***

The eleven steps of the "Respected Childbirth" Initiative:

To receive the designation "Respected Childbirth", **the hospital**, **birth center or home birth service must respect the above principles and the following criteria**:

They must:

1) Offer any woman in labor:

• the possibility of having at her side one or two persons of her choice (including the father, her companion, family members or friends) or, in case of cesarean birth, one person of her choice in the operating room;

• unrestricted access to continuous psychological, emotional and physical support from a person of her choice (a trustworthy person, a doula, etc.);

• the possibility to have labor and birth attended by a midwife of her choice who is guaranteed access to the establishment's services (8).

2) Provide accurate descriptive and statistical information to the public about the practices and protocols for birthcare, including statistics of interventions and outcomes (inductions, episiotomies, extractions, cesarean births, etc.);

3) Provide culturally competent care, that is sensitive to and respectful of the specific beliefs, values and customs of the mother and of her religion (7).

4) Except in case of emergency or complications, provide the woman in labor with freedom to walk about, move and assume positions of her choice during labor and birth, and combat habits and prejudice tending to consider lithotomy (flat on back or semi-inclined with legs elevated) as the only acceptable position, contrarily to studies proving that it is not physiological. Make sure that the light and sound environment is respectful of the parents' need for a peaceful atmosphere. Any unnecessary transfer from one place to another should be avoided.

5) Have clearly defined policies and procedures concerning :

• collaboration with a previously identified and financially established network of perinatal services, including perinatal consultations with a professional caregiver chosen by the pregnant woman and transfer to an establishment of higher level if necessary for medical reasons,

• information on the sites, resources and professionals at the disposal of the mother and her baby concerning pre- and postnatal follow-up and breastfeeding support.

6) Respect the WHO recommendations and not routinely employ practices and procedures not supported by scientific evidence, including, among others, the following:

• sweeping of the membranes

• insertion of bladder catheter,

• shaving of vulva and/or perinea,

• enemas,

• insertion of IV lines

• withholding food and drink during labor,

• rupture of membranes when labor starts,

• continuous electronic fetal heart monitoring,

• use of synthetic oxytocics,

• repetitive vaginal examinations done by different caregivers,

• fundal pressure,

• episiotomy,

• manual exploration of the uterus

Limit the number of interventions to the following rates and trends:

• induction of labor to a rate of 10% or less (level 1);

• episiotomy rate to 13% or less (goal: 6% or less) (level 1);

• cesarean rate to 10% or less in level 1 maternity centers, and to 17% or less in services of levels II and III (with identification of patients depending on risk);

• VBAC (vaginal birth after cesarean) to 60% or more (goal 75% or more);

• reduction of the number of epidurals.

7) Educate and train staff to non-drug methods of pain relief and resort to use of analgesics or anesthesia only at the request of the woman (after ineffective use of other alternatives) or, if needed, to treat a complication;

8) Encourage the mother/child attachment and respect the baby as a person :

• Except in case of emergency, the baby should not be separated from his /her mother after birth to undergo examinations that can wait;

• Give necessary care in a calm atmosphere while the baby is in mother's or father's arms or during breastfeeding, if this is possible;

• Give glucose or artificial milk to the baby only with the mother's or the father's consent;

• Except at the request of the mother, the baby should not be separated from his/her mother at night, including the first night;

• No painful and invasive examinations (Guthrie test**,** glucose test**,** silver nitrate) should be done without an analgesic cream or glucose to calm the baby, and these should take place when the baby is in his parents' arms or, better still, during breastfeeding. They should never be done when the mother or father are absent or without their knowledge, but with their consent and in their presence;

• Avoid multiplying redundant care and examinations (punctures, etc.) that have not been planned (visits in succession of the baby-nurse, the pediatrician, the nurse) or are untimely (awakening the baby to take his temperature, weigh him/her, give a bath or medication);

• Except if the parents asked precisely the opposite or except for a vital medical reason, do not clamp or cut the umbilical cord before the blood stops pulsating;

• Do not proceed with examinations or medical acts except when the baby's life is at stake or for medico-legal purposes;

9) Promote family harmony and manage emergency situations with appropriate measures and procedures :

• An effective policy for favouring early formation of the couple/child relationship through staff education and training, and establishment of appropriate procedures;

