



Advancing Normal Birth: Organizations, Goals, and Research

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ABSTRACT

In this column, the support for advancing normal birth is summarized, based on a comparison of the goals of *Healthy People 2010*, Lamaze International, the Coalition for Improving Maternity Services, and the midwifery model of care. Research abstracts are presented to provide evidence that the midwifery model of care safely and economically advances normal birth. Rates of intervention experienced, as reported in the *Listening to Mothers* survey, are compared to the forms of care recommended by the Cochrane Database of Systematic Reviews. Implications for perinatal education are addressed.

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To view the Healthy People 2010 document, visit www.healthypeople.gov/publications

Advocacy work, such as advancing normal birth, is easier when proponents feel well supported by influential national groups and evidence-based research. The intent of this issue's "Tools for Teaching" column is to summarize some of that support. The national health goals presented in the U.S. Department of Health and Human Service's *Healthy People 2010* document, by Lamaze International, and by the Coalition for Improving Maternity Services (CIMS) are explored for commonalities. The midwifery model of care is defined, and abstracts of selected supporting outcomes research are presented. Further comparisons of particular Cochrane database recommendations are compared to selected care reported by mothers.

HEALTHY PEOPLE 2010, LAMAZE INTERNATIONAL, AND CIMS

The United States' goals for promoting the health of the population are described in the publication *Healthy People 2010* (U.S. Department of Health and Human Services, 2000a). The total document contains 28 focus areas. Specifically of interest here, focus area No. 16 addresses maternal, infant, and child health, with a stated overall goal to improve the health and well-being of women, infants, children, and families. The clear goals of *Healthy People 2010* are built upon a national consensus process and a solid evidence base of documented research.

For comparison, Lamaze International and CIMS are examples of two sister organizations whose missions, goals, and activities are synchronous with selected objectives in focus area No. 16 of *Healthy People 2010*. As part of their missions,

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both Lamaze International and CIMS promote health related to maternity care. In carrying out any advocacy role, it is useful and strengthening to clarify how one's plans and activities have, as their foundation, both national consensus and a researched evidence base. Towards that end, Table 1 outlines the synchrony between *Healthy People 2010*, Lamaze International, and CIMS.

MODELS OF MATERNITY CARE

Lamaze International and CIMS advance their missions and goals for healthy births through implicitly promoting a midwifery model of care that can be implemented in hospitals, birth centers, and home birth practices. In contrast, *Healthy People 2010* focuses solely on birth outcomes.

The midwifery model of care is a wellness model that improves maternal/birth outcomes and substantially reduces health-care costs by charging lower fees and using fewer interventions. According to the Citizens for Midwifery (1996), the definition of the midwives' model of care includes

- monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle;
- providing the mother with individualized education, counseling, prenatal care, continuous hands-on assistance during labor and birth, and postpartum support;
- minimizing technological interventions; and
- identifying and referring women who require obstetrical attention.

The midwifery model of care is typically practiced by most midwives and can be practiced by physicians. With its focus on minimizing technological interventions and providing individualized support, the midwifery model of care can reduce costs without compromising safety. Thus, the midwifery model of care can improve birth outcomes and the accessibility to affordable health care. These viewpoints are supported by findings developed in five large research studies, briefly described below.

Outcome Comparisons of Certified Nurse-Midwives and Physicians

MacDorman and Singh (1991) compared 153,000 U.S. women attended by certified-nurse midwives (CNMs) with a random sampling of 685,000 similar women attended by physicians. After controlling for sociodemographic and medical risk factors,

the researchers reported that, compared to the singleton, vaginal-birth infants born in the physicians' group, the infants of mothers who were cared for by CNMs were

- 1/3 less likely to die in the first week;
- 20% less likely to die in the first year; and
- 1/3 less likely to be low-birth weight.

In another study, researchers conducted a comparison of midwifery care at Booth Maternity Center and medical care at Thomas Jefferson University Hospital, both located in Philadelphia (Baruffi et al., 1984). The study included 796 women who gave birth at Booth Maternity Center and 804 women with similar sociodemographic characteristics who gave birth at Thomas Jefferson University Hospital. After controlling for medical-obstetric risk, the researchers found that neonatal morbidity rates and the infants' length of stay in the nursery were lower at Booth Maternity Center than at Thomas Jefferson University Hospital. Neonatal mortality rates did not differ between the two institutions.

