Guide to a Healthy Birth

#3 of a series • 2011/2012

Choices in Childbirth

Free to the Public.

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Welcome to the 3rd Edition of the Guide to a Healthy Birth

About Us
Choices in Childbirth (CIC), founded in 2003, strives to improve maternity care through education, outreach and advocacy. We help expectant parents make informed decisions about where, how and with whom to birth; and we actively work to ensure access to childbirth services and options that support healthy birth outcomes.

CIC has had an exciting year of growth. We have put in place a dynamic team that is dedicated to expanding our programming and advocacy efforts to ensure that all women have access to the Mother-Friendly care they deserve. We are pleased to introduce CIC’s staff: Lisa Malley, Executive Director and Malorie Ferrick, Program Manager.

Guide to a Healthy Birth
We are thrilled to introduce the 3rd edition of the Guide to a Healthy Birth!

The Guide to a Healthy Birth is the cornerstone of CIC’s educational programming. In 2008, we created this Guide to help you make informed decisions about your birth. Our goal is to provide you with information, tools and guidance to help you find what’s best for you in maternity care and birth.

New Online Resource for Parents
Using the principles of the Mother-Friendly Childbirth Initiative as its foundation (see p. 34), Choices in Childbirth has launched an online, national database of Mother-Friendly Providers:

The Guide to a Healthy Birth Online Provider Network!

The goal of this network is to connect parents with providers who share a similar philosophy of birth and who will respect and support a woman and her family during pregnancy, birth and postpartum. By simply entering their zip code on our website, parents can instantly find all the participating Mother-Friendly care providers near them.

Through this new searchable online database, thousands of expectant parents, from New York to Alaska, will now be able to find and connect with practitioners who share the belief that birth is a normal, natural and healthy process.

Visit our website to find a Mother-Friendly care provider near you!

Thank You!
On behalf of Choices in Childbirth, I would like to thank the Coalition for Improving Maternity Services (CIMS) and BirthNetwork National for inspiring this publication through the principles of the Mother-Friendly Childbirth Initiative. We would also like to thank the activists, volunteers, and talented interns who have helped us in our mission to protect access to quality maternity care in our community.

We are grateful to our article contributors for sharing their wisdom, expertise and experiences in this edition of the Guide.

Thank you to the practitioners listed in the Online Provider Network for the important work you do by believing in women, recognizing the power of their bodies, trusting the birth process and for helping the next generation enter the world in a healthy, peaceful and loving way.

We want to thank our generous partners who have supported us in our launch of the Guide to a Healthy Birth Online Provider Network - Midwives Alliance of North America, DONA International, Lamaze International, the International Childbirth Education Association, the International Center for Traditional Childbearing, CIMS, and BirthNetwork National.

And thank you to the mothers, fathers and babies who continue to enrich and inspire our work and our lives.

Élan McAllister
President

Special thanks to the generous sponsors who have made the printing of the 2011/12 Guides possible:

Midwives Alliance of North America
Mothering Magazine
DONA International
Midwifery Institute of Philadelphia University
Lamaze International
International Childbirth Education Association
BirthNetwork National
Coalition for Improving Maternity Services

...
Choices in Childbirth’s 5 Steps to a Healthy Birth

“I’m Pregnant!! Now what?”

*We love it when a woman asks questions, educates herself, and takes an active role in her maternity care decisions!*

The birth of your child will be one of the most important and memorable experiences of your life. It is worth the effort and time to learn about all of your childbirth options so that you can make the decisions that are right for you and your family. Once you’ve identified what’s important to you, you’ll be able to clearly communicate your wishes and choose a care provider and birth environment that will respect and honor your choices.

We’ve put together a list of 5 basic steps that will help guide you through the process of making these decisions. We encourage you to identify a birth partner (spouse, partner, family member, close friend), invite them into this process, and go through each step together. Your partner will ideally be your primary support person and advocate during labor and birth. The more prepared your partner is to ask questions and make requests on your behalf, the more you’ll be set up for an empowered and healthy birth.

**Step 1: Educate Yourself**

Start this exciting new phase in your life from an empowered position! In today’s world you have access to a seemingly limitless amount of information about pregnancy and birth. Dive in! Sign up for a comprehensive childbirth education class, read healthy pregnancy and birthing books and magazines, and watch documentaries on childbirth. Reach out to parents, providers and birth organizations in your area to find out about local resources and to get a sense of what birth options are available to you in your community. Check the CIC website for resources, our list of recommended books and films, and to find childbirth educators and parenting support classes in your area.

**Step 2: Listen to your Body**

Your body is about to embark on an epic journey. Pregnancy and childbirth will challenge you in all kinds of new and exciting ways. Despite the fast pace of life, this is a time for you to listen and connect to your body’s messages. During this time, your needs will be changing almost continually. Take time to check in with yourself each day and really listen to what your body is telling you. Making this connection now will not only optimize your health during pregnancy, but will also be invaluable during labor and birth.

Some of the things you will want to consider are your diet, the rest and exercise you’ll require, and the levels of stress in your life. Nurturing yourself and your body is the very first step in caring for your baby. Reach out for support when necessary and enjoy putting yourself and your body’s needs first. You can find nutritionists, body workers and fitness instructors in your area in the CIC Provider Network.

**Step 3: Create Your Personal Birth Philosophy**

Now that you’ve started to educate yourself about pregnancy and birth, it’s time to make some choices. Step 3 is about identifying your own personal philosophy and creating a vision for your child’s birth. It is time to be really honest and clear with yourself. For example: Do you believe the process of birth is: Safe? Scary? Sacred? Do you believe that labor and birth require medical assistance? Do you feel it is a normal, natural process? Do you fear labor is potentially dangerous? Do you want medical assistance throughout? Do you want to deliver in the most natural way possible? Do you fall somewhere in between, believing that birth is usually safe but feeling that you want a higher level of medical expertise on hand, just in case?

Ask yourself big questions and listen honestly to your answers. Notice what fears come up for you and talk them through with your partner, support people or a counselor. Once you have a sense of your beliefs about birth you will be ready to make the maternity care decisions that are right for you such as where, how and with whom to birth. The CIC Provider Network can help you find prenatal counselors and doulas who can assist you in this process.

