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Forward
The VBAC Education Project

Ninety percent of mothers who have had a cesarean section can labor for a VBAC in a subsequent pregnancy. Most published studies show 60-80% - roughly 3 to 4 out of 5 - women with a prior cesarean birth can have a safe vaginal birth (American Pregnancy Association, VBAC).

Do you hear from mothers, the following statements?
• My health care provider told me, “Once a Cesarean, always a cesarean.”
• I was just scheduled for surgery for my second baby.
• No one ever told me I could have a vaginal birth after a cesarean.
• What information do you have now that may make you consider a VBAC?

Statements from health care providers?
• It’s just easier for you to have a cesarean.
• You will have the convenience of having a scheduled birth.

Questions from educators and maternity caregivers?
• What educational information does a mother need if she chooses to labor for a VBAC?
• Where can I find educational resources to help mothers make an informed choice?

‘VBAC For Educators: A Teaching Guide,’ provides the information you need to develop and facilitate childbirth education classes for mothers with a prior cesarean birth. The classes will provide the knowledge and emotional support for mothers and families who choose this birth option. VBAC For Educators is a companion to the slide set, “Deciding if a VBAC is Right for You: A Parent’s Guide,” which includes 14 modules to help parents understand their option for VBAC and plan a safe and satisfying birth. Each of the modules provides concise answers to the many questions and concerns that parents have.

Nicette Jukelevics’s VBAC EDUCATION PROJECT offers parents, educators, and doulas evidence-based medical information, effective ways to communicate with caregivers, guidance for dealing with psychological issues with a prior cesarean, strategies and support for labor and birth, and a clear understanding of patient’s rights. A resource list is provided for VBAC and physiological birth. The program also includes educational handouts for parents.

The International Childbirth Educational Association (ICEA) acknowledges and endorses the VBAC EDUCATION PROJECT developed by Nicette. “Freedom to make decisions based on knowledge of alternatives in family-centered maternity and newborn care” is the ICEA philosophy. All childbearing women should have access to accurate information, resources, and the opportunity to express their birth preferences and share their concerns in a safe environment with a knowledgeable health care provider. A woman must be provided all options for childbirth so she can make her decisions based on evidence-based information.

Everything you need to know is in the VBAC EDUCATION PROJECT. Thank you, Nicette!

Nancy Lantz, RN, BSN, ICCE, ICD
ICEA Past President, 2013-2014
International Cesarean Awareness Network

Mission Statement
The International Cesarean Awareness Network, Inc. (ICAN) is a nonprofit organization whose mission is to improve maternal-child health by preventing unnecessary cesareans through education, providing support for cesarean recovery, and promoting Vaginal Birth After Cesarean (VBAC).

Vision Statement
A reduction in the cesarean rate driven by women assuming responsibility for their healthcare by making evidence-based, risk appropriate childbirth decisions.

Note to ICAN Volunteers:
During a time in which the U.S. cesarean rate (final data for 2013) for all women is 32.7%, 32.0% for Caucasian women, 32.2% for Hispanic women and 35.8% for African American women (http://www.cdc.gov/nchs/births.htm), the relevance of this educational curriculum cannot be emphasized enough.

As volunteers within ICAN, we are faced each day with mothers who are seeking support as they sort through their post-cesarean birth options. Many of the mothers who seek ICAN are looking for emotional support, and for many years, we have provided a listening ear and a shoulder on which to lean. We have also provided community resources that mothers have depended upon when their birth options were limited by their local birth environments.

With the endorsement of this curriculum, we seek to expand our outreach efforts to fulfill our educational initiatives as it relates to the mission of our organization. The issue of post-cesarean birth options, although deeply personal for many women, is also an issue of public health as it relates to both the long and short-term health of both the mother and child. Although birth is certainly not ‘one size fits all,’ we intend to use this volunteer educational program to reach deep into our communities to provide this pertinent information to the mothers who need it the most, empowering them to ask the questions and get the answers that they need in order to make the decisions that will work best for their families.

LaQuitha Glass
ICAN President, 2015-2016
www.ican-online.org

ICAN Disclaimer
Throughout this educational project, the terms ‘cesarean’, ‘cesarean birth’, and ‘cesarean section’ are used when referring to a cesarean. ICAN adopted the use of the term ‘cesarean’ as a catch-all term to prevent any inadvertent offense to mothers who do not feel that their cesarean was a birth as well as to those who do not feel that it was only a surgical procedure. The use of the terms ‘cesarean birth’ and ‘cesarean section’ in this collaborative project are not the express views of ICAN, and the terminology is not meant to cause offense.

LaQuitha Glass
ICAN President, 2015-2016
www.ican-online.org
Acknowledgments

The VBAC Education Project began as a one-woman volunteer project. I was asked to develop a VBAC curriculum that both childbirth educators and community leaders can use to educate mothers about the safety of VBAC and help increase access to VBAC-friendly care providers. I felt it was important that the information be widely available and at no cost.

As it was being developed I reached out to several maternity care professionals, researchers, and birth activists for their views on certain issues. One conversation led to another and I was heartened to find that many people were committed to providing their editorial assistance, expertise, or resources to help mothers make an informed decision about planning a VBAC. The International Childbirth Education Association was gracious enough to embrace this educational project and give it the credibility it needed to reach childbearing women as well as maternity care professionals.

Soon after, the International Cesarean Awareness Network Board of Directors, who was considering providing their chapter leaders with an evidence-based educational program, chose to adopt and endorse this VBAC Education Project. I am pleased to have gained ICAN’s trust to share this project with the mothers they educate, support and advocate for.

I am especially grateful to Ruth Ancheta, BA, ICCE, CD(DONA) my co-author of The VBAC Source Book and Teaching Kit (ICEA, 2000) for allowing me to use our book as a foundation for the VBAC Education Project.

I am greatly indebted to everyone who contributed to this project. Their dedication to childbearing women and their families and commitment to healthy mothers and babies have enriched this project. My heartfelt thanks go to:

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About VBAC for Educators: A Teaching Guide

For Educators and Community Group Leaders

VBAC was deemed a reasonable and safe option to a routine repeat cesarean by the National Institutes of Health decades ago (1981). But, in recent years, misinformation about its safety and lack of clear national practice guidelines have succeeded in virtually eliminating VBACs in many hospitals.

Mothers have the legal right to make their own health care decisions, but that right, more often than not, is not upheld. Denial of medical care for mothers who want to labor for a VBAC has put healthy mothers and babies at risk for several health complications associated with repeat cesarean sections.

The contributors and supporters of this volunteer collaborative project, to whom I am deeply grateful, would like to see all mothers make their own informed decision about how they want to give birth. I hope VBAC for Educators: A Teaching Guide will be helpful to you and ultimately to the mothers and families you work with, support, and care for.

Nicette Jukelevics, MA, ICCE
July 2015
What’s Wrong With A Cesarean Section?

Although a cesarean delivery can be life-saving for the mother, the baby, or both, the rapid increase in cesarean births in the last two decades in the United States has brought little evidence of health benefits for mothers or babies (ACOG & SMFM, 2014). The majority of cesareans do not lead to improved health outcomes and many of the indications for which they are performed are not based on sound scientific knowledge. Rather, the high rate of cesarean deliveries puts both women and babies at increased short-term and long-term health risks (Main, Morton, Hopkins, et al., 2011).

According to Centers for Disease Control data, the number of cesarean births increased by 71% from 1996 to 2007. In 2007 the cesarean rate was the highest ever reported in the United States (32%). Cesarean rates rose for women in all age groups and in all racial and ethnic groups. Rates increased for infants of all gestational ages, and for births to mothers in all U.S. states. In six states, cesareans increased by more than 70% (Menacker & Hamilton, 2010).

The Agency for Health Research and Quality reports that cesareans increased by 51% between 1997 and 2006.

In 2013, 32.7% of all births in the United States were by cesarean section (Martin, Hamilton, Osterman, et al., 2015), more than double the rate recommended by the World Health Organization for high-risk births (Wagner, 1994). Higher cesarean rates increase harms for mothers and babies without improving outcomes.
What are the risks of cesarean section for mothers?

Compared with vaginal birth, women who have a cesarean are more likely to experience: post-operative complications; re-hospitalization; a high probability of future repeat cesareans; difficulties with attachment and breastfeeding; complications in a future pregnancy, and a twice the risk of death.

Research shows that repeat cesareans may do more harm than good for low-risk mothers and their babies. Mothers and babies experience these harms both in the short- and long-term. With a cesarean mothers are more likely to need assistance with breathing and to develop a blood clot in the legs or lungs that could be life-threatening. Surgical injuries to internal organs can happen during the operation as well. Adhesions (internal scar tissue that forms between tissues and organs) can create Ileus, a blockage of the intestines (Goer, Romano, & Sakala, 2012).

Multiple cesareans put mothers at increased risk for serious life-threatening complications. After the first cesarean, each additional cesarean increases the odds for placental problems: placenta previa (covering the cervix); placenta accreta (grows into the uterine wall); and placenta percreta (grows through the uterine wall and may grow into other abdominal organs); and sometimes both together, a placenta previa and accreta. Mothers with multiple cesareans are more likely to need admission to intensive care. Problems with the placenta increase the risk for hemorrhage and a hysterectomy if the bleeding cannot be stopped (Cunningham, Bangdiwala, Brown, et al., 2010).

A study that examined trends in the increase of obstetric complications for hospital births in United States from 1998-1999 to 2004-2005 found that severe obstetric complications paralleled the increase in cesarean sections. There was an increase in renal failure, adult respiratory distress syndrome, shock, and ventilation (assistance with breathing). Cesareans also contributed to the increased rate of pulmonary embolism and blood transfusions (Kuklina, Meikle, Jamieson, & More, 2009).

What are the risks of repeat cesareans in a future pregnancy?

Having a cesarean impacts future pregnancies. Repeat cesareans make it difficult to become pregnant again. A future fetus is more likely to be born pre-term or low-birth weight. Placental problems interfere with optimal growth of the fetus and may result in fetal malformation. Sometimes the embryo implants in the cesarean scar (cesarean scar ectopic pregnancy), a life-threatening condition for the mother and a loss of the pregnancy (Goer, Romano, & Sakala, 2012).

What are the risks of cesarean birth for babies?

Babies born by cesarean section without labor are more likely to be born preterm, have breathing problems, or need admission to a special care nursery. When mothers and babies are separated after birth and require medical care, mothers and babies are less likely to have the opportunity to be skin-to-skin, maternal-infant attachment is more likely to be delayed, and babies are less likely to be breastfed and continue breastfeeding during infancy (Jukelevics & Wilf, 2009).

Emerging evidence suggests that experiencing labor and passing through the birth canal prepares babies for receiving beneficial microorganisms from their mothers which play a key role in the development of their immune system. Human microbiomes are essential to health and well-being (Proctor, 2013).