Examples of Outcomes of CNM Services for Low-Income/High-Risk Pregnant Women

Over a period of 12 years, researchers examined a total of 36,400 nurse-midwife-attended births at the Los Angeles County and University of Southern California Women's Hospital Birth Center (Grulich et al., 1994). Among low-income women who qualified for care in the facility's in-hospital birth center, the researchers collected the following statistics:

1. 2% had a primary cesarean birth;
2. 2% had an instrumental birth;
3. 5% had an episiotomy;
4. 60% had intact perineums; and
5. newborn outcomes were excellent, with intensive care for 1.5%.

In another study conducted in the United States, researchers examined maternity care and outcomes at North Central Bronx Hospital in New York, a city hospital for the medically indigent (Haire & Elsberry, 1991). Midwives cared for low-risk mothers, and physicians comanaged all high-risk mothers. Obstetric interventions were used only when medically indicated. The researchers found that

- 70% of mothers were considered at risk or high risk;

TABLE 1

The Relationship of *Healthy People 2010*, Lamaze International, and the Coalition for Improving Maternity Services (CIMS)

	<i>Healthy People 2010</i>	Lamaze International	CIMS
Contact Information	Washington, DC www.healthypeople.gov/ Publications 1-800-367-4725	Washington, DC www.lamaze.org 1-800-368-4404	Ponte Vedra Beach, FL www.motherfriendly.org 1-888-282-2467
An Overview of Goals Related to Health and Wellness	The goals of <i>Healthy People 2010</i> are centered around 28 focus areas with 467 specific objectives. The over-riding goals are to <ul style="list-style-type: none"> • increase the quality and years of healthy life and • eliminate health disparities. <p>Among the 28 focus areas, No. 16 addresses maternal, infant, and child health. The overall goal is to improve the health and well-being of women, infants, children, and families.</p>	Lamaze International's stated mission is to promote, support, and protect normal birth through education and advocacy. The organization's vision is a world of confident women choosing normal birth.	The goal of CIMS is to promote a wellness model of maternity care that will improve birth outcomes and substantially reduce costs.
Organization and Involvement in Community Partnerships	An alliance of more than 350 national organizations and 250 state public health, mental health, substance abuse, and environmental agencies. The first document was entitled <i>Healthy People 1980</i> . "Community partnerships, particularly when they reach out to nontraditional partners, can be among the most effective tools for improving health in communities."	An organization formed in 1960 under the name of the American Society for Psychoprophylaxis in Obstetrics (ASPO). The organization later changed its name to Lamaze International. In 1994, Lamaze International sponsored a summit of similar groups, which over time formed into CIMS. For several years, Lamaze International provided leadership and office support for CIMS as the organization evolved and was eventually launched.	A collaborative effort among a broad spectrum of maternity service providers including midwives, physicians, nurses, childbirth educators, lactation consultants, and labor support and postpartum doulas. The coalition has grown to include more than 90,000 birthing professionals. Additionally, a multitude of organizations endorse the coalition's Mother-Friendly Childbirth™ Initiative (see below).
Decision-Making Processes	<i>Healthy People 2010</i> is grounded in science, built through a public consensus process with the members of its alliance. It is an example of the private and public sections working together. A new objective first appeared in <i>Healthy People 2010</i> after Lamaze International and others lobbied for its addition. Now, focus area No. 16 includes the goal to increase the proportion of pregnant women who attend a series of prepared childbirth classes.	Lamaze International is a membership organization open to childbirth educators, parents, and perinatal care providers. Members elect a board of directors. The board of directors develops strategic plans that are ratified by Lamaze International members at the organization's annual meetings.	CIMS is a coalition open to all organizations that share its goals. It has a board of directors. The cornerstone of CIMS is The Mother-Friendly Childbirth™ Initiative. The initiative was developed by consensus and initially ratified by 26 major birth organizations and 31 leading birth professionals. Many others have since joined, including a group of Physicians for Midwifery Care.

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To view focus area No. 16 in the *Healthy People 2010* document, visit www.healthypeople.gov/Document/HTML/Volume2/16MICH.htm



To view *The Mother-Friendly Childbirth™ Initiative*, visit www.motherfriendly.org/MFCI

TABLE 1
(Continued)