**Step 4: Choose Your Care Provider**

Choosing a maternity care provider is the single most important decision that you will make. Take the time to interview providers to ensure that you find the best possible match. Ask your provider many questions to make sure he/she supports and agrees with your personal birth philosophy (for some guidelines, see “Questions to Ask Your Care Provider,” pg. 8). You should feel confident that your provider is skilled AND that he/she will respect your wishes. Trust your gut! Once you’re in labor you won’t be able to convince your care provider to go against his/her own birth philosophy and follow your wishes. This is an unrealistic and often disappointing expectation. Listen to your instincts NOW as to whether or not the provider is the right one for you.

Options for maternity care providers include Obstetricians, Midwives, Family Physicians, and Osteopaths. Check the CIC website for listings of Mother-Friendly providers in your area.
5 Steps to a Healthy Birth (continued)

Step 5: Choose Your Birth Environment

Your personal philosophy and vision for your birth will help you determine the right birth environment. The vast majority of women in the United States birth in hospitals. While this is the dominant choice, it is not necessarily your only one. In many locations, women may also have the choice of birthing in free-standing birth centers, hospital-based birth centers or in their own homes. Which of these choices best matches your philosophy and vision? For instance, women wishing to have a natural, unhurried birth generally have a hard time finding support for this choice in a hospital setting. Likewise, women who believe that birth is potentially dangerous might not feel safe birthing at home. Where will you feel best supported and safest birthing your child?

“If only I’d known then what I know now.”

These are heartbreaking words.

Birth doesn’t always go the way that we expect it to. Sometimes women are disappointed when their birth takes an unexpected turn. This is understandable. But there’s a big difference between not having the birth that you hoped for because of unforeseen complications and not having the birth that you hoped for because the providers serving you didn’t share your philosophy or respect your wishes.

We strongly encourage you to take the time to become educated about your options, connect to your birth philosophy, develop your vision, and select the providers and setting that will support you to the fullest.

For more information, including local provider listings, resources and recommended books and films, visit choicesinchildbirth.org.

the rewards

this room is the world made small
and I go the journey
I’ve chosen
set in the evolving perfection that only comes with time
leave the haze
leave the dictators quiet and gentle
I surrender
and ride these growing waves until I harden and break
into a million pieces (and let it be known that I’m not easily fractured)
then soften and meld like wax and break again and meld like wax
and break and meld and break into a million pieces and then meld back into one until I’m tempered through and through brave and bold and powerful and no one can ever take this away from me
my warrior found
my valiant glory
my victory
mine!
labored on the altar
of this sweet birth

–MTC 09/10
Questions To Ask Your Care Provider

Here are some suggested questions to encourage dialogue and to help you get a sense of your care provider’s approach. It is a good idea to interview at least 2 or 3 providers. It is never too late to change providers if you are not comfortable with the answers you receive.

1. Is there a limit to the number of people who can accompany me during my birth? How do you feel about a labor support professional such as a doula or massage therapist joining my birth team?

2. Will I be able to eat and drink in labor?

3. If I were interested in having a natural, unmedicated birth, how would you feel about it?

4. What comfort measures do you recommend?
   • Freely changing positions and walking around
   • Water therapy (shower/tub)
   • A doula
   • Epidural
   • Narcotics (Stadol/Demerol)

5. What would you recommend I do if my water breaks before contractions have begun? How long after my water breaks would you recommend induction if my labor doesn’t start on its own?

6. What are your protocols regarding my due date, i.e. inducing labor at 40 weeks? 41 weeks?

7. Do you believe in active management of the first stage of labor? For example, would progress of less than one cm per hour call for artificial rupture of membranes (AROM) or Pitocin? If everything is fine with me and my baby, will I be able to labor at my own pace and for as long as I need?

8. If you feel that labor has to be stimulated what methods do you recommend?
   • Herbs
   • Nipple stimulation
   • Castor oil
   • Intercourse before spontaneous rupture of membranes (SROM)
   • Enema
   • Acupuncture
   • Stripping of membranes
   • Artificial rupture of membranes (AROM)
   • Pitocin

9. What is your protocol regarding the following procedures and how often do you perform them?
   • IVs
   • Continuous versus intermittent fetal monitoring
   • Internal fetal monitoring
   • Artificial rupturing of the membranes (AROM)
   • Epidural
   • Assisted vaginal delivery (forceps/vacuum)
   • Episiotomy

10. What is your cesarean rate? What factors do you believe contribute to that rate? What is your VBAC rate? What are your standard protocols for VBAC mothers?

11. Will I be able to choose the position in which I will push and give birth, such as, side-lying, all fours or squatting?

12. Can my baby remain with me at all times from the moment of birth? Do you support skin to skin contact between me and my baby immediately after birth?

13. (For home birth midwives) How long will you stay with me after my baby is born?

14. (For home birth midwives) What is your rate of transfer to the hospital? Who are your consultant obstetricians? Will I be able to meet or interview them?
Childbirth Education: Making Informed Decisions

By Judith Lothian, PhD, RN, LCCE

When childbirth moved to the hospital and physicians began providing maternity care, woman-to-woman knowledge about birth faded away. Formal childbirth education began in the early 1960’s as women demanded that childbirth once again “come out of the dark.” Those early classes gave women basic information about birth physiology and coping strategies, like breathing and relaxing, to enable them to labor and give birth without medication. Partners attended classes and learned to “coach” women through contractions and provide emotional support throughout labor. The information was basic, and the skills were simple.

The technology that has grown up around birth in the U.S. during the past fifty years has made it progressively harder to give birth simply and without intervention. Those interventions, when used unnecessarily, can actually make birth less safe for mothers and babies. A good childbirth class gives you the information you need to make truly informed decisions, and teaches you ways to advocate for yourself. Today’s childbirth education classes help make sense of the vast amount of information you are likely to encounter during your pregnancy. Childbirth education can bring birth back to the basics and help you let go of fear (really). The end result is a safer, more empowered birth.

Research suggests that the women who are most satisfied with childbirth have high personal expectations of the birth, excellent labor support, a good relationship with their caregiver and are actively involved in decision making.* Childbirth classes help you achieve all of these.

What do women have to say about childbirth classes?

Maggie wanted a VBAC (vaginal birth after prior cesarean) and chose a doctor who said it was possible. She then attended a childbirth education class that encouraged her to ask questions. She asked her doctor how many VBACs he had done. When he said, “None,” she realized he probably had no intention of supporting a VBAC. She changed to a hospital midwifery practice and went on to vaginally deliver a 9 pound baby after a short labor. “If I hadn’t gone to childbirth classes, I wouldn’t have known the right questions to ask my doctor and I wouldn’t have realized I had the option to change to someone else.”