Some of these microorganisms help to produce vitamins and anti-inflammatory substances. Microorganisms in the gut are believed to play an important role in illnesses including Crohn’s disease and ulcerative colitis. An underdeveloped immune system may allow autoimmune diseases such as diabetes and rheumatoid arthritis to develop (U.S. National Institutes of Health, 2012).
Babies born by cesarean are more likely to experience: Type I diabetes; food allergies; obesity; Allergic rhinitis; and asthma (Goer, Romano, & Sakala, 2012).

A recent Danish study that examined the method of birth with childhood onset of chronic immune diseases over a 35-year period found that children born by cesarean section had a significantly increased risk of several illnesses: asthma, systemic connective tissue disorders, juvenile arthritis, inflammatory bowel disease, immune deficiencies, and leukemia (Sevelsted, Stockholm, Bønnelykke, & Bisgaard, 2014).

Emerging research on the hormonal physiology of childbearing, the biologic process of birth from pregnancy through postpartum and the newborn period, and the significant role of the four hormones (oxytocin; beta-endorphins; epinephrine-norepinephrine; and prolactin) which have a significant impact on the well-being of the mother-infant dyad tells us that interfering with that process-scheduling a cesarean section without labor or artificially inducing labor, compromises the optimal care mothers should receive when giving birth. Dr. Sarah J. Buckley’s research adds a new and significant dimension to the increasing cesarean rates.

“Physiologic childbearing” refers to childbearing conforming to health biologic processes. Consistent and coherent evidence finds that physiologic childbearing facilitates beneficial (salutogenic) outcomes in women and babies by promoting fetal readiness for birth and safety during labor, enhancing labor effectiveness, providing physiologic help with labor stress and pain, promoting maternal and newborn transitions and maternal adaptations, optimizing breastfeeding and maternal-infant attachment, among many processes... Common maternity care practices and interventions can impact the hormonal physiology of mother and baby... and consequences for mother/and/or baby may occur in the perinatal period and beyond (Buckley, 2015).

Women who have a cesarean are less likely to have their babies with them skin-to-skin. With skin-to-skin contact babies are more likely to breastfeed early and breastfeed longer. Not breastfeeding deprives mothers of several health benefits. Breastfeeding lowers a mother’s risk for developing ovarian and pre-menopausal breast cancer and heart disease, and may decrease the risk of osteoporosis later in life. The benefits increase the longer a mother breastfeeds. Breastfeeding women without a history of gestational diabetes are less likely to develop Type 2 diabetes later in life (Jukelevics & Wilf, 2009).

The United States has one of the highest cesarean rates compared to European countries. A cesarean may take only 45 minutes to perform, but the health risks for mothers and babies can last a lifetime.

### Comparison of U.S. Cesarean Rate with Highest and Lowest Cesarean Rates in European Countries (2010)

<table>
<thead>
<tr>
<th>Country</th>
<th>Cesarean Rate %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cyprus</td>
<td>52.2</td>
</tr>
<tr>
<td>Italy</td>
<td>38.0</td>
</tr>
<tr>
<td>Romania</td>
<td>36.9</td>
</tr>
<tr>
<td>Portugal</td>
<td>36.3</td>
</tr>
<tr>
<td><strong>United States, 2013</strong></td>
<td><strong>32.7</strong></td>
</tr>
<tr>
<td>Sweden</td>
<td>17.1</td>
</tr>
<tr>
<td>Netherlands</td>
<td>17.0</td>
</tr>
<tr>
<td>Finland</td>
<td>16.8</td>
</tr>
<tr>
<td>Iceland</td>
<td>14.8</td>
</tr>
</tbody>
</table>

What’s Wrong With a Cesarean?

Cesarean sections increase costs for payers and parents often without added health benefits.

<table>
<thead>
<tr>
<th>Average Commercial Payment for Vaginal Birth</th>
<th>Average Commercial Payment for a Cesarean Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>$18,329</td>
<td>$27,866</td>
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<tr>
<td>Average Commercial Payment for Newborn Care After Vaginal Birth</td>
<td>Average Commercial Payment for Newborn Care After Cesarean</td>
</tr>
<tr>
<td>$5,809</td>
<td>$11,193</td>
</tr>
<tr>
<td>Medicaid Payment for Maternal and Newborn Care</td>
<td>Medicaid Payment for Maternal and Newborn Care</td>
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<td>$9,131</td>
<td>$13,590</td>
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References


Increasing Access to VBAC Matters

Providing care for women who want to labor for a VBAC can substantially improve health outcomes. Given the opportunity to labor for a VBAC, 3 out of 4 mothers can have a safe vaginal birth and avoid the complications from a cesarean section. Given what we know of the risks of cesareans for mothers and babies, it would make sense to encourage mothers to plan a VBAC rather than schedule a routine repeat cesarean.

In the United States, however, denial of care for VBAC by physicians and hospitals, malpractice insurance companies, controversial professional VBAC guidelines, and little regulatory oversight have substantially decreased the VBAC rate since its peak of 28.3% in 1996 (Cunningham, Bangdiwala, Brown, et al., 2010).

According to the Northern New England Perinatal Quality Improvement Network (NNPQIN), prohibitive medical malpractice premiums for physicians who support VBAC and pressure from insurers to hospitals to stop providing care for VBAC have played a significant role in reducing access to VBAC (NNPQIN, 2011).

In 2006, only 9.7 percent of women with a previous C-section had a hospital VBAC, as compared with 35.3 percent in 1997—a 73 percent decline. In contrast, there was a 40 percent rise in the rate of repeat C-sections among women with a previous C-section, from 64.7 percent in 1997 to 90.3 percent in 2006.

THE RATE OF REPEAT C-SECTIONS INCREASED 40 PERCENT WHILE THE VBAC RATE DECREASED 73 PERCENT, 1997-2006*

*Based on all-listed diagnoses and DRGs
Source: AHRQ, Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project, HCUPnet, Nationwide Inpatient Sample, 1997-2006
Since 1996 at least one third of hospitals and one-half of physicians have stopped providing care for VBAC (Cunningham, et al., 2010).

Almost half of expectant mothers with a prior cesarean who gave birth in the United States between 2011-2012 considered planning a VBAC, but 46% were denied care for that option. One in four providers and 15% of hospitals did not support VBAC. In prenatal discussions with their care provider about their birth options, 88% of the providers expressed an opinion in favor of a repeat cesarean (Declercq, Sakala, Corry, et al., 2013).

In 2012, nine out of 10 mothers had a repeat cesarean (Martin, et al., 2013). Routine repeat cesareans increase harms for mothers and babies (Goer and Jukelevics, 2010).

The United States ranks last with regard to VBAC rates when compared to other industrialized countries.

### Comparison of U.S. VBAC Rate with Selected European Countries (2004)

<table>
<thead>
<tr>
<th>Country</th>
<th>VBAC Rate %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Netherlands</td>
<td>55</td>
</tr>
<tr>
<td>Germany</td>
<td>41</td>
</tr>
<tr>
<td>France</td>
<td>35</td>
</tr>
<tr>
<td>United States (2012)</td>
<td>9.7</td>
</tr>
</tbody>
</table>


References


Why Support Physiologic (Normal) Birth?

Evidence tells us that allowing birth to begin and proceed normally without unnecessary medical interventions is safer and healthier for mothers and babies, and is less likely to progress to a cesarean section (Sakala & Corry, 2008). A cesarean can be a life-saving procedure for the mother and/or her baby. However, leading maternity care authorities have concluded that too many women with healthy pregnancies are having a cesarean when short- and long-term harms of this major abdominal surgery outweigh the benefits (American College of Obstetricians and Gynecologists & Society for Maternal-Fetal Medicine, 2011). In the United States, one in three women give birth by cesarean section. Twice as many as recommended by the World Health Organization (Wagner, 1994).

Current research (Goer & Romano 2012, Buckley, 2015) validates that optimal outcomes for mothers and babies result from allowing the process of childbirth to evolve without unnecessary interventions and involving mothers in their care. Leading maternity care organizations have changed their established views of birth and state, “Most births are normal and require minimal intervention… Decisions about interventions should incorporate the woman’s personal values and preferences and should be made only after she has had enough information to make an informed choice, in partnership with her care team” (American College of Obstetricians and Gynecologists, American Academy of Pediatrics, American Academy of Family Physicians, et al., 2011).

Physiologic childbirth—labor and birth, newborn transition to life outside the womb, and the first hour after birth also ensures the mother’s psychological wellbeing and provides for her newborn’s needs. Allowing birth to begin and progress on its own, giving mothers freedom of movement, providing a supportive birth environment, continuous emotional support, and a variety of comfort measures, and non-drug options for pain relief improves a mother’s chances of having a safe, uncomplicated, vaginal birth. Placing a healthy newborn skin-to-skin on his/her mother’s chest immediately after birth enhances mother-infant attachment and helps to initiate breastfeeding (American College of Nurse-Midwives, Midwives Alliance of North America, National Association of Certified Professional Midwives, 2012).

In the last three decades, childbirth has increasingly become a medical event controlled by medical interventions unsupported by evidence. This perspective of childbirth accompanied with a medical model of care has alienated women from their own innate power to give birth, protect, and breastfeed their newborns. Increased interventions and surgical births have not improved health outcomes, but have increased maternal and newborn complications that impact both short- and long-term health outcomes. An increase in interventions and cesarean sections has not improved health outcomes for mothers and babies.

In 2011, the United States ranked last in neonatal mortality (deaths in the first 27 days of life) compared to 15 other industrialized countries—4.04/1,000 neonatal deaths compared to Korea, 1.7/1,000 and Japan 1.7/1,000. With regard to the maternal mortality rate (deaths per 100,000 live births) for the same year, the U.S. ranked 9th out of 10 industrialized countries—the U.S. maternal mortality rate was 10.5/100,000 compared to Italy’s, 2.9/100,000 (Declerq, 2014).

Supporting physiologic birth helps to avoid the first cesarean and increases the odds for a normal healthy birth for mothers with a prior cesarean who want to labor for a VBAC.

Putting VBAC in Perspective:
References


Teaching about VBAC:

How To Use the Modules With This Teaching Guide

The slide set, Deciding if VBAC Is Right for You: A Parent’s Guide along with this Teaching Guide have been developed to help the childbirth educator or leader of a VBAC support group create the program that best meets mothers’ needs. They can also be used for an in-service training or for a continuing education offering. If you are a doula, you can share the information in the slides, Educational Handouts for Parents, and Resource List with the families you work with, or offer an educational day to your doula community about how best to support VBAC mothers.

Planning Your VBAC Class

• The kind of class you will offer or the parents’ group you will lead in your community, birth center, or hospital will depend on the needs of your students and the time frame you have.

• The topics you cover, the number of sessions you offer, and the length of each session, will all vary according to your students’ needs. What you include will also be influenced by other resources available to your students.

• If most of your parents are also taking well-taught classes on labor coping techniques and labor progress, or have experienced labor support from a doula, you might want to teach a short class that focuses only on VBAC.

• If the parents in your community have fewer resources, you may want to offer a longer class series that also addresses labor coping techniques. You can also offer a one-session VBAC Orientation Class that covers the benefits and risks of VBAC and repeat cesarean section and the chances of having a vaginal birth.