	<i>Healthy People 2010</i>	Lamaze International	CIMS
Achievable, Evidence-Based Objectives	<p><i>Healthy People 2010</i> is grounded in science and presents data to support the following objectives related to maternity care:</p> <ul style="list-style-type: none"> • 16-1. Reduce fetal and infant deaths. • 16-4. Reduce maternal deaths. • 16-5. Reduce maternal illness and complications due to pregnancy. • 16-6. Increase the proportion of pregnant women who receive early and adequate prenatal care. • 16-7. Increase the proportion of pregnant women who attend a series of prepared childbirth classes. • 16-8. Increase the proportion of very low birth weight (VLBW) infants born at Level III hospitals or subspecialty perinatal centers. • 16-9. Reduce cesarean births among low-risk (full term, singleton, vertex presentation) women. • 16-10. Reduce low birth weight (LBW) and very low birth weight (VLBW). • 16-11. Reduce preterm births. • 16-12. Increase the proportion of mothers who achieve a recommended weight gain during their pregnancies. • 16-17. Increase the proportion of pregnancies begun with an optimum folic acid level. • 16-18. Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women. • 16-19. Increase the proportion of mothers who breastfeed their babies. 	<p>Lamaze International sponsors the Lamaze Institute for Normal Birth, which was founded upon six care practices that support normal birth. These care practices are based on recommendations from the World Health Organization and include the following:</p> <ol style="list-style-type: none"> 1. Labor begins on its own. 2. Freedom of movement throughout labor. 3. Continuous labor support. 4. No routine interventions. 5. Nonsupine (e.g., upright or side-lying) positions for birth. 6. No separation of mother and baby after birth, with unlimited opportunities for breastfeeding. <p>Lamaze International developed a licensing program to recognize hospitals, birth centers, group practices, and other institutional providers who meet Lamaze standards and offer excellence in childbirth education. The licensing program also includes standards for Lamaze Approved Providers.</p>	<p>The Mother-Friendly Childbirth™ Initiative was developed and ratified by CIMS (see www.motherfriendly.org/MFCI/steps/). The initiative urges maternity care givers to:</p> <ol style="list-style-type: none"> 1. Offer unrestricted access to birth companions and support in labor. 2. Provide information about its birthing practices and procedures. 3. Offer culturally competent care. 4. Allow freedom of movement for laboring women. 5. Provide policies and procedures for linking with other services. 6. Allow no routine practices that are not evidence-based. 7. Educate staff in nondrug pain relief. 8. Encourage maternal/family contact with ill and preterm infants. 9. Discourages nonreligious circumcisions. 10. Strive to achieve the WHO/UNICEF "Ten Steps of the Baby-Friendly Hospital Initiative" to promote breastfeeding.
Set Time Lines for Achievable Goals	<p><i>Healthy People 2010</i> provides baseline measurements for goals and targets that should be achieved by the year 2010.</p>	<p>Progress in maternity care that is congruent with the Lamaze mission and standards can be measured by the numbers of facilities that become approved Lamaze providers. Trends such as the cesarean birth rate and epidural choice can be monitored.</p>	<p>Improvement in maternal and infant health care can be measured by the numbers of facilities designated as mother-friendly.</p>



For more information on the Lamaze Institute for Normal Birth, visit www.normalbirth.lamaze.org



For more information on becoming a Lamaze Approved Provider, visit www.lamaze.org/childbirth/GetApproved.asp

(Continued)

TABLE 1
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	<i>Healthy People 2010</i>	Lamaze International	CIMS
	Both Lamaze International and CIMS encourage maternal infant care providers to offer services that will improve selected aspects of maternity care and meet <i>Healthy People 2010</i> objectives. While both organizations focus heavily on the birth itself, Lamaze International and CIMS advocate patient education programs that address the broader topic of maternity care, including holistic maternity care throughout the pregnancy.	One of the primary ways Lamaze International pursues its mission is by educating new childbirth educators through its internationally recognized Lamaze Childbirth Educator Program and Certification Examination. To date, Lamaze has educated and certified over 11,000 with the LCCE educator credential.	
Address Disparate Mortality Rates	According to <i>Healthy People 2010</i> , the fetal mortality rate among African Americans was 12.7 per 1,000 in 1995, 1.8 times that of the entire population. Moreover, this gap has widened since 1990. The fetal mortality rate among African Americans declined by only 4.5% over this period, a decline of less than 1% per year. Targeting prenatal risk screening and intervention to high-risk groups, particularly African-American women, is critical to reducing this gap.	Lamaze public documents are silent on this issue.	In the preamble to The Mother-Friendly Childbirth™ Initiative, CIMS recognizes that the maternal mortality rate in the U.S. is four times greater for African-American women than for Euro-American women. The preamble also notes the current maternity care system in the U.S. does not provide equal access to health-care resources for women from disadvantaged population groups, women without insurance, and women whose insurance dictates caregivers or place of birth.
The Relationship Between a Healthy Birth and a Healthy Society	<i>Healthy People 2010</i> states the health of mothers, infants, and children is of critical importance, both as a reflection of the current health status of a large segment of the U.S. population and as a predictor of the health of the next generation.	The Lamaze Philosophy of Birth includes the statement that the experience of birth profoundly affects women and their families. It also states women's confidence and ability to give birth is either enhanced or diminished by the care provider and place of birth.	In the preamble to The Mother-Friendly Childbirth™ Initiative, CIMS recognizes that, in spite of spending far more money per capita on maternity and newborn care than any other country, the U.S. falls behind most industrialized countries in perinatal morbidity and mortality rates.