Clara chose a midwife with a hospital practice. The tour of the hospital was an eye-opener. She realized she was not comfortable with the rules and restrictions and changed to a birthing center. “My childbirth educator was so knowledgeable and honest that I had the information I needed to change to a birthing center.”

Cynthia wanted a natural birth and attended classes at the hospital. It became clear that the classes were simply preparing her to be a good patient. She and her husband realized they needed to know more about how to have a natural birth in the hospital. They attended another class outside of the hospital and learned about natural birth as well as how to talk to the doctor and develop a personal birth plan. “Thanks to attending both classes, I had a natural birth in a hospital that had a 60% cesarean rate!”

Though information in childbirth classes scared Eve, she was glad she had learned ahead of time about the risks of some routine maternity practices and the rules at the hospital. The classes helped her clarify what she wanted and then helped her set priorities. “Before the classes I just went along with what my doctor said without even thinking that it might be important to think about what was best for me and my baby.”

Mary never thought she wanted to give birth naturally. But after an engaging childbirth education class taught her how simple birth can be, Mary changed her mind. “No one was more surprised than I was to give birth naturally. I was thrilled.”

Jamie had a cesarean after a long, difficult labor. Based on what she learned in class, she let labor start on its own and used a wide variety of comfort measures during her long labor. She was part of the decision making when it came time to consider a cesarean. “I feel okay about the cesarean. I worked really hard in labor and I am happy about that. What I learned in class helped me be confident enough to talk straight with my doctor when we all started thinking cesarean.”
A word of caution: beware of classes that prepare you to be a good patient. These are the classes that focus on hospital rules, possible complications, and medical interventions. Learning about labor and birth shouldn’t focus on what might go wrong. Classes should instead build your trust in the process of birth and confidence in your own birthing ability.

Finally, good classes are small (preferably no more than ten couples) and interactive. There should be lots of time for discussion, practicing, questioning, and strategizing as you make your birthing plans. Consider enrolling in a childbirth education class early in your pregnancy.


Judith Lothian, PhD, RN, LCCE, is a maternal child nurse and childbirth educator. She is an associate professor at Seton Hall University, the Associate Editor of the Journal of Perinatal Education and chair of the Lamaze International Certification Council. She has five children and nine grandchildren.

SHARE: If you have birthed in the United States in the last three years, please visit www.thebirthsurvey.com and click on the “Share” button to anonymously share information about your birth experience.

CONNECT: Click on the “Connect” button to see how other women in your community have rated the care they’ve received from local doctors, midwives, hospitals and birth centers.

LEARN: Do you know your hospital’s cesarean section rate? Click on the “Learn” button to get intervention rates for hospitals in your area.
National Cesarean Section Rates by State Comparative 2000 & 2007

At printing, the most recent state-by-state information available for cesarean section rates were the 2007 data reported by the Center for Disease Control (CDC). While the information is slightly outdated, these comparative rates can provide you with some general information and insight about the rates of cesarean sections around the country.

In 2010, the CDC published a report on the recent trends in cesarean section in the United States and found:

• The cesarean rate rose by 53% from 1996 to 2007, reaching 32%, the highest rate ever reported in the United States.
• From 1996 to 2007, the cesarean rate increased for mothers in all age and racial and Hispanic origin groups. The pace of the increase accelerated from 2000 to 2007.
• Cesarean rates also increased for infants at all gestational ages; from 1996 to 2006 pre-term infants had the highest rates.
• Cesarean rates increased for births to mothers in all U.S. states, and by more than 70% in six states from 1996 to 2007.
• To view the full report, visit: http://www.cdc.gov/nchs/data/databriefs/db35.pdf

Additionally, the CDC has released a preliminary report for live births occurring in 2008. The report states “The cesarean delivery rate rose to 32.3% in 2008—the 12th consecutive year of increase.” To view the full report, visit: http://www.cdc.gov/nchs/data/nvsr/nvsr58/nvsr58_16.pdf.

**The World Health Organization recommends that the cesarean section rate for industrialized nations should not exceed 15%. A safe range, as determined by WHO experts, is 10-15%.**

Contact your state department of health and your local hospitals directly to find out the rate of cesarean section in your community.

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### National Cesarean Section Rates (continued)

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<td>Northern Marianas</td>
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### Maternal Health in Crisis for U.S. Women

Despite the fact that the United States spends more money on health care than any other country — and more on maternity care than any other type of hospital care — maternal mortality rates are actually increasing for U.S. women rather than decreasing. Maternal mortality rates have doubled since 1987, and the United States ranks 37th in the world in terms of maternal mortality.1 These discrepancies in maternal health outcomes are parallel in time with rising rates of cesarean section, decreased rates of vaginal birth after a previous cesarean section, and an increase in the amount of medical interventions in the “standard” hospital birth.

Several reports have emerged in the past year that reveal troubling information about the state of Maternal Health in our country.

- **DEADLY DELIVERY:** The Maternal Health Care Crisis in the USA
  Amnesty International, 2010

- **California Maternal Quality Care Collaborative**
  www.cmqcc.org/maternal_mortality
  www.californiawatch.com

- **No Woman, No Cry (Documentary Film)**
  Christy Turlington, 2010
  www.everymothercounts.org

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**Resources for Learning More**
Childbirth Connection’s website at www.childbirthconnection.org includes many resources to help pregnant women learn more about cesarean section and other childbearing topics. Resources include *What Every Pregnant Woman Needs to Know About Cesarean Section* and results from the Listening to Mothers I and II surveys.

For additional information about cesarean section and vaginal birth after cesarean (VBAC), visit the International Cesarean Awareness Network, Inc. at www.ican-online.org.
VBAC: A Safe Alternative to Repeat Cesarean

By Nicette Jukelevics, MA, ICCE

As recently as 1995, one out of four women with a prior cesarean had a vaginal birth after cesarean (VBAC). But today, the VBAC rate has plummeted to less than one in ten. This is mainly the result of several factors, including highly-publicized (and largely unfounded) fears about the supposed “dangers” of VBAC, resistance by malpractice insurers to cover VBAC and the high profitability of repeat cesareans. As the cesarean rate continues to climb year after year, it becomes increasingly important for women to have access to VBAC, and to more information about the benefits and risks of VBAC and repeat cesarean.