• All births of babies destined for adoption should be taken in charge by a team of specialized professionals according to an established protocol;

• Management of perinatal loss by means of the following measures : presence of a grief-support professional or specialist (psychologist); adequate staff training; diffusion of a protocol in the establishment; access to a list of community health workers who can give help for the burial or other administrative tasks;

• Management of social or psychological distress by specialized caregivers and use of a written procedure for linking with community health services;

• Management of high risk pregnancies and births within the framework of a codified relationship with an identified network of appropriate structures;

• Support of trained multidisciplinary teams for parents of premature babies or babies presenting pathologies, and establishment of a protocol;

• Support from a city-hospital network under the guidance of (in France) the Direction régionale de l'action sanitaire et sociale or a policy on early discharge and support during the postnatal period. In addition, a written procedure for systematic follow-up by community health services should be drawn up. This follow-up procedure comprises either registration for a transfer to a neighbouring perinatal center or an appointment with a midwife within a 48 hour period. Early discharge should take place only at the woman's request and never be imposed on her.

10) Comply with the ten steps established by WHO and UNICEF for baby-friendly establishments to promote breastfeeding :

• Have a written breastfeeding policy that is routinely communicated to all health care staff and publicized;

• Train all health care staff in skills necessary to implement this policy;

• Inform all pregnant women about the benefits and management of breastfeeding;

• Help mothers initiate breastfeeding within a half-hour of birth;

• Show mothers separated from their babies how to breastfeed and how to maintain lactation even if they are separated from their infants;

• Give newborn infants no food or drink other than breast milk unless otherwise indicated for medical reasons;

• Allow mothers and infants to remain together 24 hours a day except on the mother's request to the contrary;

• Encourage breastfeeding on the baby's (or the mother's) demand;

• Give no artificial teat or pacifiers to breastfed babies;

• Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the birthsite.

Moreover, in case of need, artificial milk offered to the mother for her baby should be bought by the maternity center and not be furnished as a gift from industrial firms.

11) Respect the fundamental human rights by providing objective and complete information : respecting informed consent to all medical acts, allowing participation in decisions relative to therapeutic acts and/or diagnoses, respecting the conscience

clause of the law and the right to refuse care, ensuring quality care that respects privacy and dignity, providing sufficient and competent staff.

Glossary

Birth center : Free-standing maternity center..

Doula : A woman who gives continuous physical, emotional, and informational support during labor and birth – may also provide postpartum care in the home.

Episiotomy : Surgically cutting to widen the vaginal opening for birth.

Induction : Artificially starting labor.

Morbidity :Disease or injury.

Perinatal : Around the time of birth.

Rupture of membranes : Breaking the “bag of waters”.

For more information, see www.ciane.info

Notes

(1) **CIMS National Office**, POB 2346, Ponte Vedra Beach, FL 32004, (888) 282-CIMS, 01(904) 285-1613, fax : 01(904) 285-2120, email info@motherfriendly.org, website www.motherfriendly.org

(2) 5.8 % of GDP in 1970 versus 9.7 % in 2001 (source: Compte de la Santé 2000-2002)
i.e. 2,437 euros per person and per year.

(3) Wildman et al. explored whether variation in the level of maternal mortality ratios among European countries reflected differences in obstetric care. They analysed 290 maternal deaths occuring between 1992 and 1995. Mortality ratios delineated two groups of countries: one with a low MMR averaging 5.9 per 100,000 live births comprizing, among others, Norway (3.3) and Germany (7.6) and one with a higher MMR averaging 10.2, among which France (11.3).
Source: Wildman K, Bouvier-Colle MH; MOMS Group. Maternal mortality as an indicator of obstetric care in Europe. BJOG. 2004 Feb;111(2):164-9.

Other source: DGS / Bureau de la Qualité des pratiques 8, avenue de Ségur, 75007 Paris, July 2001.