- of 3,287 deliveries in 1988, 86.1% were performed by midwives;
- the rate of instrumental delivery was 0.3%;
- the rate of oxytocin augmentation was 6.4%;
- 11.1% of infants required special or intensive care;
- there was a 9.2/1,000 neonatal mortality rate for all birth weights; and
- there was a 3.7/1,000 neonatal mortality rate for infants over 1,000 g.

In a vulnerable-populations study, Paine and colleagues (2000) compared visits and care practices of nurse-midwives to those of obstetrician-gynecologists (OB/GYNs). The researchers found that

1. 70% of women and newborns seen by nurse-midwives were considered vulnerable by virtue of age, sex, education, ethnicity, or place of residence;
2. these groups are at risk for poor outcomes or poor health-care access; and
3. in addition to services provided in urban and suburban settings, 20% of the nurse-midwives provided services in rural areas.

When the researchers examined a subset of 4,305 visits to CNMs compared to 5,473 visits to OB/GYNs in similar settings, they found that

- a larger proportion of CNM visits were made by women who were publicly insured and less than 25 years old;
- the majority of CNM visits were for maternity care;
- the majority of visits to OB/GYNs were for gynecological and/or family planning concerns;
- face-to-face time was longer for CNMs; and
- visits with CNMs involved more client education and counseling.

Research Supports the Efficacy of a Midwifery Model of Care

Collectively, the data reported in these studies confirm that the midwifery model of care differs from medical care in that the approach is holistic and educational and uses fewer invasive interventions. This applies even when caring for high-risk mothers, with whom midwifery care can produce good birth outcomes with lower intervention rates. From this, one may logically conclude that fewer interventions lead to lower health-care costs. It is important to note the economic savings because in some practices midwives are pressured to be more economically efficient in seeing more patients within a shorter period of time, thus generating more revenue for a practice. The extra time taken in a midwifery model of care with prenatal women is sometimes seen as “mothering and smothering” if attention is not paid to the potential eventual economic savings from lower rates of surgery and other interventions. For more information on differences in care, see *The Thinking Woman’s Guide to a Better Birth* by Henci Goer (1999). Goer compares cesarean birth rates with instrumental birth rates among obstetricians, family practitioners, and certified nurse-midwives. Across many studies, both cesarean rates and instrumental birth rates are consistently lower for family practitioners and midwives than for obstetricians.

INTERVENTIONS: EVIDENCE AND REALITY

There are instances in which almost all medical interventions are the route of choice for specific individuals who have conditions in which the use of interventions is warranted. However, when unneeded, the routine use of interventions interferes with the promotion of normal birth. Thus, to promote normal birth, it is useful to understand more about specific unwarranted interventions. The gold standard for evidence-based maternity care can be found in the Cochrane Database of Systematic Reviews. Cochrane reviewers identify studies that are

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likely to provide the best evidence for evaluating interventions. The reviewers then use systematic analysis to provide information for those whose decisions affect care. *A Guide to Effective Care in Pregnancy and Childbirth* (Enkin et al., 2000) provides a summary of the conclusions presented in the Cochrane Database of Systematic Review related to interventions for pregnancy and childbirth. Interventions (forms of care) are classified under one of six options:

1. beneficial forms of care;
2. forms of care likely to be beneficial;
3. forms of care with a trade-off between beneficial and adverse effects;
4. forms of care of unknown effectiveness;
5. forms of care unlikely to be beneficial; and
6. ineffectiveness or harm demonstrated by clear evidence.

