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EDITORIAL

NEW INSIGHTS INTO MATERNITY CARE DESIGN AND DELIVERY

# New insights into maternity care design and delivery: editorial commentary

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This series of articles sets the design and delivery of Italian maternity care within the global arena, in terms of guidelines for practice; the design of labor wards and birth spaces; medical and midwifery education; the impact of the media; and the views and experiences of those who use the maternity services.

There are significant changes occurring globally in relation to the official framing of health care in general,[1] and maternity care in particular.[2] This is captured broadly in the United Nations (UN) millennium development goals, that are now focused on enhanced wellbeing, as well as on the need to reduce mortality and morbidity.[3] Specifically, in terms of women and adolescent girls, the UN is proposing a move from immediate clinical "survival" alone, to a whole-life notion of "Survive, Thrive, Transform."[4] This is picked up in global dialogue about respectful care,[5] and a recognition by the World Health Organization (WHO) that optimal maternity care is a combination of both safety and positive well-being.[6] It also reflects an increasing awareness that what happens during pregnancy, labor and birth probably has effects into the medium and longer term (and even potentially transgenerationally) for the mother and the baby.[7, 8] This includes increasing concern about the iatrogenic risks of interventions that are undertaken "too much too soon" as well as those undertaken "too little too late."[9] Cesarean section and widespread induction of labor are both included in the list of procedures undertaken "too much too soon" in some contexts and for some women and babies, as well as in the list of those undertaken "too little too late" for other populations and individuals.[9] The implications of this for fathers, parents, families and societies is also generating debate, as is recognized, for instance, in the endorsement by the International Federation of Gynecology and Obstetrics (FIGO) and the International Confederation of Midwives (ICM) among others of the new evidence based International Childbirth Initiative 12 steps for MotherBaby-Family friendly maternity care.[10]

There are a number of parallel movements happening in maternity care in Italy, including the creation of birth centers, and the evidence from some sites of positive collaboration between women, midwives, obstetricians, and others working in maternity care. As Skoko *et al*. have noted in their article published in the present issue of *Minerva Ginecologica*,[11] there is evidence of good practice around Italy from the Italian Babies Born Better survey of the views of women who have children under the age of 5. In recognition of the global move towards the need for health services to promote thriving, the authors note that there are areas

of Italy where respondents to the survey only provided positive comments. It is possible that some of these responses were promoted by positive childbirth environments (for women and for staff).

Setola *et al.*[12] pursue this possibility in their case studies of the architectural design of, and philosophy behind, two Italian birth centers. As for the other papers in this issue, the conscious creation of the conditions in which positive human relationships can thrive seems to be a key component of the success of these birth centers. Morano *et al.*[13] present another facet of this so called "mechanism of effect" in their examination of the integration (or not) of a range of humanities subjects into the Italian medical and midwifery undergraduate curriculum. Intriguingly, and against expectation, they find that the differences are not so much between disciplines (though there is some evidence of this), but within each discipline. This means that professionals with the same qualification may have very variable exposure to the knowledge and insights from the humanities. This is particularly concerning in terms of the very low percentage of medical and midwifery schools that integrate ethics into their formal curriculum, given the highly complex ethical dilemmas that can emerge during the maternity episode.

Italy has one of the highest caesarean section rates in Europe, second only to Cyprus.[14] Some of the issues underneath this statistic are also explored by Skoko *et al*.[11] In addition, they are picked up by Hadjigeorgiou *et al*.[15] who examine the way the media report on matters relating to maternity care in both Italy and Cyprus. They contrast these findings with the approach of the media in Iceland, which has one of the lowest caesarean section rates in the world,[14] as well as one of the lowest perinatal mortality rates.[16]

In a further analysis of what could underpin different practices and outcomes across Europe, Iannuzzi *et al.*[17] examine national ANC guidelines in 11 European countries, in relation to the recent WHO ANC guidelines. Again, the story is of variation, even though most national guideline stakeholder groups use a similar evidence base. Part of the variation is explained by the different kinds of philosophies that guide maternity care in each country, with an increasing emphasis in most (but not all) national guidelines on the balance between clinical practice and maternal views, experiences, and values.

To sum up, there is an increasing move towards recognizing the importance of emotional and psychosocial elements of maternity care. This Series shows that when women are asked, many do report some very positive experiences from their Italian maternity care. However, this is variable, with particular geographical areas of the country where the story is less positive overall. This variation in the quality and design of maternity care is reflected in maternity unit architecture, in media coverage of maternity care between countries, and in the inter-country content and uptake of national guidelines. Comparisons both between the local and regional maternity care services of a specific country (such as Italy) can identify the locations and reasons for best practice and serve as examples of such good care for less well performing local units. At the international level, the comparisons undertaken in this Series also indicate that improvement in outcomes and in women's experiences of both safe and personalized care require a willingness to find out how the best performing countries and services organize and deliver maternity care. Enabling positive, empowering relationships between and among service using women and their partners, and maternity service staff and managers, seems to be critical. In the international arena, there is a move towards 'Asking Different Questions'[18] for maternity care. These proposals underpin a new research agenda to restore the balance between the 'too little too late' and the 'too much too soon' extremes that drive different philosophies of maternity care. The intention is to address both excessively high levels of iatrogenic intervention in some environments, and dangerously low levels of care delivery in others, while maximizing optimal wellbeing in both the short and longer term. As this Series indicates, learning from the best, within and between European countries with different kinds of service design, philosophy and outcomes, has the potential to benefit everyone, now, and into future generations.

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