Global Health & Medicine. 2023; 5(5):301-305.
DOI: 10.35772/ghm.2023.01054

Lessons from the "Humanization of Childbirth" Projects: Qualitative analysis of seven projects funded by the Japan International Cooperation Agency

Emi Tahara-Sasagawa[1,2,*], Keiji Mochida[3], Toru Sadamori[4], Miho Suzuki[5], Carmina Guerrero[5], Megumi Haruna[2], Chizuru Misago[6]

[1] Graduate School of Nursing, Japanese Red Cross College of Nursing, Tokyo, Japan;
[2] Graduate School of Medicine, The University of Tokyo, Tokyo, Japan;
[3] Earth and Human Corporation, Tokyo, Japan;
[4] Samauma Consulting LLC., Tokyo, Japan;
[5] TA Networking Corp., Tokyo, Japan;
[6] Department of International and Cultural Study, Tsuda University, Tokyo, Japan.

Abstract: The "Humanization of Childbirth" Project is one of the various maternity care models that respect women and their newborn children. For more than a quarter of a century, the Japan International Cooperation Agency (JICA) has been implementing technical cooperation projects worldwide that place the humanization of childbirth at the center of the concept. By reviewing the project reports, the following 11 key processes were found for the formulation and implementation of future projects for the humanized maternity care: *i*) project-finding/exploration of unmet needs, *ii*) identification of local key persons, *iii*) organization of a project team and a back-up committee, *iv*) development of an action plan, *v*) sharing of concepts, *vi*) development of local leadership, *vii*) organization of infrastructure, *viii*) final evaluation and wrap-up seminar, *ix*) ensuring sustainability, *x*) development of younger generation experts, and *xi*) sustainable and autonomous action.

***Keywords*:** humanization of childbirth, respectful care, maternity care, childbirth, Japan International Cooperation Agency (JICA)

Introduction

The significance of person-centered and respectful maternity care is becoming widely recognized (*1*). Poor quality of care was identified as the most crucial barrier to improving maternal health and was found to be closely related to unnecessary or excessive medical interventions which undermine women's ability to give birth and impair their childbirth experience. Subsequently, the World Health Organization (WHO) undertook a strategic change of making maternity care more people-centered and created the "Quality of care framework for maternal and newborn health" in 2015 (*2,3*). Further, the WHO recommended respectful care aimed at enabling women to fulfill their potential and have positive childbirth experiences (*4*).

Concept of the humanization of childbirth

Currently, several models for maternity care have been proposed. "Humanization of childbirth" is one of these models overlapping the concept of respectful care (*5*). For more than a quarter of a century, the Government of Japan, through the Japan International Cooperation Agency (JICA), has been implementing technical cooperation projects with counterparts around the world that prioritize the humanization of childbirth. The term "dehumanization" may be able to explain the notion of "humanization" in the context of childbirth. Women giving birth are treated with disregard for their dignity in settings where they should be supported, suffer unnecessary mental and physical burdens as a result of inappropriate medical interventions that have no scientific evidence, and do not receive appropriate care when they require it. These "dehumanizing" situations take place worldwide. JICA's "humanization of childbirth" initiatives aim to make the birthplace more "humanized" by respecting the dignity and autonomy of women.

Previous projects related to the humanization of childbirth

Table 1. Target countries and projects for this study

Country	Project Title	Duration
Brazil	The Maternal and Child Health Improvement Project in North-Brazil	1996.04 – 2001.03
Bolivia	Project for Strengthening Health Network in Rural Region Focusing on Mother and Children Health in the Municipality of La Paz	2004.01 – 2005.12
	Project for Strengthening Health Network in Rural Region Focusing on Mother and Children Health in the Department of La Paz	2010.08 – 2014.08
Armenia	Reproductive Health Project	2004.12 – 2006.11
Benin	Program on Maternal and Child Health	2006 – 2016
Madagascar	Project for Improvement of Maternal, Newborn, and Child Health Service	2007.01 – 2010.01
Senegal	Project for Enforcement of Management of Health System in Tambacounda and Kedougou	2009.01 – 2011.12
	Project for Reinforcement for Maternal and New Born Health Care Phase 2	2012.11 – 2018.03
Cambodia	Project for Improving Maternal and Newborn Care through Midwifery Capacity Development	2010.03 – 2015.08

The original version of this table is presented in the report (*9*) written in Japanese and created by the authors, which has been translated into English and presented in this paper.