Whereas the Cochrane database provides guidance as to the efficacy of interventions used in maternity care, the next question to examine is the nature of the care actually received by women in the United States. This question was addressed in a study developed by the Maternity Center Association. The *Listening to Mothers* survey (Declercq, Sakala, Corry, Applebaum, & Risher, 2002) examined women’s childbearing experiences that occurred within 24 months prior to the survey. A total of 136 mothers were interviewed by telephone and 1,447 completed a written survey. Harris Interactive, a well-known leader in interactive health surveys, conducted the survey, and the results provide an estimate of the frequency with which interventions are used. For comparison purposes, Table 2 lists the Cochrane ratings of various maternity care procedures, along with women’s experiences with those procedures, as reported in the *Listening to Mothers* survey. From comparing the data, shaving, enemas, IVs, withholding nourishment and water, early rupture of membranes, electronic fetal monitoring, inductions, episiotomy, and cesarean birth are interventions shown to be overused in the United States. In addition to being costly, this overuse interferes with advancing normal birth and its benefits.

POSTPARTUM DEPRESSION

In addition to physical safety and economic outcomes, psychological outcomes of maternity



Henci Goer’s *The Thinking Woman’s Guide to a Better Birth* is available at the Lamaze Bookstore and Media Center (www.lamaze.org).



For a synopsis of *A Guide to Effective Care in Pregnancy and Childbirth* (Enkin et al.), visit www.maternitywise.org/guide/synopsis

TABLE 2

Common Birth Care Interventions: Recommended for Mothers vs. Experienced by Mothers

Birth Care Interventions	Cochrane Database of Systematic Reviews Rating	Listening To Mothers Survey Results
Shaving	Ineffectiveness or harm demonstrated by clear evidence	Nearly 1 out of 5 women
Enemas	Ineffectiveness or harm demonstrated by clear evidence	Fewer than 1 in 20 women
IVs	Forms of care unlikely to be beneficial	Almost 9 out of 19 women
Withholding nourishment and water	Forms of care unlikely to be beneficial	2/3 not allowed to drink Almost 9 out of 10 not allowed to eat
Early rupture of membranes	Forms of care of unknown effectiveness	Over half of the mothers had ruptured bags of water (RBOW) for augmentation; nearly 6/10 mothers had RBOW for induction
Electronic fetal monitoring	Ineffectiveness or harm demonstrated by clear evidence	Over 9 out of 10 mothers
Induction	Forms of care with a trade-off between beneficial and adverse effects	Almost 6 out of 10 for medical reasons; nearly 1 in 5 mothers for nonmedical reasons
Episiotomy	Forms of care likely to be ineffective or harmful	Over 1/3
Cesarean Rate	The optimal rate is not known, but from national data available, little improvement in outcome appears to occur when rates rise above about 7%.	1 in 4
Vaginal Birth After Cesarean (VBAC) Rate	Forms of care that are likely to be beneficial	1 in 4 of those with prior cesarean; nearly half denied option of VBAC

experiences are also important. As reported in *A Guide to Effective Care in Pregnancy and Childbirth* (Enkin et al., 2000), the Cochrane report of research notes the following:

- Lack of social and psychological support during the days and weeks after birth is one of the main reasons why unhappiness after childbirth is such a common problem.
- Sociological and psychological studies have provided strong evidence of a relationship between some social conditions and postpartum depression.
- The social conditions linked with depression are only rarely out of the ordinary; more often, they correspond to social expectations about normal womanhood and normal motherhood.

In the *Listening to Mothers* survey (Declercq et al., 2002), women reported high levels of depression and relatively low levels of related professional care:

- 1 out of 5 (19%) women who had given birth in the past two years scored 13 or above on the Edinburgh Postnatal Depression Scale.
- 1 out of 5 (19%) respondents said they had consulted a health-care or mental-health professional.
- Nearly 6 out of 10 women (57%) scoring 13 or higher on the Edinburgh Postnatal Depression

Scale had not seen a professional about concerns for their mental health since giving birth.

These numbers suggest that monitoring psychological and social well-being is an important part of perinatal care. The midwifery model of care recognizes and addresses this critical aspect of support.

BREASTFEEDING SUPPORT

An aspect not discussed in many documents on advancing normal birth is the connection between normal birth and an alert newborn infant ready to launch breastfeeding. Both Lamaze International and CIMS propose promoting normal birth and initiating breastfeeding as routine perinatal care. One of the specific objectives in *Healthy People 2010* is to increase breastfeeding rates. The authors of *A Guide to Effective Care in Pregnancy and Childbirth* (Enkin et al., 2000) also connect pregnancy, childbirth, and breastfeeding in the following statement:

Those who care for women during pregnancy and childbirth play a crucial role in enabling a woman to breastfeed successfully. Now that sound, research-based information is readily available to them, the professional ignorance that may have been understandable in the past is no longer tolerable (p. 453).