Low Risk of Uterine Rupture
The single most controversial issue regarding VBAC is the possibility of a uterine rupture, the separation of the uterine scar from a prior cesarean during labor or birth. The risk is less than 1% for women with one prior low-segment horizontal uterine scar, and 60–75% of mothers who choose VBAC successfully avoid a repeat cesarean. In addition, the likelihood of having a safe VBAC increases with each subsequent labor and vaginal birth.

Repeat Cesarean is Not Necessarily Safer
While some argue that VBAC is unsafe, the truth is there is no evidence that routine repeat cesarean is safer than a planned VBAC. To the contrary, there is plenty of evidence about the risks of repeat cesarean delivery, including:

- Higher risk of infection, adhesions, intestinal obstruction, chronic pain, ectopic pregnancy and placental problems compared to mothers who have a successful VBAC.
- Increased risk of hemorrhage severe enough to require a blood transfusion due to placental problems from accumulating cesareans.
- Higher likelihood of being re-hospitalized for complications related to the surgery.
- Decreased fertility and increased risk of miscarriage in future pregnancies.
- Greater likelihood of difficulty with mother-infant attachment as well as establishing and continuing breastfeeding.
- Elevated risk for premature delivery and serious neonatal respiratory problems in baby.

What if the Uterine Scar Gives Way?
Even though the risk is very low, uterine rupture is a serious complication associated with VBAC and requires immediate medical attention. If the uterine scar gives way, a rapid cesarean is necessary. With a rapid cesarean, mothers and babies usually have favorable outcomes, although sometimes serious complications can arise.

For most women, having a VBAC is safer than having a repeat cesarean and it increases the safety of any future pregnancies and births for you and your baby. For a more complete comparison of the relative risks and benefits of VBAC and cesarean, visit www.childbirthconnection.org.

Ultimately, the choice is up to you, your partner and your care provider whether VBAC is right for your upcoming birth. Arm yourself with as much information as possible about the benefits and risks of VBAC to help you make an informed choice.

Know Your Legal Rights

This is a compilation of federal laws on a variety of topics relevant to maternity care and rights. The information below is adapted from various texts and is not intended to be legal advice.

The United States currently has no federal Patients’ Bill of Rights; matters relating to health care tend to be the responsibility of the individual states and many individual states do have legislation covering patients’ rights. Contact your state Department of Health to learn more about what rights and standard of care you can expect as a maternity patient.

Many hospitals and health care organizations, such as the American Hospital Association, also have their own versions of a patients’ bill of rights, a code of ethics or code of conduct. These codes mandate compliance with certain practices and will give you an idea of the level and kind of care you can expect — and demand — from health care providers belonging to such institutions.

• www.childbirthconnection.org/pdfs/rights_childbearing_women.pdf
• www.aha.org/aha/issues/Communicating-With-Patients/pt-care-partnership.html
• www.acog.org/from_home/acogcode.pdf

Consistent and Timely Treatment

• You have the right to be treated in a hospital if you arrive in active labor, unless the staff transfers you in a safe and timely manner. You are to be cared for from the time of contractions through the delivery of the baby and the placenta.
• www.emtala.com

Maternity Leave

• You may be entitled to up to 12 weeks of unpaid, job-protected leave under the Family and Medical Leave Act (“FMLA”). This federal law applies to both women and men who work in a public agency, school or a company with 50 or more employees within 75 miles. The leave can be used for pregnancy complications as well as for the birth and care of your newborn.
• You may have the right to claim Disability and/or Unemployment Benefits during your pregnancy. Under the federal Pregnancy Discrimination Act, it is illegal for you to be denied benefits because of your pregnancy. Check your local state provisions to see what you may be entitled to claim.

• www.dol.gov/dol/topic/benefits-leave/fmla.htm
• www.dol.gov/compliance/laws/comp-fmla.htm
• www.eeoc.gov/types/pregnancy.html

Breastfeeding

• You have the right to breastfeed your child at any location in a federal building or on federal property, as long as you and your child are otherwise authorized to be present at the location.
• There are no laws in the United States forbidding breastfeeding outside the home. However, different states have different legislation around breastfeeding. Check your local state legislation to find out your rights as a breastfeeding mother. Visit La Leche League’s website (below) for more information.
• www.llli.org/law/lawUS.html
• www.maloney.house.gov

International Breastfeeding Icon

This symbol indicates baby-friendly areas and breastfeeding-friendly facilities, and serves to increase awareness of breastfeeding.

Insurance Coverage

You may have the right to have your maternity care and birth paid for by your health insurance company, even if it takes place with an out-of-network provider. Check with your state’s Department of Insurance to find out if such provisions exist in your area.

Maternity Information Act

A Maternity Information Act legally requires all hospitals and birth centers to provide a brochure containing clear information about the maternity care they provide, including rates of induction of labor, cesarean section, episiotomy and other obstetrical interventions. It also includes statistics relating to the proportion of vaginal births after cesarean (VBAC) or vaginal breech deliveries, as well as other information including the percentage of deliveries by midwives and the availability of rooming-in (keeping your baby with you after birth).

At present only New York and Massachusetts have a Maternity Information Act, though other states are considering similar legislation.

• www.mass.gov/legis/laws/mgl/111-70e.htm
• www.health.state.ny.us/facilities/hospital/maternity/public_health_law_section_2803-j.htm
Did you know that acupuncture can help to relieve morning sickness?

Did you know that a postpartum Doula can help you with newborn care in your home after the baby arrives?

Did you know that chiropractic care can help to position the fetus before birth?

Did you know that, in addition to attending births, midwives can also provide your annual well-woman care?

