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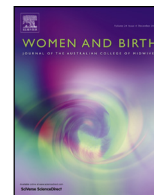

Women's attitudes towards the medicalization of childbirth and their associations with planned and actual modes of birth

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ABSTRACT

Problem: Rates of medical interventions in childbirth have greatly increased in the Western world.
Background: Women's attitudes affect their birth choices.
Aim: To assess women's attitudes towards the medicalization of childbirth and their associations with women's background as well as their fear of birth and planned and unplanned modes of birth.
Methods: This longitudinal observational study included 836 parous woman recruited at women's health centres and natural birth communities in Israel. All women filled in questionnaires about attitudes towards the medicalization of childbirth, fear of birth, and planned birth choices. Women at <28 weeks gestation when filling in the questionnaire were asked to fill in a second one at ~34 weeks. Phone follow-up was conducted ~6 weeks postpartum to assess actual mode of birth.
Findings: Attitudes towards medicalization were more positive among younger and less educated women, those who emigrated from the former Soviet Union, and those with a more complicated obstetric background. Baseline attitudes did not differ by parity yet became less positive throughout pregnancy only for primiparae. More positive attitudes were related to greater fear of birth. The attitudes were significantly associated with planned birth choices and predicted emergency caesareans and instrumental births.
Discussion: Women form attitudes towards the medicalization of childbirth which may still be open to change during the first pregnancy. More favourable attitudes are related to more medical modes of birth, planned and unplanned.
Conclusion: Understanding women's views of childbirth medicalization may be key to understanding their choices and how they affect labour and birth.
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Statement of Significance

Problem or issue

Medicalization of childbirth is on the rise and it is important to understand what influences women's inclination to use or reject birth-related medical technology.

What is already known

Women have become more accepting of medical technology but at the same time there is a growing demedicalization trend. Both medicalization and demedicalization have been linked to women's birth choices.

What this paper adds

Women's socio-demographic and obstetric background is related to their attitude toward medicalization of childbirth, which in turn is linked to their birth choices and planned and unplanned modes of birth.

1. Introduction

1.1. Medicalization and demedicalization

The dominant birthing model in most of the Western world is medicalized childbirth.[1,2] This is evident in the overall high use of

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medical interventions, often without any medical indication, such as epidural analgesia, caesarean births, and the controversial option of caesarean birth on maternal request. Caesarean rates are on the rise: in 2014 they accounted for 32.3% and 25.0% of births in Northern America and Europe, respectively.[3] Medicalization begins earlier in the pregnancy, with prenatal care that transforms pregnancy into a permanent at-risk condition in need of medical monitoring.[4] Together with recognizing the benefits of medicalization, there has been growing concern among healthcare professionals that the medicalization of childbirth may have gone too far.[5] Correspondingly, there have been calls for clinical practice based on evidence-based procedures that would better support physiological birth.[6]

Alongside increasing medicalization there is also a trend of demedicalization,[7] expressed by both professionals and birthing women. Women's yearning to naturalize birth is expressed in choices such as midwife-led natural birth and homebirth. Such choices are uncommon but are on the rise and in 2014 home births accounted for 2.3% of births in England[8] and out-of-hospital births accounted for 1.5% of births in the United States.[9]

These two trends are also noticeable in Israel, the location of the current study. On the one hand, medicalization is high: nearly 99% of all births are performed in hospitals, with caesarean birth rates close to 20%.[10] Although this is lower than the rates cited above for the Western world, it exceeds the WHO recommendation of up to 15% caesarean births. In addition, only 57% of women who had one previous caesarean birth attempt a trial of labor.[10] Rates of epidural analgesia, which is the most common and almost exclusive pain relief method, are 43%,[10] with some hospitals reaching over 90% among primiparae. While uncomplicated physiological births in hospitals are assisted by midwives, overall, labour and birth are led by obstetricians, who make all medical decisions. On the other hand, groups calling for demedicalization are slowly gaining popularity. Home births attended by midwives are on the rise (although the rates are still very low), in-hospital natural birth centres and maternity wards offering rooming-in are opening and midwife-led antenatal community clinics are being established.