The first JICA-funded "Humanization of Childbirth" Project was launched in Brazil in 1996, at a time when hospital-based medicalization of childbirth was prevalent, with high cesarean section rates which were over 80% in private clinics (*6,7*). The concept of "humanization of childbirth" was brought forth by the integration of the Japanese midwifery philosophy of a "safe and satisfied birthing experience" with the Brazilian educator Paulo Freire's thoughts on "humanization", which he referred to as the "process of regaining dignity and autonomy of people who have been deprived of it". Project activities identified that humanization of childbirth includes the following aspects: fulfilling and empowering both women and their care providers, promoting the active participation and decision-making of women in all aspects of their care, providing care in which physicians and non-physicians have an equal relationship, and providing care based on scientific evidence (*8*). Since the successful introduction of this concept, JICA has implemented similar projects globally, accumulating their experiences to improve the quality of maternity care in pioneering international trends.

This study aims to describe the lessons learned from the previous JICA projects and determine the processes required for the formulation and implementation of future projects for humanized maternity care. To achieve the objectives, a qualitative study was conducted by analyzing unpublished but relevant documents, such as baseline and final evaluation reports, monthly reports, and quarterly reports of JICA projects that were completed by 2018. In addition, non-personally identifiable interview data from pregnant women, postpartum women, and key informants included in the report were also used in the analysis.

This paper is a partial work of the completion report of the "Research Project on Improving Quality of Care through the 'Humanization of Childbirth'", which was conducted under an outsourcing agreement with JICA; the full 140-page report written in Japanese is available on the JICA Web site (*9*).

Lessons from the "Humanization of Childbirth" Projects

From 1996 to 2018, nine JICA projects had been completed in seven countries, including Brazil, Bolivia, Armenia, Benin, Madagascar, Senegal, and Cambodia (Table 1). The first project was launched in 1996 in Brazil, and the most recent project was completed in 2018 in Senegal, indicating the technical cooperation of JICA of over 22 years. Based on the results of the review, 11 processes of the projects were identified and categorized into 4 phases: *i*) project-finding/exploration of unmet needs, *ii*) identification of local key persons, *iii*) organization of a project team and a back-up committee, in the "project formation" phase, *iv*) development of an action plan, *v*) sharing of concepts, *vi*) development of local leadership, *vii*) organization of infrastructure, *viii*) final evaluation and wrap-up seminar, in the "project implementation" phase, *ix*) ensuring sustainability, *x*) development of younger generation experts, in the "project follow-up" phase; and *xi*) sustainable and autonomous action, which "always needs to be noted" (Figure 1). Furthermore, promoting factors of each of the processes were extracted.

Phases of project formation

i) Project-finding/exploration of unmet needs

Typically, JICA projects begin in response to a request from partner countries. However, prior to these requests, each project had a principal person from the Japanese side who recognized the unmet needs in maternity healthcare, played an active role in the formation of the projects, and contributed to the conceptualization and development of the project design. Those principal