There are over 35 types of care providers that offer specialty services to women and their families during pregnancy, birth and the postpartum period. Find out more about how each of these types of care can assist you during this exciting time and visit our Online Provider Network to find these professionals in your neighborhood.

choicesinchildbirth.org/network

Choices in Childbirth can help connect you with Primary Care Providers and a range of specialty service providers. From Acupuncture to Well-Woman Midwifery Care, from Breastfeeding Support to Parenting Classes, the Online Provider Network has you covered!
Straight Talk on Epidurals for Labor

By Henci Goer

No doubt about it. Epidurals are aptly named the “Cadillac of analgesia.” Epidurals allow women to be awake and aware yet free from pain during labor and birth. They permit an exhausted woman to rest or sleep. And while their usual effect is to slow labor, the profound relaxation they offer can sometimes put a stalled labor back on track. Despite these benefits, you would do well to look under the hood before you decide to drive this “Cadillac” off the lot. Like all medical interventions, epidurals have potential harms. The wise woman will want to weigh them against her other options. Unfortunately, many care providers don’t supply complete information. To give you a more balanced picture, here are the disadvantages of epidurals according to the research:

• A minimum of 5 more women per 100 will have a vacuum extraction or forceps delivery. Consequences of these types of delivery include increased probability of a tear into the anal sphincter muscle and injury to the baby.
• Seventeen more women per 100 will experience a drop in blood pressure which may pose a risk to the baby.
• The narcotics included in epidurals greatly increase likelihood of nausea and can cause itching.
• Epidurals interfere with establishing breastfeeding. Studies specifically link fentanyl, a common narcotic component, to early problems and higher probability of switching to bottle feeding. Associated interventions such as instrumental vaginal delivery may also affect early breastfeeding.
• Somewhere between 1 in 1,400 and 1 in 4,400 women will experience a life-threatening complication.
• Combined spinal-epidurals, sometimes called “walking epidurals,” increase complications. Compared with standard epidurals, more women will experience itching, some will have breathing problems or difficulty swallowing, and some babies will experience a prolonged episode of abnormally slow fetal heart rate.

Epidural side effects can also have negative psychological consequences. Fetal heart rate disturbances, a drop in blood pressure, or difficulty breathing or swallowing may cause intense alarm and distress. Itching or nausea can make a woman miserable.

While complete pain relief may make for a more comfortable labor experience, epidurals interfere with the natural interplay of hormones, which has its downside. During unmedicated labor, beta-endorphin levels rise in response to pain, producing a “high” that enables women to transcend labor pain and experience that “top of the world” feeling after giving birth. An adrenalin surge in late labor dispels exhaustion, gives a woman extra oomph to push out the baby, and ensures that she is excited and alert to greet her baby. Oxytocin is the hormone of love, not just contractions, and unmedicated women have higher levels after childbirth than any other time in their lives.

Still, labor is unpredictable. You don’t want to cross an epidural off your dance card. Just be sure that you make your decision freely, not because you feel pressure or lack an alternative. Here are some ways to do that as well as minimize potential harms:

• Choose a care provider with a cesarean surgery rate of 15% or less. Studies show that in the hands of care providers with low rates, epidurals do not increase cesarean odds. Practitioners who have vaginal birth as a goal will have more patience and manage labor and epidurals differently than others.
• Choose a mother-friendly birth environment. In most hospitals, confinement to bed, continuous fetal monitoring, and restricting labor support companions such as doulas, along with lack of amenities such as showers, deep tubs, and birth balls make it difficult to cope with labor without an epidural. Where epidurals are the norm, nurses may not know how to support a laboring woman without one, and staff may actively promote their use.
Delivering a Healthy Baby

• Delay an epidural until active, progressive labor. This will help prevent two problems: running a fever, which becomes more likely the longer the epidural is in place, and the baby persisting in the occiput posterior position (head down, facing the mother’s belly). These complications increase the likelihood of cesarean or instrumental vaginal delivery. Since epidural-related fever cannot be distinguished from fevers caused by infection, babies are more likely to be kept in the nursery for observation, undergo blood tests and possibly a spinal tap, and be given precautionary IV antibiotics.

• Choose a standard epidural of the lightest intensity that keeps you reasonably comfortable over a spinal or “walking” epidural.

Finally, whether an epidural is Plan A or B, take classes that prepare you for coping with labor without one and consider hiring a doula. You will want a variety of comfort measures and coping strategies at your fingertips. For one thing, you may need these coping strategies if you are delaying an epidural until active labor. For another, the anesthesiologist may not be available when you want your epidural, or you may be among the 1 in 10 women for whom it does not work. It is also possible that labor will turn out to be easier than you thought and you decide you don’t need one after all.

My Little Sister’s Birth

Adapted from Lady’s Hands, Lion’s Heart, A Midwife’s Saga by Carol Leonard.

My younger sister, Wendy, has asked me to be her midwife. She is a serious professional businesswoman, so I spend a lot of time helping her learn how to let go and surrender to her birth. I am a little concerned that she might have what I call the “Liberated Woman Syndrome,” which is when powerful women try to dictate the physical process, often resulting in calamity when their bodies rebel and refuse to cooperate. But despite my worrying, in the end, my sister surrenders to birth and directs how it goes.

Wendy goes into labor in the middle of the night. The next day, I suggest we go to lunch at our favorite local Mexican restaurant. I tell Wendy that eating hot peppers will help put her into good labor. I am totally making this up because I am hungry, and I want to go there. I am torturing my kid sister, of course, but she still believes me. She eats a bunch of raw jalapenos, and damn if it doesn’t work.

She starts breathing very heavily every few minutes — and not only from the heat of the peppers. Our waiter is eyeing her warily. He becomes very anxious every time she stops to loudly blow out her breath. He doesn’t like this at all.

After one whopping contraction, he says, nervously, “Don’t you people have somewhere you should be going?”

I say, “Nah, just boil some water, will you?”

Later that evening, I go to Wendy and Jim’s house. They have lit candles and burned some sage to create a safe space, and they are playing soft Native American flute music. Wendy is soaking in a tub and relaxing well. Jim has put a pillow in a plastic bag, and Wendy is leaning against it, almost asleep. Sitting on the edge of the tub, Jim rhythmically pours warm water over Wendy’s giant belly. She looks hypnotized, her eyelids fluttering as if in a trance. What a sweet scene.

I sit quietly on the bathroom floor, observing, until I almost fall asleep myself. When I rally, I check her and am astounded. She is almost completely dilated! I watch as Wendy begins to moan as she does the hardest work of opening up completely. I am so proud of her; she is really doing it.

When Wendy is ready to begin pushing, she wants to be out of the water and in bed. Fanny’s head becomes visible, and I am very excited as the new auntie. I start babbling on and on about how well my sister is doing.
My Little Sister’s Birth (continued)

I exclaim, “Wow! This is awesome! You’re doing such a good job! Everything looks great!” Fanny’s head comes down a bunch more. “Wow! You’re doing fabulous! This is so good!” Fanny’s head is almost crowning. “Wow! Unbelievable! Whoo — weee! You’ve got tons of room!”

