Opportunity for a paradigm shift in maternity care:
guiding principles for getting the most out of COVID-19

Mostly, things were already not working.

- A baby is born every 8 seconds in the United States and quality care during pregnancy and birth is foundational.
    - But as a society we do not put a proportional focus on the perinatal period, or what is most effective in the perinatal period.[1]
- We have the poor health outcomes to show for it[2]:
    - inequitable disparities (Native and Black women are 2 and 3 time more likely than white women to die as a result of pregnancy);
    - severe morbidity (almost dying from pregnancy) rose 45% from 2006-2015;
    - the worst outcomes at the highest price in the world (the U.S. is ranked after dozens of other countries on most indicators).
- Mistreatment and human rights violations during reproductive health care and specifically childbirth occur in high and low resource countries all over the world[3], and the United States is not immune with some surveys suggesting 1 in 6 are impacted.[4]
- A paradigm shift is required if we want to do better. We can't just make some tweaks, we need an overhaul.

In the middle of a crisis we're not likely to fix things but we might see what we couldn't see before, and if we take note we can make way for paradigm shift. Here are some things to look for:

- A lot of healthy people rely on hospitals during the intrapartum and immediate postpartum period for things that could be delivered separately, differently, or in less expensive ways:
    - Information: about childbirth, postpartum, nursing, early parenthood;
    - Shelter: a safe and special place to be during the intensity of birth;
    - Structure: a way to organize pregnancy and prepare for parenthood.
- A lot of sick people rely on hospitals for those same things plus medicine.
- Knowing when intrapartum and postpartum people need medicine is key[5].
- How is it paid for, what does it cost; does anyone know?
    - It is not easy to know[6].
- People are taking risks, facing risks, and talking about risks; but people's risks are not equal or the same, and language about risk lacks nuance[7].
    - Notice who is scared and what they are scared of.
- There are a lot of parts in the system that rely on other parts. But those parts aren't well connected.
- The system doesn't adjust to change - separate parts just continue or fail on their own.
    - If some part fails a "solution" is cobbled together with duct tape (making things even more sticky and less responsive and harder to fix).
    - People cling to their duct-taped solutions.

There are things that work.

- People are creative and resourceful. They find ways to approximate what they need.
    - Focus on the fact that they are resourceful *and* that they have needs.
    - People who have been marginalized (whether due to race, poverty, sexual orientation or many other things) are often exceptional at creativity and resourcefulness.
        - People who have lived with privilege should look to them, learn from them.
- People resource themselves with things that are near; information, family, friends.
    - The things people hold close, like access to their doula, or birth plan, or phone tell us about *both* what they can get ahold of (a person, a phone) and what they need (support, comfort, reassurance).
- The least expensive things are often some of the best things for perinatal health[8].
    - Don't just dismiss the low-tech, low-cost options.
    - There are already experts in the low-tech, low-cost options, look to them (i.e. midwives and doulas, see below).
- People will give anything for safe harbor during birth:
    - people need a safe place to land, a refuge, a reliable spot;
    - the spot will ideally feel safe based on their own measure of safety;
    - a person's measure of safety may by influenced by popular culture, health care providers, family, but may also be unique to them.
    - Risk and cost-benefit analyses will heavily favor this safe harbor, even when there are concomitant costs that in other times may be intolerable (actual monetary costs, human rights costs, or costs to priorities and values).
- Doulas work[9].
- Midwives work[10].
- Physiology works.
    - Birth happens, even in crisis, even in war zones, even alongside death.

Notes:

[1] National Partnership for Women & Families, Maternity Care in the United States: We Can - and Must - Do Better, Issue Brief, February 2020. Available at: https://www.nationalpartnership.org/our-work/resources/health-care/maternity-care-in-the-united.pdf

[2] *Id.*

[3] United Nations General Assembly Report. July 11, 2019. "A Human Rights-based Approach to Mistreatment and Violence Against Women in Reproductive Health Services With a Focus on Childbirth and Obstetric Violence." Available at: https://www.un.org/en/ga/search/view_doc.asp?symbol=A/74/137

[4] Vedam, Saraswathi, et al. "The Giving Voice to Mothers Study: Inequity and Mistreatment during Pregnancy and Childbirth in the United States." Reproductive Health, vol. 16, no. 1, June 2019, p. 77. BioMed Central, doi:10.1186/s12978-019-0729-2

[5] See, The Birth Place Lab, Best Practice Guidelines for Interprofessional Collaboration: Community Midwives and Specialist Providers. Available at: https://www.birthplacelab.org/best-practice-guidelines-for-transfer-and-collaboration and The Birth Place Lab, Best Practice Guidelines: Transfer from Planned Home Birth to Hospital. Available at: https://www.birthplacelab.org/best-practice-guidelines-for-transfer-and-collaboration/

[6] Truven Health Analytics, The Cost of Having a Baby in the United States, prepared for Childbirth Connection et. al (2013). Available at: https://www.nationalpartnership.org/our-work/resources/health-care/maternity/archive/the-cost-of-having-a-baby-in-the-us.pdf

[7] Linda Fentiman, Blaming Mothers: American Law and the Risks to Children's Health (2017).

[8] Carol Sakala and Maureen P. Corry, Evidence-Based Maternity Care: What It Is and What It Can Achieve, Co-published by Childbirth Connection, the Reforming States Group, and the Milbank Memorial Fund (2008). Available at: https://www.nationalpartnership.org/ our-work/resources/health-care/maternity/evidence-based-maternity-care.pdf

[9] Rebecca Dekker, Evidence on: Doulas. Available at: https://evidencebasedbirth.com/the-evidence-for-doulas/

[10] The World Health Organization, The Case for Midwifery. Available at: https://www.who.int/maternal_child_adolescent/topics/quality-of-care/midwifery/case-for-midwifery/en/