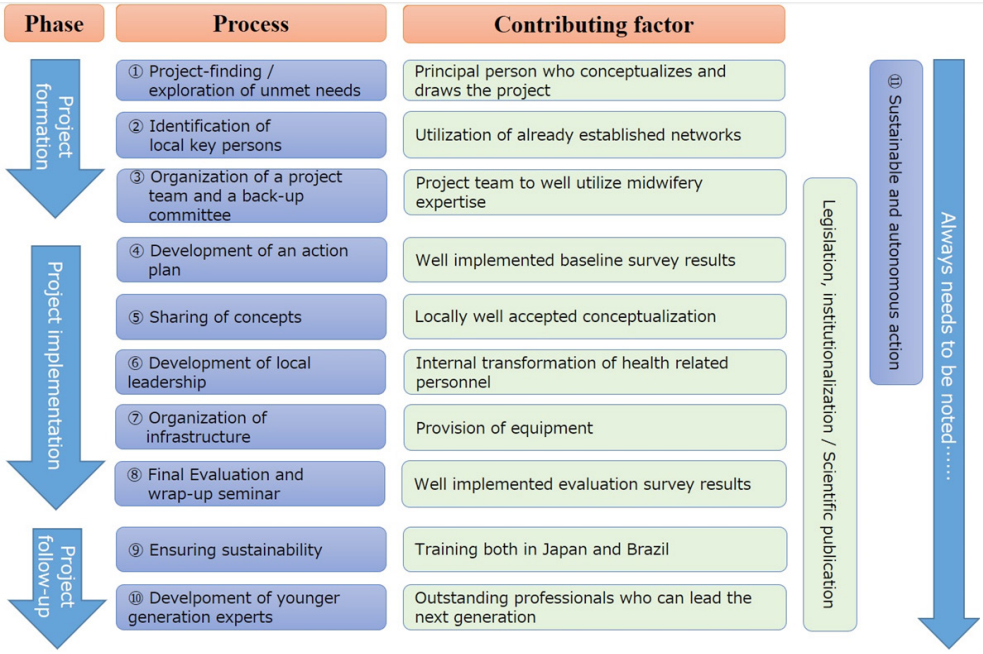

Figure 1. The processes for the formation of the project and the contributing factors. The original version of this table is presented in the report (*9*) written in Japanese and created by the authors, which has been translated into English and presented in this paper.

people included experts (as in the case of Brazil and Armenia), staff of the JICA overseas office (Bolivia), and members of the National Committee for the Project (Brazil, Cambodia, Madagascar, Senegal, and Benin).

ii) Identification of local key person

Solid and friendly partnerships had already been built in the project sites, which was critical in establishing a network of local key person. Such partnerships have been observed in places where JICA had constructed tertiary-level medical facilities (Bolivia, Cambodia, Madagascar, and Benin), where JICA had already implemented technical cooperation projects in the health sector (Cambodia), and where several midwives had been dispatched as Japan Overseas Cooperation Volunteers (JOCV) (Bolivia).

iii) Organization of a project team and a back-up committee

In projects where midwives could concentrate on their activities, they had demonstrated midwifery care in practice and could facilitate local understanding of the concept of humanization (Brazil, Cambodia, Madagascar, and Senegal). To accomplish this, a well-organized project team had to collaborate with specialists in epidemiology and/or public health who were consistently involved with planning, implementing, evaluating, and disseminating the concept of the "humanization of childbirth" throughout the project. Furthermore, the presence of a back-up committee from Japan was critical as they provided organizational support (Brazil).

Phases of project implementation

iv) Development of an action plan

The development of an action plan based on a thorough examination of the field situation at the beginning of the project was recommended. For example, appropriate action plans were derived from well-designed survey results obtained *via* the Rapid Anthropological Assessment Procedure (RAP) using anthropological methods (Brazil and Senegal).

v) Sharing of concepts

The concept of "humanization of childbirth" was shared using locally and culturally accepted terms. For example, the concept was rephrased as "Evidence-Based Medicine (EBM)" in Armenia, Madagascar, Benin, and Senegal; however, EBM itself does not encompass the entire concept of humanization. Alternatively, phrases such as "women and baby-friendly childbirth care" and "the physiological model of childbirth", were used widely.

vi) Development of local leadership

The project aimed to transfer technology and promote changes in behaviors and attitudes among the health personnel of the partner countries. Participatory workshops were useful in the realization of humanization as a sense, rather than a theory. Consequently, terms like "empowerment", "transformation", and "internal change" emerged among the care providers. At the start of these projects, such workshops were conducted by project specialists; by accumulating the experiences from the workshops, local counterparts became leaders themselves, driving the "humanization of childbirth" concept in the local context.