My sister finally snaps, “Will you shut up already? Room? What room? It feels like I’m pushing a square TV out of here! I thought this part was supposed to feel good? You just forget what this feels like, that’s all. It’s been too long for you to remember. You should have another kid!”

I think about my son Milan and how he is prematurely starting his teen-rebellion years.

I say, “Thanks, I’m all set.”

I am aware of the other family members standing out in the hall — our mother, Jim’s parents, and Wendy’s two stepchildren all anxiously waiting to be invited into the room to watch.

I ask Wendy if she wants them to be present for the birth.

She says, “Yes, but I don’t want them to come in until after the head is born.”

Okey dokey, that’s pretty specific.

She pushes for about another ten minutes, and Fanny’s head is easily (in my estimation) born. As Fanny hangs suspended, half in and half out, Wendy stops and looks around.

She says, “OK, they can come in now.”

She waits until everyone is in and settled comfortably in front-row seats. Then, ever in control, she gives a little “ugh.”

Fanny comes flying out, making a stellar debut amid the cheers and clapping of her admiring family. Fanny opens one eye and eyes me suspiciously.

I greet her. “Hey there, little niece! Welcome to the family. I’m your favorite auntie!”

Fanny is a riot. She is the spitting image of her paternal grandfather, with blonde hair sticking up, intense blue eyes, and freckles. I am tremendously relieved; everything has gone perfectly. Fanny is here, and she is adorable. A close pediatrician friend of mine says that he will make a house call to check her out in the morning.

Watching my sister nurse her newborn daughter fills me with so much love. Man, my sister has always been so much fun. She always does what I tell her to; she falls for it every time. I suppose now I should apologize for lying about that bogus hot peppers theory.

Instead, I kiss her good night. “I’m really proud of you, kid.”

Carol Leonard, a “foremother of the modern midwifery movement,” was the first midwife licensed to practice in New Hampshire. She is co-founder of the Midwives Alliance of North America (MANA), representing midwives in the US, Canada and Mexico. Over the last 35 years, Carol has safely delivered approximately 1,200 babies at home.
Understanding the Research on Home Birth

By Gene Declercq, PhD


The two largest increases of home birth since recording began have occurred in the last three years: an increase of 1,318 from 2004-2005 and 1,697 from 2006-2007.

Is Home Birth On The Rise?

Between 2004 and 2007, home births in the United States increased by 16%, but these increases still leave the total number of home births well below where it was in 1991 when recording began. Interestingly, the increase occurred before the most recent publicity around home birth — and well before the release of a spate of movies highlighting it. Such a development is not without precedent. In the United Kingdom, a government endorsed movement called Changing Childbirth has been credited with leading to a growth in home births that has continued until the present, raising the rate from 0.9% of all births in the late 1980s to the most recent rate of 2.9% in 2008. However, the home birth rate had already been increasing for 5 consecutive years before Changing Childbirth came into being. It may well be that women are choosing home births independently of the increased media and childbirth activism.


The Home Birth Debate

Does research play a significant role in the current debate over the safety of home birth? Unfortunately, no. The debate over home birth is a largely ideological one in which information from research studies sometimes is disregarded. Home birth opponents, who believe that birth is “safe only in retrospect,” view home birth as carrying unnecessary risks for mothers and especially babies. They also assume that the interventions associated with hospital birth add little or no risk. On the other hand, home birth advocates see birth as a natural process that works best when a prepared mother is in a setting in which she feels comfortable and the birth process is interfered with only when necessary. They argue that place of birth is a matter of choice for a mother and that, even though few may choose a home birth, their right to do so must be respected.

Understanding the Research

Valuable studies of home birth do exist, though several factors affect how definitive they can be. Firstly, the most powerful design, a study in which mothers would be randomized to have either a home or hospital birth, is not feasible. Secondly, since home birth is rare in industrialized countries and the major outcomes of concern — infant or maternal death — are also rare, it is unusual for studies to include enough cases to be able to identify significant differences in outcomes between home births and low risk hospital births (the typical comparison group). Finally, in the U.S. we currently lack the recorded information necessary to conduct a comprehensive study of birth outcomes. While birth certificates have, since 1989, identified home births, until recently they could not distinguish between planned home births and unplanned, “emergency” births at home (where a hospital birth was intended). They still cannot identify cases where a planned home birth results in a transfer to the hospital and therefore the home births with the least favorable outcomes are listed as hospital births. What is needed are studies that: (1) distinguish between planned and unplanned home births; and (2) follow those planned home births that result in a hospital transfer and include those outcomes with the planned home births.

What The Studies Say

In recent years, several studies have come out which, while not randomized trials, have addressed most of these challenges. The first, published in 2009 and the largest study of its kind to date, was based on more than a half million home births in the Netherlands from 2000-2006. It controlled for factors including parity (the number of times a woman has given birth), gestational age of the baby, maternal age, ethnic background and socio-economic status. This study found no
Understanding the Research (continued)

significant differences in adjusted relative risks of perinatal mortality between planned home births and a comparable group of planned hospital births. Its authors concluded that “women can safely choose where they want to give birth, provided the maternity care system is well equipped for homebirths.”

Another recent study, this time out of British Columbia, Canada, included all 2,889 planned home births attended by registered midwives in BC between 2000 and 2004. It compared these with 4,752 hospital births attended by the same group of midwives and 5,331 hospital births attended by physicians. The latter two groups were matched to the home births on a number of key variables like gestational age and exclusion of breeches and twins. Most importantly, mothers in the hospital groups needed to meet the stated criteria for a home birth. As in the Dutch study they found no difference in perinatal mortality rates. They also found reduced rates of obstetric interventions and other adverse outcomes in the home birth group compared with the hospital groups.

A third study is slightly older, published in 2005, but more directly relevant to a U.S. audience. It was based on 5,418 women in the U.S. and Canada (2% of total) planning home births with certified professional midwives in 2000. It included the outcomes of planned home births that resulted in transfers to a hospital. As in the Canadian study, the authors found a neonatal mortality rate comparable to low risk hospital births reported in other published studies (1.7/1,000) and a substantially lower rate of obstetrical intervention.

In essence, a growing body of research suggests that planned home births are just as safe as comparable low risk hospital births. Some of these studies were completed in settings (e.g. the Netherlands and British Columbia) with integrated systems where home birth is an accepted part of the maternity care process. While that’s hardly the case in many parts of the U.S., advocates are working towards developing systems in which a women’s choice of a home birth will become an integral part of routine care.