• If you are leading a VBAC support group in your community, you will probably want to spend some time on the psychological impact of an unexpected cesarean, the rights of mothers to make their own health care decisions, and how parents can improve their chances for a VBAC. You will probably want to create a directory of VBAC-friendly providers, birth centers, and hospitals in your area.

• Consider what core issues you most want to include and write an outline framed around those issues. Remember that parents will also have access to the visual slide presentation, Resource List and Educational Handouts for Parents so they can access the information they want even if you don’t cover it in class.

• You can teach the material just as it is presented in each of the modules. You can also take the main ideas, present them in your own way, and distribute the accompanying Educational Handouts for Parents for the corresponding topic.

• Choose appropriate audio-visual materials for each of your core ideas.

• Consider having a VBAC film night for your community. Invite nurses, midwives, physicians, parents, and doulas with VBAC experience for a panel discussion or a Q & A. Provide appropriate Educational Handouts and/or the Resources list.
Teaching Tips

Depending on how much time you have, and the physical space you are teaching in, these suggestions may be helpful to you.

Before you begin your first class, look at the Resources for Parents at the end of the modules you plan to teach. You will also find the links for each of them in the Resources for VBAC and Physiologic Birth. Select the ones you think would be helpful for your particular students. Make copies of each, or refer parents to the links if you think they all have access to the Internet.

1. If you have the names of the parents who will be attending your class, you might want to give them a call before class begins. This will give mothers the opportunity to clarify some of their personal concerns and give you specific information that you may want to add for discussion in your class.

2. Use a room set-up that encourages participation and interaction, circle and U-shaped set-up instead of classroom style. Given the opportunity, VBAC students learn a lot from each other.

3. Make your role clear. Present the information in a neutral manner without trying to influence parents to choose one option over another. Refer them to their caregivers for medical issues, but help them to feel comfortable asking questions to get the answers they need.

4. Parents need to feel safe. Birth is personal. Parents need to get to know each other and feel comfortable sharing personal issues. Establish some ground rules. Ask your students what those ground rules might be (e.g. not criticizing each other, respecting each mother’s choice).

5. Find out your students’ needs before you begin teaching. Take a few minutes for each parent to find out what his/her main concern is.

6. Allow time for mothers to share their cesarean experience. Let everyone listen without commenting until she has finished her story. Allow time for partners to do the same. Often this is the first time that a partner has heard how the birth affected him/her and the first time the mother has heard how the last birth impacted her partner.

7. Invite parents who have planned a VBAC to share their experience with the class, whether their birth was a VBAC or a cesarean section.

8. Let your students who are planning a hospital VBAC that providers’ care practices vary widely on issues like when to arrive at the hospital, fetal monitoring, IVs, Heparin locks (capped IVs), and how long a woman can labor before “failure to progress” is determined. Help your students discuss these issues within a physiologic birth framework.

9. Avoid substituting opinion for facts and help your students assess the accuracy of what they may have heard or found on the Internet. Refer your students to the Resources for VBAC and Physiologic Birth for evidence-based information.

10. Avoid giving advice if your students are asking about a medical issue (i.e., I have herpes or I am diabetic). Refer mothers to other health professionals you may know so they can get a second opinion, if needed.
11. Encourage your students to discover their strengths. Emphasize that the overwhelming majority of births are normal and that VBAC labors tend to have very safe outcomes.

12. Become aware of the variety of cultural approaches to helping women through childbirth, and remember that each can enrich class content. Ask parents to share their customs of birth and describe how their culture supports women in labor.

13. For students who have strong religious beliefs—validate that faith and being part of a religious community can be powerful sources of support for them.

14. Many women have been told by their caregiver that their “pelvis is not shaped properly,” they are “too small,” or they’ll “never be able to birth their baby without a cesarean.” These comments have a strong impact on women’s confidence to give birth. Emphasize how a woman’s body changes during pregnancy to facilitate the process of labor. For example, how softening of connective tissues make the pelvis, cervix, and vagina flexible, the ability of the baby’s head to mold, and the increase in endorphins in labor.

15. Help students to consider other challenges and painful experiences that they may have faced in life. Help them to identify the inner resources they used to cope with those challenges and experiences.

16. Inform your students of their legal rights. Their right to be involved in all medical decisions that affect them and their baby, their right to informed consent and refusal, their right to respectful maternity care, and their right to make the final decisions about how they want to give birth.

17. Refer mothers to cesarean/VBAC support groups. For many women who have had a cesarean, support groups are an opportunity to meet their emotional needs which may have been ignored by their caregivers, family, and friends who had never had similar experiences. A support group can help women process a prior traumatic birth and restore their confidence in their ability to give birth without surgery.

18. Keep up to date with developing research and other information by signing on to receive updates from the websites in the Resource List for VBAC and Physiologic Birth.
Module 1
VBAC: The Benefits and Risks for Mothers and Babies

Why Is It Important to Educate Parents About VBAC and Repeat Cesarean?

The Listening to Mothers III Pregnancy and Birth (Declercq, Sakala, Corry, et al., 2013) U.S. national survey of childbearing women who gave birth in hospitals in 2011-2012, revealed that nearly 7 out of 10 women felt mothers should have a choice to have a VBAC. Nine out of ten mothers wanted as much information as possible about the risks associated with cesarean and VBAC. More than half of the mothers who had a primary or repeat cesarean said they would unlikely choose a repeat cesarean.

What Do Mothers Know About VBAC and Repeat Cesarean?

Caregivers have an obligation to provide accurate medical information to their patients so they can make an informed decision about how they want to give birth. Unfortunately, in the United States most women are very poorly informed when it comes to the benefits and risks of cesarean section and VBAC.

The Listening to Mothers III report stated that most mothers were not sure about two of the most frequent complications of cesareans: placental problems in a future pregnancy and breathing problems in newborns. Women who did have a cesarean were no more informed than women who had a vaginal birth. In fact women who did have a cesarean believed the contrary, that a cesarean is protective of newborn breathing problems.
How Comfortable Are Mothers Asking Questions of their Caregivers?
With regard to having frank communications with their care provider, 30% of women held back from asking questions because their caregiver seemed rushed. More than I out of 5 did not discuss issues important to them because they were afraid to be seen as difficult patients.

What Do Caregivers Tell Mothers About VBAC and Repeat Cesarean?
Among women surveyed who had one or two prior cesareans, more than one in four reported that the discussion about how they would give birth this time was not framed as a matter of choice. Of the care providers who expressed an opinion about VBAC or repeat cesarean, 88% recommended a repeat cesarean. At the end of their pregnancy, 93% of these women had a repeat cesarean section.

Forty-Eight percent of mothers with a prior cesarean wanted the option of laboring for a VBAC, but 24% of physicians and 15% of hospitals told them they did not provide care for VBAC.

What do mothers think about the quality of care they received?
Overall, 82% of mothers surveyed believed that their provider’s recommendations reflected evidence-based care and 65% preferred that their caregivers make the best decision for them. The majority of first-time mothers (76%) and experienced mothers (82%) reported that their caregiver was the most valuable source of information about pregnancy and birth.

How does the U.S. VBAC rate compare with other industrial countries?
When compared with industrialized countries the United States ranks last.

<table>
<thead>
<tr>
<th>2004 VBAC RATES for SELECTED COUNTRIES</th>
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<tbody>
<tr>
<td><strong>Countries with the Highest VBAC Rates</strong></td>
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<tr>
<td>Netherlands</td>
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<td>Germany</td>
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<tr>
<td>France</td>
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<tr>
<td><strong>Countries with the Lowest VBAC Rates</strong></td>
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<tr>
<td>Canada</td>
</tr>
<tr>
<td>Lithuania</td>
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<tr>
<td>Latvia</td>
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<tr>
<td>United States</td>
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Implications for Educators
Although VBAC is encouraged by ACOG and viewed by the National Institutes of Health as a reasonable option to a routine repeat cesarean, less than 10% of U.S. women had a VBAC in 2010. It appears that care providers are not educating their patients about the benefits of VBAC or risks of repeat cesarean and women may not be making an informed decision when they “consent” to have a routine repeat operation.

Educators can fill in the information gap about the benefits of laboring for a VBAC so mothers can make an informed choice about how they want to give birth.
References


Module 2
What Are the Main Concerns When Laboring For a VBAC?

VBAC Fear is a Recent Phenomenon

Fear associated with VBACs in the United States is a relatively recent phenomenon associated more with medical malpractice suits and fixed reimbursement rates for childbirth rather than any recent scientific evidence. In fact laboring for a VBAC after a prior cesarean is not any more dangerous today than it was in 1981 when the National Institutes of Health (NIH) Consensus Report, *Cesarean Childbirth* concluded that the risk of a uterine rupture for planned VBAC with a low-segment transverse scar was low-less than 1%. With support and proper care within safe guidelines, the report stated about 75% of women will have a normal birth and avoid the complications of a repeat cesarean operation (National Institutes of Health, 1981). The U.S. cesarean rate was 15% when the NIH investigated ways to reduce the number of cesarean sections.

The single most controversial issue regarding birth after cesarean is the probability of a uterine rupture- the separation of the uterine scar from a prior incision during labor or birth. Over the years studies have reported the risk as less than 1%. Yet some women are still warned that if they plan a VBAC their “uterus will explode.” Planning a VBAC is “selfish” putting the baby’s life in danger for the sake of the mother’s “birth experience.”
In recent years, the risk of a uterine rupture while laboring for a VBAC has overshadowed all other unpredictable obstetric complications likely to occur for any woman in labor. Unpredictable emergencies such as a prolapsed umbilical cord, fetal distress (non-reassuring fetal heart rate), and hemorrhage from a placental abruption.

**Implications for Educators**

Women have the right to know all the facts before they make a decision to labor for a VBAC or to schedule a repeat cesarean section. However, given the same facts women are likely to draw different conclusions about which option is “safest” for them or their baby. Women have a right to know that the risk for a uterine rupture is less than 1%, but they also have a right to know the consequences of that risk since they will ultimately decide how, where, and with whom they will give birth.

There is no easy way to present the facts about a uterine rupture, although it’s important to keep a proper perspective in the conversation. Parents may get a better perspective by looking at other more frequent potential complications of labor that also require a rapid cesarean section. The chart below, included in the slide presentation, *Deciding If a VBAC Is Right for You: A Parent’s Guide* can be used to make the comparison.

Women who labor for a VBAC as well as women without a prior cesarean can experience complications in labor that require an emergency cesarean.

<table>
<thead>
<tr>
<th>Per 1,000 women who labor</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Uterine rupture,</strong>  symmetrical separation of uterine scar</td>
</tr>
<tr>
<td><strong>Shoulder Dystocia,</strong> baby’s shoulders are too wide to fit through the pelvis</td>
</tr>
<tr>
<td><strong>Placental Abruption,</strong> placenta separates from the uterus before the baby is born</td>
</tr>
<tr>
<td><strong>Umbilical Cord Prolapse,</strong> umbilical cord precedes the baby’s head through the cervix</td>
</tr>
</tbody>
</table>


Discuss the Educational Handouts for Parents for Module 2, *General Information About Uterine Scar Rupture*. It will help parents get a better sense of the risks associated with planning a VBAC.