vii) Organization of infrastructure

Minimal environmental arrangements, such as the provision of Doppler device, installation of curtains, and introduction of balance balls to promote safety, satisfaction and comfort in women, were cost-effective approaches that were implemented in most projects. In Brazil, the JICA project supported the development of the Ministry of Health's building standards related to the "labor, delivery, and recovery (LDR) systems", which allow women to spend the entire process of their childbirth in a single room in public hospitals (*10*). Moreover, the project collaborated on the development of an LDR bed that promotes free positioning during childbirth.

viii) Final evaluation and wrap-up seminar

Conducting a survey, along with counterparts, to evaluate the impact of the project is recommended to look back at the accomplishments and identify the remaining challenges. The present study revealed that the process indicators commonly utilized for the final evaluations were easy to quantify, for example, the number of training sessions held, the number of participants, and the test scores indicating knowledge of evidence-based maternity care. However, the most crucial indicator of the childbirth experience of women was rarely evaluated. Considering the intentions of the projects to introduce the concept of humanization, indicators that appropriately capture women's childbirth experiences and care providers' internal changes are required. Additionally, a wrap-up seminar at the end of a project was found to be beneficial in summarizing project accomplishments and ensuring project sustainability after its completion. At the end of the project, Brazil hosted the first international conference about the humanization of childbirth, with approximately 2,000 participants from more than 23 countries sharing their findings and lessons learned (*11*). This conference caused the establishment of the "Latin American and Caribbean Network for the Humanization of Childbirth (RELACAHUPAN)" whose international conferences have been held regularly for the past 20 years.

Phases of project follow-up

ix) Ensuring sustainability

Efforts were made to ensure the sustainability of the humanization of childbirth after the project ended *via* training in Japan. Training at birthing homes run by midwives impressed the participants deeply with their autonomy and discipline. Since the law prohibits midwives from practicing medicine, Japanese midwives use only simple equipment, wait for the physiological processes of childbirth, and detect early deviations from the normal course of pregnancy and childbirth through continuous humanized care. Moreover, South–South cooperation in conducting training for the humanization of childbirth in Brazil has played a critical role in the sustainability of these projects. The Sofia Feldman Hospital in Brazil, in particular, is regarded as a model hospital that realizes the humanization of childbirth by providing the highest level of maternity care. Counterparts from the JICA projects globally who are in the process of introducing the concept of "humanization of childbirth" have attended the training held at this hospital.

x) Development of younger generation experts

In the early 2000s, the concepts of the humanization of childbirth were reimported to Japan from Brazil and were enthusiastically received. Since the return of the project specialists to Japan, they have been role models for the younger generation and have actively promoted human resource development. Consequently, motivated persons have been developed and play a crucial role in the implementation of successive projects (Bolivia, Armenia, Benin, Madagascar, Senegal, and Cambodia).

Always needs to be noted

xi) Sustainable and autonomous action

Looking ahead to the end of the projects, project experts are always required to take note of sustainable and autonomous actions. For example, the establishment of an educational system for obstetric and neonatal nurses, as well as that of regulations to guarantee the humanization of childbirth as a fundamental human right, were found to be effective. In addition, the publication of academic papers on this topic provided opportunities to share knowledge and expand networks.

Conclusion and suggestions

This study reviewed a quarter-century of experience of JICA in projects for the humanization of childbirth, extracting lessons learned from 9 projects in 7 countries and describing 11 necessary processes divided into 4 phases. Building partnerships between project members and their counterparts in host countries was found to be fundamental throughout the projects, as described in each process.