References:

Gene Declercq, PhD (Dept. of Community Health Sciences, Boston University School of Public Health) is an Assistant Dean and Professor at the Boston University School of Public Health. He served as lead author of Listening to Mothers I & II, two national studies of women’s experiences in childbirth, and is working on a book on cesarean childbirth. Gene was also a technical advisor to the film documentary, The Business of Being Born.

Choosing a Home Birth

Choosing the appropriate place to birth your child is an important maternity care decision. In the United States the vast majority of women choose to birth in a hospital setting. Most Americans consider the hospital to be the safest place to birth. Many believe that it is the only legal place to birth. This is not true. For many women, birthing at home or at a birth center, with a qualified and experienced care provider, is a safe and legal option.

Is Home Birth For You?

• I am healthy and have had a healthy pregnancy.
• I am considered low-risk by my health care provider.
• I want to labor, birth and meet my baby in a safe and familiar environment.
• I am concerned about the discomfort of the trip to the hospital.
• I want to avoid the risks of the routine interventions used in hospitals.
• I want to avoid an unnecessary cesarean section.
• I want to have access to my partner, family and support people at all times during labor, birth and the postpartum period.
• I want to be with my baby continuously from the moment s/he arrives in the world.
• I believe pregnancy and birth are normal, natural functions and not an illness to be medically treated.
• I believe in my body’s ability to give birth to the baby I have conceived, grown and protected.

Many countries support offering women the option of home birth. The Royal College of Obstetricians and Gynecologists of Britain states “There is ample evidence showing that labouring at home increases a woman’s likelihood of a birth that is both satisfying and safe, with implications for her health and that of her baby.”

To learn more and to find resources to help you decide whether home birth may be right for you, please visit choicesinchildbirth.org.
The Mother-Friendly Childbirth Initiative

The Mother-Friendly Childbirth Initiative is the foundation of our work at Choices in Childbirth, and is the core philosophy of the care providers listed in our Online Provider Network found at choicesinchildbirth.org/network.

The First Consensus Initiative of the Coalition for Improving Maternity Services

Principles
The principles outlined below are an excerpt from the Mother-Friendly Childbirth Initiative. To read the full text of this document, please visit the Coalition for Improving Maternity Services website at www.motherfriendly.org.

We Believe the Philosophical Cornerstones of Mother-Friendly Care to be as Follows:

Normalcy of the Birthing Process
• Birth is a normal, natural, and healthy process.
• Women and babies have the inherent wisdom necessary for birth.
• Babies are aware, sensitive human beings at the time of birth, and should be acknowledged and treated as such.
• Breastfeeding provides the optimum nourishment for newborns and infants.
• Birth can safely take place in hospitals, birth centers, and homes.
• The midwifery model of care, which supports and protects the normal birth process, is the most appropriate for the majority of women during pregnancy and birth.

Empowerment
• A woman’s confidence and ability to give birth and to care for her baby are enhanced or diminished by every person who gives her care, and by the environment in which she gives birth.
• A mother and baby are distinct yet interdependent during pregnancy, birth, and infancy. Their interconnected-ness is vital and must be respected.
• Pregnancy, birth, and the postpartum period are milestone events in the continuum of life. These experiences profoundly affect women, babies, fathers, and families, and have important and long-lasting effects on society.

Autonomy
Every woman should have the opportunity to:
• Have a healthy and joyous birth experience for herself and her family, regardless of her age or circumstances;
• Give birth as she wishes in an environment in which she feels nurtured and secure, and her emotional well-being, privacy, and personal preferences are respected;
• Have access to the full range of options for pregnancy, birth, and nurturing her baby, and to accurate information on all available birthing sites, caregivers, and practices;
• Receive accurate and up-to-date information about the benefits and risks of all procedures, drugs, and tests suggested for use during pregnancy, birth, and the postpartum period, with the rights to informed consent and informed refusal;
• Receive support for making informed choices about what is best for her and her baby based on her individual values and beliefs.

Do No Harm
• Interventions should not be applied routinely during pregnancy, birth, or the postpartum period. Many standard medical tests, procedures, technologies, and drugs carry risks to both mother and baby, and should be avoided in the absence of specific scientific indications for their use.
• If complications arise during pregnancy, birth, or the postpartum period, medical treatments should be evidence-based.

Responsibility
• Each caregiver is responsible for the quality of care she or he provides.
• Maternity care practice should be based not on the needs of the caregiver or provider, but solely on the needs of the mother and child.
• Each hospital and birth center is responsible for the periodic review and evaluation, according to current scientific evidence, of the effectiveness, risks, and rates of use of its medical procedures for mothers and babies.
• Society, through both its government and the public health establishment, is responsible for ensuring access to maternity services for all women, and for monitoring the quality of those services.
• Individuals are ultimately responsible for making informed choices about the health care they and their babies receive.

To learn more about the Coalition for Improving Maternity Services and to read their report, Evidence for the Ten Steps of Mother-Friendly Care, visit www.MotherFriendly.org.

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Resources

Like care providers, there are innumerable organizations and agencies that offer services of interest to birthing women. Here are a few we think you might find helpful:

**Advocacy**

**BirthNetwork National**
Phone: 888.452.4784
Website: www.birthnetwork.org

**Citizens for Midwifery**
Phone: 888.CfM.4880
Website: www.cfmidwifery.org

**Coalition for Improving Maternity Services (CIMS)**
Phone: 919.863.9482
Website: www.motherfriendly.org

**National Advocates for Pregnant Women**
Phone: 212.255.9252
Website: www.advocatesforpregnantwomen.org

**National Latina Institute for Reproductive Health**
Phone: 212.422.2553
Website: www.latinainstitute.org

**SisterSong Women of Color Reproductive Health Collective**
Phone: 404.756.2680
Website: www.sistersong.net

**Breastfeeding**

**Human Milk Banking Association of North America**
Phone: 919.861.4530
Website: www.hmbana.org

**International Lactation Consultant Association (ILCA)**
Phone: 888.452.2478
Website: www.ilca.org

**Kellymom Breastfeeding & Parenting**
Website: www.kellymom.com

**La Leche League International**
Phone: 800.LA.LECHE (To be referred to someone for free breastfeeding advice.)
Website: www.llli.org (Website lists free local meetings and resources.)