Help mothers by also reviewing how the risk for uterine rupture can be reduced. This will identify issues important to them that they can discuss with their care provider.
Background Information: Types of Cesarean Incisions

Whether a mother can labor safely for a VBAC depends largely on what type of cesarean uterine scar she has. The “once a cesarean always a cesarean” dictum arose in the early 1900s when cesareans were done with a “classical” (high vertical) incision. Most cesareans today are done with low-transverse uterine incisions. There is some debate about which scars are dependable enough for VBAC labors. Here is a review of various types of uterine incisions.

Low Transverse Incisions (used in the vast majority of cesareans)

This incision is cut horizontally (transversely) in the lower-segment of the uterus, which tends to be fibrous, stretchy, and strong. Since this incision cuts between important horizontal muscle fibers, instead of across them, it does not damage those fibers. VBAC studies have included tens of thousands of women who had low-transverse cesarean scars. Most studies show the risk of uterine rupture in a subsequent labor with this type of scar is less than 1%.

Low Vertical Incisions

This incision is also made in the lower segment of the uterus. It is used when the baby is large or a transverse lie, or for placenta previa. For women with low vertical scars, physicians are concerned about whether the original incision did in fact extend into the upper (contractile) part of the uterus. If it did, it would increase the risk of rupture in a future labor. The physician is likely to review a copy of the operative report, and may question the mother about the reason for the cesarean.

The caregiver may also ask about the cesarean-born infant’s birth weight and gestational age. If the baby was premature, the mother’s uterus may not have had time to develop the usual full-term shape in which the lower segment is distinct from the upper segment. If the baby was premature, the original incision is more likely to have cut into the higher part of the uterus.

Current ACOG guidelines for VBAC allow for a trial of labor with one low-vertical incision (ACOG, 2010).

Cesarean section. (A), Classic; (B), low vertical; (C), transverse incisions.
**Inverted T, J, and T-shaped incisions**

“Inverted T” and “J” incisions are done when a surgeon has made a low-transverse incision and needs more room to deliver the baby. “T” incisions sometimes happen as accidental extensions of low-transverse incisions. These uterine scars are uncommon.

**Classical incision**

This is a vertical incision in the upper portion of the uterus. Classical incisions are sometimes used for babies in transverse or breech position, for delivering premature babies, or for rapid cesareans done in emergency circumstances. The upper part of the uterus is thicker and more muscular than the lower part. It is the upper part that does the work of contracting. When classical scars rupture, the rupture is likely to happen faster and cause more damage to the uterus.

**Unknown uterine incision**

Sometimes women are not told what type of uterine incision they have, and they are unable to obtain copies of their operative record. Some studies have included closely monitored women having planned VBACs with unknown uterine incisions, and found no increased risk for rupture. This is probably due to two factors. First, most of these “unknown scar” cesareans were done with low-transverse incisions. Secondly, during prenatal care, caregivers can often deduce whether a mother’s previous cesarean might have been done with a high vertical scar, and can advise her not to labor. A mother almost always knows the reason why her cesarean was performed, and at what stage in her pregnancy (pre-term or at term). This gives her care provider some indication whether her scar may have a high vertical component. It’s also possible that she may have been told that she can safely plan a VBAC.

**Can mothers labor for a VBAC with these unusual uterine scars?**

The American College of Obstetricians and Gynecologists (ACOG) states that women can plan a VBAC with a documented low-vertical uterine incision. Women with one previous cesarean with an unknown uterine scar can also plan a VBAC unless the caregiver suspects a high classical incision was used (ACOG, 2010).

The Society of Obstetricians and Gynaecologists of Canada (SOGC) guidelines for VBAC states that the risk for uterine rupture with a previous classical or inverted T incision is 4% to 9% and thus a contraindication for VBAC (SOGC, 2005).

The Royal College of Obstetricians and Gynaecologists (RCOG) in Britain recommends that women with a prior high classical uterine scar have a repeat cesarean section. They site the risk of uterine rupture to be 2% to 9%. Women with another type of incision who want to plan a VBAC can consult with their caregiver who should have access to the full details of the prior cesarean surgery (RCOG, 2007).

Goer and Romano (2012) state that the risk of uterine rupture with these three kinds of scars may be lower than once thought. They site 171 published cases of women laboring with classical vertical scars with 0 ruptures. They also site 103/105 women who labored for a VBAC with classical, inverted T, and J-shaped uterine incisions without any problems.
References


Module 3
A Closer Look at Repeat Cesareans

The U.S. cesarean delivery rate, which had been stable at 32.8% for 2010-2012, declined to 32.7% of all U.S. births in 2013. However, the rates are still much higher than recommended by the World Health Organization; 10% for community hospitals and 15% for facilities serving high-risk expectant mothers (Wagner, 1994).

2013 Cesarean Rates for Selected U.S. States and Puerto Rico

<table>
<thead>
<tr>
<th>Three States with the Highest Cesarean Rates</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Louisiana</td>
<td>38.9</td>
</tr>
<tr>
<td>Mississippi</td>
<td>38.5</td>
</tr>
<tr>
<td>New Jersey</td>
<td>38.4</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Three States with the Lowest Cesarean Rates</th>
<th>Percent</th>
</tr>
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<tbody>
<tr>
<td>Utah</td>
<td>22.4</td>
</tr>
<tr>
<td>New Mexico</td>
<td>24.3</td>
</tr>
<tr>
<td>South Dakota</td>
<td>25.5</td>
</tr>
<tr>
<td>Puerto Rico</td>
<td>48.8</td>
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</table>

Leading Maternity Care Organizations Are Calling for Fewer Cesareans

As Module 3 shows, cesarean section impacts the health of mothers and babies in the short- and long-term. Emerging research also suggests that physiologic birth and breastfeeding have significant implications on mother and infant health.

As complications of multiple cesareans have been rising, leaders in maternity care are realizing that too many cesareans are being performed exposing mothers and babies to avoidable harms without improved outcomes.

In unprecedented joint consensus guidelines issued in 2014, the American College of Obstetricians and Gynecologists (ACOG) and the Society of Maternal-Fetal Medicine (SMFM) called for a reduction in cesarean sections.

Although cesarean delivery can be life-saving for the fetus, the mother, or both in certain cases, the rapid increase in the rate of cesarean births without evidence of concomitant decreases in maternal or neonatal morbidity or mortality raises significant concern that cesarean delivery is overused. Therefore, it is important for health care providers to understand the short-term and long-term tradeoffs between cesarean and vaginal delivery, as well as the safe and appropriate opportunities to prevent overuse of cesarean delivery, particularly primary cesarean delivery (ACOG & SMFM, 2014).

Childbirth Connection’s extensive research on cesareans and VBAC leaves no doubt that the operation should be considered only when the benefits outweigh the risks.

More recent studies reaffirm earlier World Health Organization recommendations about optimal rates of cesarean section. The best outcomes for women and babies appear to occur with cesarean section rates of 5% to 10%. Rates above 15% seem to do more harm than good...

Most mothers are healthy and have good reason to anticipate uncomplicated childbirth. Cesarean section is major surgery and increases the likelihood of many short- and longer-term adverse effects for mothers and babies...

Our society is more tolerant than ever of surgical procedures, even when not medically needed. This is reflected in the comfort level that many health professionals, insurance plans, hospital administrators and women themselves have with cesarean trends. Further, the cesarean rate varies quite a bit across states and areas of the country, hospitals, and maternity professionals. Most of this variation is due to “practice style” rather than differences in the needs and preferences of childbearing women (Childbirth Connection, 2013).

Stanford University’s California Maternal Quality Care Collaborative (CMQCC) conducted extensive research on the impact of increasing cesarean rates in California. In Cesarean Deliveries, Outcomes, and Opportunities for Change in California: Toward a Public Agenda for Maternity Care Safety and Quality: White Paper, it stated the following:

In many contexts, cesarean delivery has come to be regarded as the safer option, when in fact it has greater risks and complications than vaginal birth. Higher cesarean delivery rates have brought higher economic costs and greater health complications for mother and baby, with little demonstrable benefit for the large majority of cases. With the marked decline in vaginal births after cesarean, cesarean deliveries have become self-perpetuating; and every subsequent cesarean brings even higher risks...

Primary cesarean delivery today is safer than ever; and because major complications are rare with a first birth, the risks of primary cesarean are not visible to practicing obstetricians. However, repeat cesareans, in particular, carry significant risks and complications. Unfortunately, these “future” risks or repeated cesareans are not well appreciated by either obstetricians or the public (Main, Morton, Hopkins, et al, 2012).
Implications for Educators

This is an opportune time for educators to raise awareness about the risks of cesarean section. Over the last two decades scheduling or performing cesareans after labor has become, “No big deal.” As the Listening to Mothers III report indicated, the majority of mothers trust that their caregivers are practicing according to best evidence (Declercq, Sakala, Corry, et al., 2013) so it will not be an easy task to now reverse course and tell consumers that cesareans are more risky than we once thought.

Sharing the concerns from the three organizations listed here (you may also know of others) may help parents to understand the serious health implications of routine repeat cesareans. Without educating parents that cesareans are best reserved for medical indications the cesarean rate is not likely to go down in the near future.

Many of the recommendations made by leaders in maternity care to reduce cesarean sections include a consumer education component. The CMQCC recommends encouraging VBAC, and “increasing public engagement with education, public service announcements, celebrity spokespersons, and shared decision tools.”

In the last two decades repeat cesarean births without labor more than doubled in New Jersey, from 40% to 85%. According to the New Jersey Department of Health currently one in four cesareans are routine repeat operations without serious risk indications. The New Jersey VBAC Task Force explored the capacity for hospitals to provide care for VBAC and found that many of New Jersey’s hospitals already have the resources that can meet the safety standards recommended to support mothers who want to plan a VBAC. One of the VBAC Task Force recommendations is to develop a VBAC education program to educate expectant parents about the benefits and risks of laboring after a prior cesarean (New Jersey Hospital Association, 2012).
A Group Discussion Helps Parents Weigh the Pros and Cons of VBAC & Cesarean

To help parents consider what option they are likely to choose for themselves, solicit from the group what they see as the Pros & Cons for laboring for a VBAC or scheduling a repeat cesarean. Parents are also likely to obtain new information or want to discuss issues brought up in this conversation with their own care provider.

### VBAC AND CESAREAN PROS AND CONS

<table>
<thead>
<tr>
<th>Laboring For VBAC</th>
<th>Scheduling a Repeat Cesarean</th>
<th>Arranging a Cesarean to Be Done After Labor Starts</th>
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<tbody>
<tr>
<td>Pros for Mothers:</td>
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<td>Cons for Mothers:</td>
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### If It’s a Cesarean

After learning about the risks of cesarean section some mothers may still choose to schedule a repeat operation and some will end up needing one after laboring for a VBAC. Mothers’ informed choice should be respected and as educators we can try make their cesarean birth a positive experience.