The current global goal of maternal and child health is to lower the maternity mortality ratio (MMR). In contrast, MMR may only represent severe cases that require emergency care. The reduction of maternal deaths is not, in itself, the same as improving maternity care. The WHO Quality of Care Framework may have been developed in an attempt to capture the care provided and the childbirth experiences of women (*3*); unfortunately, this framework did not exist when the target projects in this study began. As mentioned in the 8th process, indicators that appropriately capture women's childbirth experiences and care providers' internal changes are required.

This study had several limitations. First, this study did not go into detail about the activities, interventions, and outcomes of the projects in the seven countries. Second, obstructive factors, such as a lack of funds and human resources, were not described because majority of the obstructive factors could not be solved through project intervention. Finally, this study could not include information on the current situation at the project sites. However, we believe that this study has been able to compile a list of points to consider when implementing projects related to the humanization of childbirth.

Funding: This work was supported by the Japan International Cooperation Agency (JICA) under the Research Project on Improving Quality of Care through the "Humanization of Childbirth".

Conflict of Interest: The authors have no conflicts of interest to disclose.

References

1. World Health Organization. The prevention and elimination of disrespect and abuse during facility-based childbirth. 2015. *https://apps.who.int/iris/bitstream/handle/10665/134588/WHO_RHR_14.23_eng.pdf* (accessed May 1, 2023).
2. Tunçalp Ö, Were WM, MacLennan C, Oladapo OT, Gülmezoglu AM, Bahl R, Daelmans B, Mathai M, Say L, Kristensen F, Temmerman M, Bustreo F. Quality of care for pregnant women and newborns-the WHO vision. BJOG. 2015; 122:1045-1049.
3. World Health Organization: Standards for improving quality of maternal and newborn care in health facilities. 2016. *https://www.who.int/publications/i/item/9789241511216* (accessed May 1, 2023).
4. World Health Organization: WHO recommendations: Intrapartum care for a positive childbirth experience. 2018. *https://www.who.int/publications/i/item/9789241550215* (accessed May 1, 2023).
5. Curtin M, Savage E, Leahy-Warren P. Humanisation in pregnancy and childbirth: A concept analysis. J Clin Nurs. 2020; 29:1744-1757.
6. Misago C, Kendall C, Freitas P, Haneda K, Silveira D, Onuki D, Mori T, Sadamori T, Umenai T. From 'culture of dehumanization of childbirth' to 'childbirth as a transformative experience': changes in five municipalities in north-east Brazil. Int J Gynaecol Obstet. 2001; 75: S67-S72.
7. Hopkins K. Are Brazilian women really choosing to deliver by cesarean? Soc Sci Med. 2000, 51:725-740.
8. Misago C, Umenai T, Onuki D, Haneda K, Wagner M. Humanised maternity care. Lancet. 1999; 354:1391-1392.
9. Japan International Cooperation Agency. Work completion report 2021 – Research Project on Improvement of Quality of Care through the "Humanization of Childbirth". *https://openjicareport.jica.go.jp/pdf/12362737.pdf* (Accessed August 5, 2023). (in Japanese)
10. Ministério da Saúde no Brasil. Portria MS/GM Nº 985, de 05 de agosto de 1999. *https://cvs.saude.sp.gov.br/zip/Portaria%20GM%20MS%20n%C2%BA%20985,%20de%2005ago99.pdf* (accessed May 1, 2023).
11. Umenai T, Wagner M, Page LA, Faundes A, Rattner D, Dias MA, Tyrrell MA, Hotimsky S, Haneda K, Onuki D, Mori T, Sadamori T, Fujiwara M, Kikuchi S. Conference agreement on the definition of humanization and humanized care. Int J Gynaecol Obstet. 2001; 75: S3-S4.

Received May 1, 2023; Revised August 11, 2023; Accepted August 24, 2023.

Released online in J-STAGE as advance publication September 8, 2023.

**Address correspondence to*:
Emi Tahara-sasagawa, Graduate School of Nursing, Japanese Red Cross College of Nursing, 4-1-3 Hiroo, Shibuya-ku, Tokyo 150-0012, Japan.
E-mail: e-sasagawa@redcross.ac.jp