To view the full report of the Listening to Mothers survey, visit www.maternitywise.org/listeningtomothers/

IMPLICATIONS FOR PERINATAL EDUCATORS

The information addressed in this article would suggest questions to ask when expectant mothers choose a perinatal care provider. The expectant mother who aspires to experience a normal birth should plan to interview potential care providers with questions about the rate of their use of the various interventions common to obstetric care.

However, childbirth and perinatal educators often do not see expectant parents until the care provider has been chosen. The majority of these women may have already arranged for assistance from a care provider who uses a medical model of care that will result in interventions beyond those that are evidence-based by research studies or desired by the expectant mother. Thus, when facing a class of expectant parents, the childbirth educator can predict that 1/4 of the mothers will have cesarean births, some of which will be neither desired nor medically indicated. Yet, after prenatal care has been chosen and begun, limitations exist on what an educator can say within her professional role. It would be more disturbing than helpful to many expectant parents to even consider changing care providers late in pregnancy. Further, it would be outside the childbirth educator's professional scope of practice to express opinions on the practices of a specific care provider, as long as those practices are legal. How then can a childbirth educator advance normal birth with a group of expectant parents who have already chosen their care provider?

Using one approach, childbirth educators have long encouraged couples to write out a preferred

When facing a class of expectant parents, the childbirth educator can predict that 1/4 of the mothers will have cesarean births, some of which will be neither desired nor medically indicated.

birth plan and engage in a discussion with their care providers. This can readily be done without pointing fingers at the practice of any given care professional. Further, knowing what an expectant mother wants will positively guide the practice of some care providers. It may facilitate the conversation if all those who participate in helping the woman develop a birth plan (e.g., the care provider and the childbirth educator) have common definitions of terms such as *natural birth*, *normal birth*, *fully-supported birth*, and *fully informed parent*. Currently, some care providers refer to any vaginal birth as a "natural birth"—a definition not used by LCCE educators. Thus, encouraging expectant mothers to ask questions to confirm that discussions about birth plans are based on common definitions may be helpful.

In class, a handout can be provided to give the expectant couples Web addresses listed in this article wherein they can read in more depth what is said by a variety of professionals, organizations, and research—such as Lamaze International, CIMS, *Healthy People 2010*, and the *Listening to Mothers* survey (see Table 3). The couples will learn a lot about care choices they can make or topics they can discuss with their health-care provider.

Childbirth educators can also play an advocacy role outside their classrooms. They can volunteer to speak to high school or college students about choices in childbirth. They can also organize prepregnancy sessions at locations such as the library or other places that might provide a room and publicity. They can join young parents to find common ground in developing an advocacy plan for their community for educating prepregnant women about choices in childbirth. Young parents can be effective normal birth advocates, with the childbirth educator as their counsel and a source of information.

In summary, advocacy work is easier when proponents feel well supported by national groups and evidence-based research. The intent of this article is

Young parents can be effective normal birth advocates, with the childbirth educator as their counsel and a source of information.



An excellent resource for expectant parents is the CIMS document, "Having a Baby? Ten Questions to Ask" (www.motherfriendly.org).



For a list of birth networks and advocacy groups or to learn how to start a birth network, visit www.normal-birth.lamaze.org

TABLE 3

Recommended Web Sites with Information to Advance Normal Birth

- Lamaze International: www.lamaze.org
- Lamaze Institute for Normal Birth: www.normalbirth.lamaze.org
- The Coalition for Improving Maternity Services (CIMS): www.motherfriendly.org
- *Healthy People 2010: Understanding and Improving Health*: www.healthypeople.gov/Publications
- *A Guide to Effective Care in Pregnancy and Childbirth*: www.maternitywise.org/guide/synopsis
- *Listening to Mothers* survey: www.maternitywise.org/listeningtomothers/
- The Mother-Friendly Childbirth™ Initiative: www.motherfriendly.org
- Citizens for Midwifery: www.cfmidwifery.org
- *HHS Blueprint for Action on Breastfeeding*: www.cdc.gov/breastfeeding/report-blueprint.htm



For more ideas on childbirth advocacy, see Judith Lothian's "Navigating the Maze" column in this issue ("The Dance of Advocacy," pp. 37–40).

to summarize some of that support. However, it takes individuals in each community to bring that advocacy to the level of the childbearing woman. Normal birth advocates, start your engines!

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OTHER RESOURCES FOR PERINATAL EDUCATORS

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