Table 6: MMR in number of deaths per 100,000 live births
based on civil register data in 1990-94:

Source [3] http://www.sante.gouv.fr/htm/pointsur/maternite/n32

Pays	Effectifs des décès maternels	Taux pour 100000 naissances	Intervalle de confiance à 95%
FINLANDE	18	5,5	3,3-8,7
DANEMARK	18	5,6	3,3-8,8
NORVÈGE	18	6,0	3,5-9,5
AUTRICHE	29	6,2	3,9-8,5
PAYS-BAS	69	7,0	5,4-8,7
ROYAUME-UNI	270	7,0	6,1-7,8
ALLEMAGNE	292	7,1	6,3-7,9
PORTUGAL	54	9,5	6,9-12,0
FRANCE	414	11,2	10,1-12,3
HONGRIE	88	14,5	11,5-17,5
TOTAL PAYS	1385	6,9	6,8-7,0

(4) OMS – WHO : **Care in normal birth: A practical guide** :
http://www.who.int/reproductive-health/publications/MSM_96_24/MSM_96_24_table_of_contents.en.html
The French national perinatal survey in 1998 (http://www.sante.gouv.fr/) indicates 17.5 % c-sections (increasing), 12.5 % forceps, 71.3 % episiotomies on primiparous women and 36.2 % on multiparous, thus averaging 53.7 % (i.e. 350,000 women each year), 58 % epidurals (3.9 % in 1981 ; 48.6 % in 1995 ; 30 to 95 % depending on the location), 20.3 % induction of labor. This deliberate interventionism yields perinatal statistics among the worst in Europe.

(5) It is often called “nocebo effect”.

(6) See *« Pour une charte du Naissant »*, Blandine Poitel, Les Dossiers de l'Obstétrique, 302, 2002, <http://users.swing.be/carrefour.naissance/Articles/refl/PourUneCharteDuNaissant.htm>

(7) Code de la Santé Publique et Code de Déontologie Médicale. Rappel des principaux articles du CSP :

« Art. L. 1110-2. - La personne malade a droit au respect de sa dignité ».
« Art. L. 1110-3. - Aucune personne ne peut faire l'objet de discriminations dans l'accès à la prévention ou aux soins ».
« Art. L. 1110-5. - Toute personne a, compte tenu de son état de santé et de l'urgence des interventions que celui-ci requiert, le droit de recevoir les soins les plus appropriés et de bénéficier des thérapeutiques dont l'efficacité est reconnue et qui garantissent la meilleure sécurité sanitaire au regard des connaissances médicales avérées. Les actes de prévention, d'investigation ou de soins ne doivent pas, en l'état des connaissances médicales, lui faire courir de risques disproportionnés par rapport au bénéfice escompté ».
« Toute personne a le droit de recevoir des soins visant à soulager sa douleur. Celle-ci doit être en toute circonstance prévenue, évaluée, prise en compte et traitée ».
« Art. L. 1111-2. - Toute personne a le droit d'être informée sur son état de santé. Cette information porte sur les différentes investigations, traitements ou actions de prévention qui sont proposés, leur utilité, leur urgence éventuelle, leurs conséquences, les risques fréquents ou graves normalement prévisibles qu'ils comportent ainsi que sur les autres solutions possibles et sur les conséquences prévisibles en cas de refus ».

Art. L. 1111-4. - Toute personne prend, avec le professionnel de santé et compte tenu des informations et des préconisations qu'il lui fournit, les décisions concernant sa santé.
« Le médecin doit respecter la volonté de la personne après l'avoir informée des conséquences de ses choix. Si la volonté de la personne de refuser ou d'interrompre un traitement met sa vie en danger, le médecin doit tout mettre en oeuvre pour la convaincre d'accepter les soins indispensables.
« Aucun acte médical ni aucun traitement ne peut être pratiqué sans le consentement libre et éclairé de la personne et ce consentement peut être retiré à tout moment.
« Lorsque la personne est hors d'état d'exprimer sa volonté, aucune intervention ou investigation ne peut être réalisée, sauf urgence ou impossibilité, sans que la personne de confiance prévue à l'article L. 1111-6, ou la famille, ou à défaut, un de ses proches ait été consulté ».
« L'examen d'une personne malade dans le cadre d'un enseignement clinique requiert son consentement préalable. Les étudiants qui reçoivent cet enseignement doivent être au préalable informés de la nécessité de respecter les droits des malades énoncés au présent titre ».

(8) See the recommandations of WHO, UNICEF and HAS in France.