1.2. Women's birth choices and attitudes

Altogether, the various trends yield a wide variety of choices for women giving birth in modern society, ranging from caesarean birth on maternal request, on one end, to home birth, on the other end. Between those two extremes are various preferences regarding where and how to birth (e.g., natural birth centres, use of epidural analgesia, labour induction, continuous foetal heart-rate monitoring, etc.). Many studies have investigated women's preferences for specific birth options as well as the consequences of these options (see reviews[1,11]). Much less is known about the underlying attitudes and perceptions that may be related to women's choices from the wide spectrum of birth options. This is important since in practice, women are often offered a restricted range of choices.[12] The lack of knowledge on what women prefer and why makes it difficult to change these practices.

Research suggests that many women nowadays are ambivalent. Even in a medicalized system dominated by obstetricians, most women prefer a vaginal birth yet view it as the "natural but hard way" whereas caesarean sections are "the easy choice".[13] Many women take an active part in medicalization by seeking and welcoming medical interventions in childbirth, or at least openly accepting them, if offered.[14] A systematic review showed that many women desire a drug-free labour yet expect that they will need some medical pain relief.[11] Thus, there seems to be a continuum of attitudes towards medicalization and every woman is somewhere along this continuum.[4]

Several studies have investigated women's views and their association with different birthing choices. Women's definitions of childbirth as 'natural' versus 'risky' were found to be related to the choice of a midwife-led or obstetrician-led birth.[15] Birth attitudes were related to pregnant women's fear of birth, mode of birth, and experience of labour and pain.[16] Greater acceptance of medical interventions in childbirth increased the odds of epidural use, which in turn was related to more operative and instrumental births. This link between attitudes, fear of birth and preferred birth choices was also found among childless college students.[17]

1.3. Aims

Existing studies on women's attitudes towards childbirth have often included questions about the perception of the nature of childbirth itself and the relational style with the care provider, along with questions about the use of medical technologies during labour and birth. The current study focused specifically on *Attitudes towards the Medicalization of Childbirth* among pregnant women. Previous studies have mainly focused on specific choices (such as caesarean birth on maternal request or use of medical analgesia) whereas the current study examined the entire range from elective caesarean birth to homebirth. This is important because in highly medicalized birth environments, women may not be fully exposed to this entire range. Their attitudes may be one of the factors that contribute to overuse and underuse of obstetric technology, which could cause health disparities. Specifically, our aims were: (1) to assess differences in attitudes towards the medicalization of childbirth between groups of women who differ in their socio-demographic or obstetric characteristics (e.g., parity; conception via fertility treatment); (2) to investigate the association of attitudes towards the medicalization of childbirth with fear of birth reported during pregnancy; (3) To assess the associations of attitudes towards the medicalization of childbirth with *women's* planned birth choices and with their *actual mode of birth.*

2. Participants, ethics and methods

2.1. Recruitment and procedure

The study was approved by the Institutional Research Boards at the Maccabi Health Services and the Tel Aviv University and was carried out according to the ethical standards of research with human beings. Recruitment for the study took place between May 2012 and December 2013 via two routes: (1) recruiting women while they were waiting for a prenatal check-up at Women's Health Centres in central Israel. The centres belong to the Maccabi Health Services, the second largest healthcare service in Israel; (2) recruiting pregnant women through relevant websites, home midwives, and personal acquaintances, to ensure adequate representation of the full spectrum of birth choices.

Eligibility criteria for participants included at least 14 weeks of gestation, a singleton pregnancy, without complete contraindications for vaginal birth (such as placenta previa or two previous caesarean births), and Hebrew-speaking. After receiving an explanation about the study from the research team, women were asked for their written consent to participate. In the online version they were asked to indicate their consent before they could proceed to fill out the questionnaire.

The study design was prospective, with at least one measurement during the second or third trimester of pregnancy and follow-up after birth. Of 942 women approached by the study team in the women's health centres while waiting for their appointment, 551 (58.4%) agreed to participate. The main reasons for non-participation were lack of time, concerns about anonymity, and dislike of surveys. Another 299 women were recruited in the

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