Elements of a natural birth can easily be included in a cesarean birth without compromising the safety of the mother or her baby. These elements are included in what is known as the “Gentle Cesarean”, “Natural Cesarean”, or “Family- Centered Cesarean.”

Review the Educational Handouts for Module 3 with your students. Help them to identify which of these elements are important to them and how they can communicate their wishes to their caregivers. By giving the mother options and respecting her wishes she can actively participate in her birth, establish mother-infant bonding more easily and successfully initiate breastfeeding.
Skin-to-Skin in the Operating Room

Many hospitals have implemented an early skin-to-skin (STS) policy for mothers who give birth by cesarean. San Francisco General Hospital in California implemented an early STS quality improvement policy which encourages nursing staff to place healthy babies skin-to-skin with their mothers immediately after a cesarean in the OR and during recovery. One nurse is assigned to stay with the baby throughout the STS period to prepare the mother to receive her baby and properly position him/her on her body to initiate breastfeeding. The program involves the entire perinatal team, including the obstetricians, pediatricians, and anesthesiologists.

Data which was collected from the project and published in 2011 revealed that healthy newborns who were placed STS in the OR were less likely (33%) to be given breast milk substitutes (infant formula) while in the hospital compared to newborns who experienced STS within 90 minutes of birth (42%) and infants who did not experience STS in the first 90 minutes (74%) after birth (Hung and Berg, 2011).

Skin-to-skin contact has many other invaluable benefits for both mother and baby. For babies, STS helps to regulate body temperature and heart and breathing rate, increase blood glucose levels and facilitate self-attachment for breastfeeding. For mothers, STS increases maternal feelings of affection and nurturing, synchronizes sleep with their newborns, and babies are ten times less likely to cry and for shorter periods of time when compared to newborns placed in a crib (ICEA).

See a sample of policies and procedures for skin-to-skin after a cesarean section from Brookings Health System, South Dakota in Appendix A.

If you provide perinatal care in a hospital as well as teach birth or breastfeeding classes, you can help to give mothers the support they need to breastfeed their newborns. Take the lead and evaluate if your professional colleagues are ready to consider implementing a skin-to-skin policy for mothers who give birth by cesarean.

References


Laboring for a VBAC presents different challenges for different women. Some are ready to face it head on without any drugs for pain relief, choosing instead a variety of comfort measures, doula care for emotional and physical support and a midwife as their primary care provider. Others, who may have had a long, difficult, and painful labor before having a cesarean may feel they can only go through another labor if they have dependable pain relief (an epidural), the safety of electronic fetal monitoring and the reassurance of an “immediately available” physician and operating room staff in case of complications. Every mother’s choice must be respected. There are many ways to support women who labor for a VBAC within their self-selected birth choices.

ACOG’s guidelines for VBAC include studies which suggest there are factors that are likely to increase women’s odds for completing a VBAC:

- A prior vaginal birth;
- A healthy pregnancy weight;
- The prior cesarean was for malpresentation (baby in a non-vertex position);
- Going into labor at or near term;
- A labor that is not induced or augmented;
The bag of waters having ruptured on its own or the cervix having started to dilate before admission to the hospital labor and delivery unit; 

No complication such as preeclampsia. (ACOG, 2010)

However, there are other important factors that can make a difference in whether or not a mother will complete a VBAC labor.

**Physiologic birth is safest for low-risk women**

Evidence is mounting and validating what many maternity care professionals have always known, that health outcomes are better when the process of labor is allowed to unfold on its own (physiologic birth) without routine medical interventions and when mothers are full participants in their care. Women are more likely to get the support they need and the care that is best for them when care providers collaborate to bring about healthy outcomes for mothers and babies (Goer & Romano, 2012).

Simkin and Ancheta (2011) have demonstrated that women can have an easier and safer birth when they feel safe and respected by their caregivers and when their values and preferences are taken into consideration. When they have freedom of movement and can stay in upright positions as long as they feel comfortable.

**Implications for Educators**

The concept of physiologic birth, allowing birth to proceed without interventions unless medically necessary, moving around in labor, and avoiding an epidural in the early stage of labor will probably be new for most of your students. In U.S. hospitals the majority of women experience multiple interventions, two out of three women have an epidural for pain relief in labor, only four out of ten have freedom of movement once labor begins and more than six out of ten are on their back for the second stage of labor (Declercq, Sakala, Corry, et al., 2013).

To help women clarify what options are available to them and how they prefer to give birth use the list of suggested questions in the Educational Handout for Module 4 to begin the conversation so that they have the time and opportunity during pregnancy to get the answers they need.

The questions are designed to encourage parents to feel comfortable asking questions of their caregivers and to find out more about their provider’s approach and philosophy of birth. The discussion will also help partners themselves to find out if their views about having a “safe” VBAC are similar or different. Partners may decide they can both benefit from the expertise and support of a doula.

The second Module 4 Educational Handout outlines support for a physiologic birth. Again, each expectant mother is different and it’s important to validate the informed choices they make and at the same time find ways to support them.

It’s possible that an induction becomes medically necessary, or that labor becomes exhaustive and an epidural may be the right option at the right time to give a mother a rest so she can continue to labor.
Routine Interventions and Electronic Fetal Monitoring

- Avoiding routine interventions helps labor progress, but with a VBAC, monitoring the baby’s heart rate is important. The baby’s heart rate pattern frequently changes when the uterine scar separates. Up to 70% of the time electronic fetal monitoring (EFM) has detected an abnormal heart rate pattern, suggesting a separation of the uterine scar (ACOG, 2010).

- Some care providers recommend continuous EFM in active labor. Even with continuous monitoring for a hospital VBAC it’s possible to change positions, rock in a chair, stand and move side to side, lean over the back of the bed or a birth ball and use an upright position for birth. A telemetry unit (portable fetal monitor), or a waterproof handheld Doppler allows mothers to walk, change positions or use the birth tub while monitoring the baby (Simkin & Ancheta, 2011).

References


Module 5
Four Main Reasons For a First Cesarean: What You Can Do Differently This Time

Four of the main reasons for a primary cesarean are: failure to progress; fetal heart problems; malpresentation (baby in wrong position, such as breech or transverse); and macrosomia (big baby). It is important to help mothers understand the reason they had a cesarean and how they can avoid a repeat of a similar situation when laboring for a VBAC.

If a cesarean was performed for “failure to progress” or a “big baby”, often, women feel that their body betrayed them and they are reluctant to labor again. Many women don’t realize that the kind of care they receive and the philosophy and support of their maternity care team can make all the difference.

New Guidelines for Failure to Progress
Evidence shows that many care providers don’t give women enough time to complete the first stage of labor (when the cervix dilates to 10 cm) or enough time to push their baby out. You may want to review the new definition of protracted labor from the American College of Obstetrics and Gynecology and the Society for Maternal-Fetal Medicine, *Safe prevention of the primary cesarean delivery. Obstetric care consensus* and the revised safe time limits for second stage with and without an epidural (ACOG & SMFM, 2011).
The new guidelines state that women may not reach the active phase of labor (when contractions get closer together and more intense) until 6 cm. Failure to progress has been redefined to include at least 6 cm dilation, ruptured membranes, and no cervical change after four hours of adequate labor or 6 hours of augmented labor.

The new recommendations for second stage do not include a time limit after full dilation as long as mother and baby are stable. For first labors, the pushing phase may take up to 3 hours or 4 hours with an epidural. Multiparas can take up to 2 hours for the pushing stage and 3 hours with an epidural. Many women probably had their first cesarean because their caregivers may not have given them enough time to labor or give birth.

**Induction of Labor and Failure to Progress**

Mothers are at higher risk for a uterine rupture and are less likely to have a VBAC if their labor is induced (Goer & Romano, 2012). If an induction is medically necessary, the ACOG and SMFM revised guidelines for reducing the odds of a cesarean encourage health care providers to refrain from inducing labor before 41 weeks and using a cervical ripening agent to lower the risk for a failed induction. Before a cesarean is recommended due to a failed induction, Pitocin should have been administered for at least 12-18 hours with ruptured membranes. With an induction, the latent phase of labor can last up to 24 hours or longer (ACOG & SMFM, 2011). Here again, many mothers probably had a first cesarean for a “failed” induction during the latent phase of labor.

**Implications for Educators**

**Encourage Mothers to Wait For Labor to Start On Its Own**

Spontaneous labor is exceptionally beneficial for both mothers and babies. When labor begins on its own a cascade of birth hormones is released which provides natural pain relief for the mother, reduces excess fluid from the baby’s lungs, enhances mother-infant attachment after birth, warms the mother’s skin after birth and helps to warm the baby when placed in the skin-to-skin position on the mother’s chest and lastly, enhances the initiation of breastfeeding (Buckley, 2015).

**Help Parents Understand That Labor Progress is Not Just About Cervical Dilation**

There is much activity, sometimes unnoticed, that takes place in a woman’s body towards the end of pregnancy and prior to cervical dilation to prepare her for labor and birth. Helping mothers understand and appreciate those important markers may help to reduce their frustrations if they experience long hours of contractions without cervical dilation. Simkin and Ancheta (2011) describe Six Ways to Progress in Labor:

1. The cervix moves from a posterior to an anterior position.
2. The cervix ripens and softens.
3. The cervix effaces.
4. The cervix dilates.
5. The baby’s head rotates, flexes, and molds.
6. The baby descends, rotates further, and is born.

In addition to the standard framework of measuring labor progress using the 3 “Ps”: the passenger (assessing the position and size of the baby’s presenting part); the pelvis (size, shape, and flexibility of the bony pelvis); and the powers (effectiveness of contractions and pushing in second stage), Simkin and Ancheta (2011) also include two other dimensions. The psyche (the mother’s emotional state and anxiety level) and pain (the mother’s ability to cope with it).
Discuss these factors and how they can impact the progress of labor and suggest ways parents can influence these factors to help them have a VBAC.

Goer and Romano (2012) suggest that there are factors that can influence labor progress before the physiologic process even begins. They have added four more “Ps” that play a role in the progress of labor: permission; physical environment; practices; and people. Factors that influence a mother’s autonomy and mobility during labor and birth.

**Permission:** Mothers should be allowed to move freely and assume positions of their choice. Eat and drink if they are hungry or thirsty. Control the light, sounds, and ambience of their environment and wear clothing of their choice.

**Physical Environment:** Mothers do better when they have safe and private spaces to walk in, physical supports like birth balls, chairs, bars, pillows, and showers or tubs to reduce pain.

**Practices:** Caregivers should avoid using medical interventions unless they are medically necessary. I.V. lines, continuous fetal monitoring, bladder catheters, and epidurals restrict a woman’s mobility and ability to change positions in labor or for birth.

**People:** Mothers in labor need the people that care for them or support them in childbirth to be attentive, non-judgmental, reassuring, and encouraging. Mothers’ needs for privacy, dignity, and autonomy should be respected. Mothers should feel free to vocalize both positive and negative emotions without embarrassment or fear of reprisal from maternity caregivers.