**Cesarean**

**Childbirth Connection**
Phone: 212.777.5000
Website: www.childbirthconnection.org

**International Cesarean Awareness Network (ICAN)**
Phone: 800.686.ICAN
Website: www.ican-online.org

**VBAC.com**
Website: www.vbac.com

**Childbirth Education**

**Birthing from Within**
Phone: 805.964.6611
Website: www.birthingfromwithin.com

**Birthworks International**
Phone: 888.TO.BIRTH
Website: www.birthworks.org

**The Bradley Method**
Phone: 800.4.A.Birth
Website: www.bradleybirth.com

**HypnoBirthing**
Phone: 602.788.6198
Website: www.hypnobirthing.com

**International Birth and Wellness Project**
Phone: 877.334.4297
Website: www.alace.org

**Promotion of Mother’s Milk, Inc.**
Website: www.promom.org

**World Alliance for Breastfeeding Action (WABA)**
Website: www.waba.org.my/

**World Health Organization Recommendations**
Website: www.who.int/topics/breastfeeding/en/
Resources (continued)

**Childbirth Education (continued)**

The International Childbirth Education Association (ICEA)
Phone: 800.624.4934
Website: www.icea.org

Lamaze International
Phone: 800.368.4404
Website: www.lamaze.org

**Children w/ Special Needs-Early Intervention**

The Arc
Phone: 800.433.5255
Website: www.thearc.org

Family Voices
Phone: 888.835.5669
Website: www.familyvoices.org

The National Dissemination Center for Children with Disabilities (NICHCY)
Phone: 800.695.0285
Website: www.nichcy.org

Through the Looking Glass (TLG)
Phone: 800.644.2666
TTY: 510.848.1005
Website: www.lookingglass.org

**Doulas**

Childbirth and Postpartum Professional Association (CAPPA)
Phone: 888.MY.CAPPA
Website: www.cappa.net

DONA International
Phone: 888.788.DONA
Website: www.dona.org

International Center for Traditional Childbearing (ICTC)
Phone: 503.460.9324
Website: www.ictcmidwives.org

toLabor
Phone: 804.320.0607
Website: www.tolabor.com

**Intimate Partner Violence**

Battered Mothers Resource Fund, Inc.
24 Hour National Crisis Hotline: 866.592.7870
Website: www.batteredmothers.org

National Coalition Against Domestic Violence
Phone: 800.799.SAFE
Website: www.ncadv.org

**Lesbian & Gay Parenting**

Children of Lesbian and Gays Everywhere (COLAGE)
Phone: 415.861.5437
Website: www.colage.org

Family Equality Council
Phone: 617.502.8700
Website: www.familyequality.org

Gay Parent Magazine
Phone: 718.380.1780
Website: www.gayparentmag.com

LAMBDA-GLBT Community Services
Website: www.lambda.org

National Center for Lesbian Rights
Phone: 415.392.6257
Website: www.nclrights.org

**Low-Income & Teen Parent Resources**

National Advocates for Pregnant Women
Phone: 212.255.9252
Website: www.advocatesforpregnantwomen.org

Planned Parenthood
Phone: 800.230.PLAN
Website: www.plannedparenthood.org

text4baby
Phone: Text BABY to 511411 to receive free weekly informational messages through your pregnancy and baby’s first year. Envia BEBE al 511411 para Espanol.
Website: www.text4baby.org

What to Expect Foundation
Phone: 212.712.9764
Website: www.whattoexpect.org
Resources (continued)

Low-Income & Teen Parent Resources (cont.)

Women, Infants and Children (WIC) Program
Website: www.fns.usda.gov/wic

Midwives’ Professional Organizations

American College of Nurse-Midwives (ACNM)
Phone: 240.485.1800
Website: www.acnm.org

Foundation for the Advancement of Midwifery (FAM)
Website: www.formidwifery.org

International Center for Traditional Childbearing (ICTC)
Phone: 503.460.9324
Website: www.ictcmidwives.org

Midwives Alliance of North America (MANA)
Phone: 888.923.MANA
Website: www.mana.org

National Association of Certified Professional Midwives (NACPM)
Website: www.nacpm.org

The North American Registry of Midwives (NARM)
Phone: 888.842.4784
Website: www.narm.org

Pregnancy/Neonatal Loss

The Compassionate Friends
Phone: 877.969.0010
Website: www.compassionatefriends.org

HAND (Helping After Neonatal Death)
24 Hour Helpline: 888.908.HAND
Website: www.handonline.org

SHARE (Pregnancy and Infant Loss Support, Inc)
Phone: 800.821.6819
Website: www.nationalshare.com

Pre- & Postnatal Safety

American Lung Association (smoking cessation support)
Phone: 800.LUNG.USA
Website: www.lungusa.org

HUD Lead Office
Website: www.hud.gov/offices/lead

March of Dimes
Phone: 914.997.4488
Website: www.marchofdimes.com

Mother-Baby Behavioral Sleep Laboratory (Co-Sleeping Information)
Website: www.nd.edu/~jmckenn1/lab

National Lead Information Center
Phone: 800.424.LEAD
Website: www.epa.gov/lead

Research

Association for Improvements in the Maternity Services (AIMS)
Website: www.aims.org.uk

Association for Prenatal and Perinatal Psychology and Health
Website: www.birthpsychology.com

Birthworks International
Phone: 888.TO.BIRTH
Website: www.birthworks.org

Childbirth Connection
Phone: 212.777.5000
Website: www.childbirthconnection.org

The Cochrane Collaboration
Phone: 410.502.4640
Website: www.cochrane.org

The Guttmacher Institute
Website: www.guttmacher.org

National Library of Medicine’s PubMed Database
Website: www.pubmed.gov
Resources (continued)

Additional Online Resources

Attachment Parenting International
Website: www.AttachmentParenting.org

Birthing Naturally
Website: www.BirthingNaturally.net

Circumcision Resource Center
Website: www.Circumcision.org

Holistic Moms Network
Website: www.HolisticMoms.org

Midwifery Info Online Community
Website: www.MidwifeInfo.com

Midwifery Today
Website: www.MidwiferyToday.com

Mothering Magazine Online Community
Website: www.Mothering.com

Midwives Alliance of North America
Website: www.MothersNaturally.org

Our Bodies, Ourselves
Website: www.OurBodiesOurselves.org

Waterbirth International
Website: www.Waterbirth.org
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