Help your students understand the reasons why labor may slow down or progress at a slower pace than expected.

Take the time to demonstrate with a plastic pelvis, if available, how the ligaments, which are softened during pregnancy, can stretch and increase the diameter of the pelvis to allow the baby to move to a more favorable position or to move down through the pelvis.

Use the Positions to Help with “Back Labor” Parent Handout for Module 5 and give mothers time to practice different positions that may be helpful during labor. Show their partners how they can help with “Back” Labor.

**Fetal Heart Problems**

Although continuous electronic fetal monitoring has been used extensively since the early seventies, no evidence has concluded that it improves perinatal health outcomes for low-risk women (Goer & Romano, 2012). Evidence shows that first births by cesarean for fetal heart problems have been increasing and based on fetal monitor readings physicians disagree on whether or not a cesarean is necessary for the health of the baby (Barber & Lundberg, 2011). However, for women laboring for a VBAC, there is evidence that close fetal monitoring can be helpful in diagnosing the possibility of a uterine rupture. Up to 70% of the time electronic fetal monitoring (EFM) has detected an abnormal heart rate pattern, suggesting a separation of the uterine scar (ACOG, 2010). Some caregivers recommend continuous fetal monitoring in active labor.

Review with parents why the baby’s heart rate may fluctuate outside normal readings and what choices they can make to reduce them. If a mother had a cesarean for fetal heart problems she may not feel safe laboring without close fetal monitoring.

Demonstrate how a mother can stay active and change positions during labor and birth even when continuous monitoring is used. This discussion should encourage mothers to ask their caregiver about their monitoring practices and to find out if using a Doppler intermittently or if telemetry (remote monitoring without a connecting cable) is an option.

**Breech**

Breech presentation occurs in 3-4% of all term pregnancies and is the third most common reason for performing a cesarean in the U.S. More than 90% of breech babies are delivered by planned cesarean section (Barber & Lundberg, 2011). External Cephalic Version (ECV), a procedure that helps to turn a fetus from a breech presentation to a cephalic presentation has been shown to decrease the incidence of breech presentation at term for women without a cesarean scar thereby reducing the need for a cesarean section. In 2010 U.S. physicians reported 6,564 ECV procedures. The success rate was 60.1%. (National Center for Health Statistic, 2012).
ACOG’s current guidelines for VBAC encourage women with a prior cesarean to have an ECV to increase their odds for laboring for a VBAC (ACOG, 2010).

A study published in the January 2014 issue of the *British Journal of Obstetrics and Gynaecology* reaffirmed that it is safe for women with a prior cesarean to have an external cephalic version (ECV) in a medical center.

Researchers in Spain compared a group of 70 low risk women with a prior cesarean with 387 low risk women with a prior vaginal birth who had an external version at or after 37 weeks of gestation. All women were expecting one baby.

Physicians were successful in turning a breech in 67.1% of 70 low-risk women with a cesarean scar and 66.1% of women with a prior vaginal birth. There were no complications in the group of women with a prior cesarean. Of the women with a prior cesarean 52.8% had a vaginal birth (VBAC). More than half of the women avoided a repeat cesarean section (Burgos, Cobos, & Rodríguez, 2014).

**Implications for Educators**

External cephalic version is successful for at least half of all women who have the procedure. Discuss this option with your students to reduce their odds for a repeat cesarean section. Find out if any mothers are familiar with non-medical procedures and which options would be acceptable to them. Increasing awareness about ECV early in pregnancy gives women time enough to discuss the issue with their caregiver before the 37th week of gestation.

**Macrosomia: “Big Baby”**

Fetal macrosomia (big body) is defined as a fetus expected to weigh 4000 gm (8lb, 3oz) to 4500 gm (9lb, 4 oz) at birth. Sometimes care providers recommend that a woman be screened in her last trimester to determine the weight of her baby at birth (pelvimetry). Based on these measurements the care provider decides whether or not the baby is “too big” to be born vaginally.

There is a strong belief that “big” babies born vaginally are at high risk for shoulder dystocia. By planning a cesarean section, physicians believe they can avoid that risk. Shoulder dystocia is a complication that can occur in the pushing phase. When the baby’s head is delivered but the shoulders remain stuck the baby’s chest can become compressed reducing the oxygen supply to the heart and brain. Often those “big” babies are born within normal weight range.

Pelvimetry is an inaccurate method of estimating fetal size and cannot predict whether or not the baby will move down through the mother’s pelvis or not. An ultrasound screening has an error margin of 10% to 20%. Women who have pelvimetry are more likely to have a cesarean, but there is no evidence that the health outcomes of babies are improved (Pattison & Farrell, 2009).

ACOG and the SMFM state that estimates of fetal weight as determined by ultrasound in late pregnancy are inaccurate and increase the cesarean rate with no evidence of benefit to the baby. These estimates should not be used to make decisions about a vaginal or a cesarean birth. To lower the risks for birth trauma (shoulder dystocia for the baby and vaginal tears for the mother) their guidelines recommend that cesarean section be limited to babies expected to weigh at least 5000 gm (11 lb) for women who are not diabetic and 4500 gm (9 lb, 14 oz) for women who have diabetes (ACOG & SMFM, 2014).

**Implications for Educators**

There is a lot you can teach the parents about an induction or cesarean for a “big” baby. The *Listening to Mothers III* survey of U.S. women who gave birth in 2011-2012 found that 2 out of 3 mothers were asked to have an ultrasound toward the end of their pregnancy to estimate their baby’s weight. One third of the women were told that they had a “big” baby. After a discussion with their caregiver about the possibility of having a cesarean for their “big” baby, 1 out of 3 mothers did have a planned cesarean section. Twenty percent felt that they had no other choice but to schedule a cesarean.

Two-thirds of women with a “big” baby indicated that their caregiver discussed the possibility of an induction. Twenty percent of the mothers were not given any other choice, but induction. More than two-thirds of the women who had this discussion ended up being induced (Declercq, Sakala, Corry, et al., 2013).

Increase parents’ awareness about late pregnancy scans to estimate the size of their baby.

Discuss what options other than induction of labor or a planned cesarean for a “big” baby they may want to consider and discuss with their caregivers.
Plan to spend time demonstrating the various positions for “Big Baby” in the Parents’ Handouts for Module 5 and allow parents to practice so they feel comfortable and familiar with these positions when it comes to labor and birth.

Help partners practice the different ways they can help if labor becomes long and difficult.

**Questions to Ask if a Cesarean is Recommended During Labor**

Help mothers to understand that they often have the time to discuss with their caregiver a recommendation for a cesarean section. Many mothers benefit from knowing that they have fully participated in the medical decisions regarding their health care. A cesarean is sometimes recommended in labor or in second stage when it is not an emergency situation. Parents then have the time to ask these questions. Sometimes a mother knows that the baby needs to be born by cesarean, but having the time to have this discussion and giving her time to adjust to this new reality helps her to avoid postpartum feelings of having been “pushed” into a cesarean.

You can role model a question and answer scenario using the Questions To Ask Parent Handout for Module 5 in class to help parents feel more comfortable taking an active role in their care.

**References**


Module 6
Helpful Strategies for Labor and Birth

U.S. hospital birth practices are outdated and increase a mother’s risk for complications.

Although we have strong evidence that freedom of movement, change of positions in labor and freedom of choice of position for second stage improves the odds for an uncomplicated vaginal birth (Simkin & Ancheta, 2011), only 43% of U.S. women surveyed who had a hospital birth in 2011-2012 walked in labor once admitted to the hospital and regular contractions began (Declercq, Sakala, Corry, et al., 2013), the time when freedom of movement is the most helpful.

The Listening to Mothers III survey found that 68% of women pushed their baby out in the worst possible position- on their back (lithotomy position). Only 23% gave birth in a propped up (semi-sitting) position. Pushing in a back-lying position increases the risk for fetal heart intolerance, a forceps or vacuum extraction and needing an episiotomy adequate enough to insert these instruments.

The survey also reported that 49% of mothers (first-time and experienced) took weekly childbirth classes and 8 out of 10 used their computers to obtain information on pregnancy and birth. However, mothers seem to be unaware of the benefits of freedom of movement and effective positions for birth.

Mothers who have a midwife as their primary caregiver (10% of all births in 2011-2012) or have a doula at their birth (6%) will be guided and encouraged to walk and change positions during labor and birth.
The freedom to walk and use a variety of positions for labor and birth can help labour progress and help mothers who may have a baby in an OP (occiput posterior) or asynclitic (asymmetrical) position, when a baby’s head is tipped towards one shoulder as it moves down through the pelvis.

**Implications for Educators**

Take the time to allow mothers to understand how their body prepares for labor and birth. Allow time to practice the positions in Module 6 so they feel familiar and comfortable with them during labor and birth.

Try giving a one-time class focused only on freedom of movement and helpful positions for labor and birth. Show one or more videos that demonstrate mothers using these positions for a hospital birth.

**If you are also a labor and delivery nurse** invite a doula to give the staff a demonstration of the many positions and comfort measures that can make mothers more comfortable and help their labor to progress.

Help to change your policies about restriction of movement. Take a look at Step Four in *How to Become Mother-Friendly: Policies and Procedures for Hospitals, Birth Centers, and Home Birth Services* (Hotelling & Gordon, 2014) for guidance on how to change your hospital policies on freedom of movement and discouraging the use of the lithotomy position for birth.

**References**


Coping With the Pain of Labor

Pain in childbirth and how to cope with it is probably the most important concern of expectant mothers. What options for pain relief we offer women can have a direct effect on the progress of labor and ultimately on maternal and newborn health.

Simkin and Ancheta (2011) make a distinction between pain and suffering in childbirth and a mother’s emotional well-being:

...the pain of labor might be defined as an unpleasant bodily sensation that one wishes to avoid or relieve. Suffering, however, is a distressing psychological state that includes feelings of helplessness, fear, panic, loss of control, and aloneness. Suffering may or may not be associated with pain, and pain may not be associated with suffering...

(In) our discussions with pregnant women, it is not the pain of labor that worries them as much as how the pain will affect their behavior (loosing control, crying out, writhing, showing weakness, or behaving shamefully) and whether they will find themselves in a state of helplessness (not knowing how long the pain will go on and being unable to do anything to reduce it). In other words they are afraid of suffering. Suffering is similar in definition to trauma and can lead to emotional distress (even posttraumatic stress disorder) that sometimes continues long after birth.

There are a variety of options we can offer mothers for pain relief in labor to maintain their well being and alleviate suffering. They can be categorized as pharmacologic (drug) and non-pharmacologic (non-drug) methods (comfort measures) to reduce pain. The majority of women
who give birth in U.S. hospitals are almost exclusively offered pharmacologic options. Women who give birth at home or in a birth center have a variety of non-pharmacological choices for pain relief.

While giving birth in a hospital in 2011-2012, 83% of U.S. women used one or more types of medications, 62% had an epidural for a vaginal birth, 16% were given narcotics (Demerol, Stadol), and 6% used nitrous oxide gas (Declercq, Sakala, Corry, et al., 2013).

An epidural is a very effective method of pain relief, but it can also complicate labor. It can lower the mother’s blood pressure, slow down her labor, make it necessary to use Pitocin to get labor going again, increase the risk for instrumental delivery, perineal tears, and cesarean section. (Klein, 2011) An epidural can increase the second stage by up to two hours (Cheng, Shaffer, Nicholson, & Caughey, 2014). The epidural numbs the pelvic floor muscles and reduces muscle tone making it more difficult for the baby’s head to complete the cardinal movements (descent, flexion, internal rotation, extension and external rotation) that facilitate birth. With an epidural babies are more likely to be malpositioned (in a transverse or posterior position) and the mother may need an instrumental delivery or a cesarean section (Simkin & Ancheta 2011).

The baby in utero is also affected directly or indirectly by the epidural. Reduced blood supply to the placenta may cause fetal heart intolerance. The toxic drugs used cross over from the placenta to the baby and may take hours to process and to be excreted from the baby’s circulation and tissues in the brain and liver. This may have an effect on the baby’s alertness at birth, mother-infant bonding, and the newborn’s ability to initiate breastfeeding (Buckley, 2015).

An epidural for pain in labor interferes with the body’s ability to eliminate heat and may raise the mother’s body temperature bringing on a fever. There is no way to determine if the mother’s fever is caused by the epidural or an infection, making it likely that the mother and her baby at birth will be screened and treated for infection.

Leaders in maternity care are learning more and more that childbirth is a natural process that should not be interfered with unless medically necessary (American College of Obstetrics and Gynecology, et al., 2011) and that the delicate physiologic process and hormonal balance of labor and birth is inherently tuned to optimize maternal and newborn health, mother-infant attachment, mothering, and the capacity to initiate breastfeeding. (Buckley, 2015).

Mothers who plan to give birth in a hospital should be offered a choice for non-drug methods of pain relief and the opportunity for continuous support (from a doula or woman experienced in childbirth) for labor and birth.

**Implications for Educators**

In the United States the majority of women who give birth in a hospital are offered drugs, almost exclusively, to relieve the pain of labor. Evidence shows that drugs can complicate labor and birth for the mother and her baby.

Take the time in class to talk about and demonstrate a variety of comfort measures. Help parents understand the benefits of doula care for childbirth.

Make copies of the Epidural Anesthesia Education form developed by Spectrum Health Gerber Memorial in Fremont, Michigan (Appendix A) so that parents have the time to review the benefits and risks before being admitted in the hospital. At Gerber Memorial, expectant mothers are also given a copy of the Birth Plan for Vaginal Delivery which lists many non-drug options for pain relief including aromatherapy, TENS (Transcutaneous Electrical Nerve Stimulation), and use of a whirlpool and shower.

Advise mothers on how to minimize their risk for complications when laboring with an epidural. Every mother’s choice for pain relief should be respected. Sometimes, just knowing that an epidural is available gives women the courage to labor for a VBAC instead of scheduling a routine repeat cesarean. Use the Parent Education Handout for Module 7 to initiate the conversation.
References


Cesarean Birth Trauma

A traumatic birth of any kind can leave a woman feeling disempowered, violated, or betrayed. Mothers who feel fearful, sad, and withdrawn will have difficulty with the process of mother-infant attachment and while some mothers will find breastfeeding a healing and self-affirming experience, some will have an aversion to breastfeeding which can trigger memories of the traumatic birth.

Studies which focus attention on women's experiences of birth suggest that educators and caregivers need to recognize the negative psychological impact that cesarean birth may have on some mothers. Women's negative perception of birth may have an effect on their decision to have an elective repeat cesarean or a planned VBAC in a subsequent pregnancy.

Birth trauma researcher, Cheryl Tatano Beck (2013) found that 33-45% of women from several different countries perceived their births to be traumatic, thought only some went on to develop PTSD.

Current evidence suggests that the incidence of post-traumatic stress disorder after childbirth in the United States is high. A national survey of women's childbearing experiences identified 9% of women who met the clinical criteria for PTSD after childbirth and 18% who had post-traumatic symptoms (Declercq, Sakala, Corry, & Applebaum, 2008).
Health psychologist, Dr. Kathleen Kendall-Tackett, Ph.D., IBCLC, FAPA, Editor-in-Chief of *Psychological Trauma*, commented that in the weeks following the terrorist attacks in New York on September 11th fewer residents in lower Manhattan (75%) met the clinical criteria for PTSD. Kendall-Tackett stated:

“Take a minute to absorb these statistics. In at least one large study, the rates of full-criteria PTSD in the U.S. following childbirth are now higher than those following a major terrorist attack.”

In her research and work with women who have experienced a traumatic birth Cheryl Tatano Beck (2013) identified four main themes that surfaced from the stories of their births.

**Women did not feel cared for.** They felt alone and abandoned at some point during childbirth or immediately postpartum. They experienced a lack of empathy from their caregivers. The care they received was perceived as reflexive and emotionless.

**Their obstetric caregivers did not communicate with them in labor.** Mothers felt invisible and neglected when clinicians talked to each other about them without addressing them or including them in the conversation about their care.

**Women perceived that their caregivers did not provide safe care for themselves or their babies.** When things went wrong mothers felt their caregivers did not respond appropriately as they trusted them to do. This experience left them feeling powerless and out of control.

**Mothers felt that their traumatic experience was ignored.** Everyone talked about the baby, but no one asked about their own emotional well-being. They felt they paid a high price for the safety of their baby.

Caregivers who are dedicated to the health and well-being of mothers and their babies have a very difficult time understanding how the care they provide, often with the best of intentions, can have such a negative impact.

Phyllis H. Klaus, CSW, MFT, is a psychotherapist and international consultant who specializes in medical and psychological concerns of pregnancy, birth, the postpartum period, trauma, and abuse issues. She explains:

Events are traumatic and create feelings of powerlessness when they are dangerous. When they are actually or appear to be life-threatening to oneself or a loved one. When they are sudden (the situation changes quickly from “normal” to dangerous), they are experienced without explanations, and when the situation appears overwhelming.

There is no time to prepare, no way to plan an escape or to prevent something from happening. A number of events during labor or birth such as an emergency, unexpected or unwanted interventions, serious problems in the mother, physical damage, a sick or compromised infant and separation from the baby, can be classified as traumatic, with a capital T.

Major trauma for a woman occurs in childbirth when she has inordinate fear and is in a situation where she has no control. Other aspects of trauma are more subjective and relate to how a woman is treated. How she perceives her experience, and how she feels about the experience. These experiences are often man-made and cause shame, humiliation and stigma (Klaus, 2007).

In their book, *When Survivors Give Birth: Understanding and Healing the Effects of Early Sexual Abuse on Childbearing Women*, Simkin and Klaus make a strong case for survivors of early childhood abuse and the challenges they face when giving birth due to the trauma they have experienced. For these mothers, understanding how the trauma may trigger strong feelings that can interfere with the process of labor and birth and helping them to understand and deal with the experience can help to avoid a cesarean for “failure to progress.” (Simkin & Klaus 2004).
Experiences of Mothers’ Traumatic Cesarean Birth

Included here are a few examples of some women’s feelings about their cesarean birth. It may be difficult for us to understand these strong negative emotions because we wish to provide a safe and positive birth for the women we care for. These feelings may also make us feel defensive, and initially we may dismiss them. However, it is important to “hear” what the mothers have to say so that we can provide not only a medically safe birth but an emotionally satisfying one as well.

The following mothers’ experience of a traumatic cesarean birth are provided by the International Cesarean Awareness Network.

“I know this has been an awful trauma for you, my darling and I hope you recover soon. Spiritual healing is slower that physical healing...and I am so glad you have someone to help you through this most difficult time in your life.” These words written in a letter to me six months after my traumatic birth still resonate with me 5 years later. To down play the need to work thorough emotional turmoil with a skilled and trained professional is reckless or at the very least an unnecessary hindrance to healing. Over the course of a two-year span, I worked with a counselor for PPD and PTSD related to the trauma surrounding the cesarean birth of my youngest. I went from feeling an all-consuming sense of numbness and deep sadness to the ability to say, “I am walking in joy”. NO, I am not leaping for joy, but I am walking in it.

My husband refers to the time after our first daughter was born by unplanned cesarean as “the dark time”. And it very much was the dark time. There was no light, there was no joy, there was only mental torture. I woke up every single night at the exact same time as if an alarm would go off but it really didn’t---the alarm was inside my head. The only thing that would get me back to sleep in the middle of the night, laying paralyzed and terrified in my bed, reliving all of the sights and sounds and smells over and over again every single night, was nursing my baby, and the minute she started to move around looking for my breast that was when the solace from the nightmare began. Even though I’ve come out stronger on the other side of PTSD, I am forever changed by it and it will still always be a part of who I am. Once you have experienced PTSD, even after treatment, it never ever goes away. I’m one of the lucky ones, because I never gave up hope on finding treatment that would help me, and I truly believe that had I not found that treatment and angel of a counselor, I would not be here today. The dark time would have overtaken my ability to live.

Many mothers go through tough times after giving birth, and I was one of them. I didn’t have PPD, but I cried daily for three months over what had been done to me, and what had been taken away. My cesarean stripped me of my autonomy and humanity and left me angry, fearful, physically ill and shaking any time I was touched for almost a year. I had flashbacks of being strapped to a table, hearing my baby cry and not seeing him, not being able to touch him, crying out for him while I was ignored. I spent the following eight weeks on bed rest, getting treated despicably by several OBs over the course of my weekly painful trips into the office where they prodded my infection and ordered me to stay in bed, often wondering aloud why I was there. I was such a mess that I lost contact with friends, alienated my family, and could barely tolerate my husband. It took a year of ICAN meetings and knowing I wasn’t alone to bring me out of the darkness.

You sit in a room full of people, but somehow you still feel so alone. The thoughts of irrational fears haunt you, no matter how hard you try to drown them out. Being on high alert all the time. Just waiting for the next bad thing to come along. There is no way to relax. Your thoughts just won’t stop. The thoughts of not being good enough. The thoughts of, your family would be better if you just left. And then comes the guilt of you thinking of ever leaving your children. Everyday decisions are impossible to make. There is so much worry and insecurities that comes with every decision you make. Always second guessing yourself. Just when you think you are doing a little better the smallest thing will trigger a flash back. You will see or feel those moments of your trauma again. Those pictures or those feelings also come to you in your sleep. You can’t escape them for long. The feeling of being overwhelmed all the time.
Implications for Educators

Increasing Awareness About the Impact of Traumatic Birth

Before a woman can think clearly about her next birth, she may need to understand and resolve her feelings about her previous cesarean(s). It is useful, if the mother is ready, to think about and discuss these feelings with someone she trusts because they may ultimately influence her decision about whether or not to labor for a VBAC.

Because a newborn demands so much care and attention mothers often do not have the time to process these feelings and they can linger for a long time. Sometimes these feelings surface only when a woman becomes pregnant again and begins to think about the coming birth.

Educators and caregivers can help mothers recognize the negative psychological impact that a cesarean may have on some mothers and how they can do things differently this time. For women who still harbor negative feelings about their cesarean birth, it is helpful to provide a safe opportunity to discuss their previous cesarean(s) so that they may be ready to listen to the option of planning a VBAC. This means providing women with information and coping skills that will reduce the psychological stress related to anticipating another unpredictable labor.

The Educational Handout for Parents for Module 8 can help parents to clarify their experience and begin a conversation about how they can do things differently this time. However, the time and place must be determined by the mother herself. Depending on the amount of time you have to establish trust and create a safe environment for parents, you can use the Handout in different ways.

1. After presenting Module 8 you can wait to see if parents are ready to comment or ask questions about their perception of a traumatic cesarean birth. The least threatening approach is to simply provide the handouts and suggest that parents think about them at home, and if ready, talk to each other about their experiences.

2. You can also refer them to the many websites dedicated to traumatic childbirth in the Resource List. The list of online support groups for women who have experienced a traumatic birth can be helpful for mothers who are not yet ready to communicate face-to-face with someone about their experience.

3. Another “safe” approach is to allow mothers to group together and share their experience in a separate space and ask fathers/partners to do the same. Parents may then be ready to share the focus of their discussion. Allow the conversation to be led by the parents rather than asking directly who has had a similar experience. Establish safe ground rules. If a mother is ready to talk about her experience, allow her to complete her story without interruptions from anyone.

4. Educators are not usually trained as psychotherapists. It’s important to note that it may take months and sometime years for parents to process a traumatic birth experience. However, increasing awareness about this issue helps to normalize it. Allowing parents to control the time and extent of that conversation, and providing them with resources is an important first step to helping mothers regain the trust in themselves and their caregivers and the self-confidence they need to labor for a VBAC.
What Maternity Caregivers Can Do to Support Women Who Plan A VBAC

1. Take the time during prenatal visits to discuss her options and to find out what her needs are. Refer her to community groups and educational resources for additional information.

2. Provide the mother with hospital informed consent/refusal forms for each procedure that you would require her to sign-off on during her prenatal visits. Take time to discuss them. This will give her time to consider them and give her the sense of safety and sense of control she may not have had with her cesarean birth.

3. Respect the mother’s birth plan as much as possible. Women who have had a negative cesarean birth and plan to labor for a VBAC will usually seek ways to make sure that the expectant birth will take place in an emotionally safe environment. They will need to re-establish trust in their caregivers and place of birth. Mothers will look for ways to make sure that they will be involved in making decisions about their care and that their caregivers are sympathetic and supportive of their needs. Often, caregivers misinterpret this need for psychological safety as being a woman’s irrational need to be “in control.” Or she may be seen as having a “demanding birth plan.” It’s important to respect the mother’s wishes. If a request is not possible to comply with, it may help to ask the mother more about it. Why it’s important to her and if she would consider other options that you can offer her.

4. Provide mothers with community resources for support groups and psychotherapists who focus on birth-related trauma issues.

5. Establish a monthly Mothers’ Support Group for women who have had a cesarean birth. Some mothers feel isolated and are haunted by the “crazy” thoughts they have about their cesarean. Some feel they are “bad” mothers for having negative feelings and for not loving their baby as much as they think they should. This would give them a safe place and the opportunity to discuss their feelings without being judged. Participating in the group would also give them the opportunity to resolve any breastfeeding issues they may have, a common experience for mothers with a cesarean birth.

6. Consider the four main themes of traumatic childbirth identified by Tatano-Beck. What can you do within your scope of practice to help women have a safe and emotionally satisfying birth.
References


Module 9
If I Want a VBAC, Where Can I Give Birth? Planning a Hospital VBAC

The vast majority of mothers give birth in a hospital. For mothers planning a VBAC, the support and flexibility of the staff are invaluable. In a large hospital, mothers may be cared for by a variety of nurses, technicians, medical residents, or students, and may be asked to allow students to observe their labors.

Respecting a mother’s wishes, providing encouraging support and a non-hurried quiet atmosphere can go a long way to help mothers achieve a VBAC. Women who have had good experiences in large hospitals are likely to say that they were treated with kindness and respect, that nothing was done to them without their first being consulted, and that, “The staff were wonderful. They explained everything.”

A woman who has had a bad experience in a large institution is likely to say that, instead of being treated like an individual person, she was treated, “like a piece of meat on a conveyor belt.” A large high-tech hospital can provide individualized care, but doing so might require a deliberate desire on the part of the care providers, administration, and management to do so.
Kristen’s Hospital VBAC

This true story of a mother’s hospital VBAC reflects the immeasurable joy and satisfaction that a mother can experience when caregivers are willing to be supportive and flexible while still providing safe medical care.

So, yes, I birthed a baby right out of my vagina. I did it in the water, with intermittent fetal monitoring and no heparin. I did it in the hospital, with an OB. I did it with the world’s best support team (okay, I am a bit biased). But, I did it, and it was an experience that I will treasure for the rest of my life.

...I had practiced with my hypnobirthing program, these pictures (of Miles her 2-year old son born by cesarean) reaffirmed for me the unconditional love that was surrounding me during my labor. I was completely taken care of, and my body knew exactly what it was doing.

(At 4 cm) Dr. N. and/or Chris (Kristen’s husband) suggested that I try laboring in the tub. (Dr. N.) praised the water’s ability to “make the mom buoyant” during contractions and really thought that I would benefit from it. Unlike earlier in my labor, I was pretty excited to get in the water, and I hastily agreed to give it a try. And then Chris asked the question of all questions: “Dr. N. I heard...that you have done waterbirths before. Do you think that Kristen could try giving birth in the tub?” Dr. N. said, “Sure! I think that’s a great idea! She’ll be the first mom IN THE HISTORY OF THE HOSPITAL to have a waterbirth!” Oh. My. God.

(Later)...Dr. N. arrived...and checked me, and then very calmly said, “Well, Kristen, you’re fully dilated, so bare down whenever you get the urge.” Oh. My. God. I choked up, grabbed his hand, and said through my sobs, “Dr. N., I have been waiting for so long to hear someone say that to me!!!”...

My entire birth team continued to be amazing. Dr. N. had everyone dim the lights so that I could push as peacefully as possible and even unscrewed some of the light bulbs that wouldn’t dim well enough. He and Chris helped me to get into a hands-and-knees position so that I could get the assistance of gravity in my pushing. And then he turned to my nurse and said, “Well, it looks like you aren’t getting her out of the tub!” But, then he took the time to tell her the following: “Look at how beautifully she’s doing. Look at how natural and normal that is. She’s pushing on her own, and no one is yelling ‘PUSH’ in her face, no one is counting for her.” And you know what? My nurse started to get really excited about this birth...

Pushing was as intense as it was incredible. My body took over with each contraction, and I grunted and groaned like a wild animal as I felt Alec’s head moving through my pelvis....And then Alec was born. Dr. N. reached down to help me deliver the shoulders, but I pulled him up onto my chest (I did it instinctively—I don’t even remember intentionally doing it) and I massaged his back until he cried. We stayed in the water for another 10 minutes, and then we moved out of the main room. And my nurse—the one who wanted me the heck out of the tub—was nearly jumping up and down saying, “That was the most amazing thing I’ve ever seen! You are AWESOME!” Later, I learned that about five nurses rushed into the room to see the woman who had the hospital’s first waterbirth.

Everything since has been smooth and incredible. Miles (Kristen’s first-born son born by cesarean) showed up about two hours after Alec’s birth and stayed with us for a few hours. Alec was soon nursing like a champion. And I’m feeling great. On cloud nine, actually.

Excerpt from, THIS IS BIRTH! A BIRTH STORY. By Kristen O. Published in The Clarion, Volume 23, Issue 2, Late Summer, 2008.

“We Don’t Do VBACs.”

Some hospitals deny care for VBAC by referring to the costly and realistically unattainable ACOG guidelines which recommend a surgical team and anesthesia be “immediately available” when women labor for a VBAC (ACOG, 2010).
Having had a prior cesarean adds a level of risk to the subsequent labor process, however, the risks of laboring for a VBAC are the same as for women giving birth for the first time (Cunningham, Bangdiwala, Brown, et al, 2010). Yet, women giving birth for the first time are not denied medical care, nor are they told that they are at risk because the community hospital cannot guarantee an emergency cesarean in case of a prolapsed cord, placental abruption, or fetal heart intolerance. This selective approach to care is highly confusing for parents.

Many hospitals ultimately give women no choice but to “consent” to a routine repeat cesarean they do not need nor want.

ACOG’s Committee on Ethics’ Opinion on informed consent states, “Seeking informed consent expresses respect for the patient as a person; it particularly respects a patient’s moral right to bodily integrity, to self-determination regarding sexuality and reproductive capacities, and to support of the patient’s freedom to make decisions within caring relationships (ACOG, 2009).

Refusing to provide medical care for women who want to labor for a VBAC and offering them no alternative but to “consent” to a repeat surgery denies their right to bodily integrity, self-determination, and the freedom to make their own healthcare decisions. Caregivers have an ethical obligation to provide the best care possible for their patients including the primary ethical obligation, First Do No Harm. Routine repeat cesareans increase harms for both mothers and babies without improving health outcomes.

Some Community Hospitals Have Found a Way to Provide Care for VBAC

ACOG’s guidelines for VBAC state:

When resources for immediate cesarean delivery are not available, the College recommends that health care providers and patients considering TOLAC (trial of labor after cesarean) discuss the hospital’s resources and availability of obstetric, pediatric, anesthetic, and operating room staffs...The decision to offer and pursue TOLAC in a setting in which the option of immediate cesarean delivery is more limited should be carefully considered by patients and their health care providers. In such situations the best alternative may be to refer patients to a facility with available resources...

Respect for patient autonomy supports the concept that patients should be allowed to accept increased levels of risk, however, patients should be clearly informed of such potential increase in risk and management alternatives (ACOG, 2010).

Those guidelines suggest that hospitals cannot just say, “No” to women who want a VBAC. ACOG offers two alternatives for hospitals to support their patients’ choice for VBAC.

1. Have a caregiver/patient conversation about what the hospital’s capabilities are to respond to a potential complication including a uterine rupture and give women the choice and responsibility to assume those risks if this is what they choose.

2. Refer women, early on in their pregnancy, to nearby hospitals that do provide care for VBAC.

Examples of Community Hospital Policies for VBAC

Two examples of communities who found a way to provide care for VBAC are Spectrum Health Gerber Memorial in Fremont, Michigan, a community hospital and the Northern New England Perinatal Quality Improvement Network (NNEPQIN) in Vermont and New Hampshire. Hopefully, these examples will inspire other hospitals to reconsider providing care for VBAC.
See examples of hospital protocols and patient education materials from Spectrum Health Gerber Memorial in Fremont, Michigan and the Northern New England Perinatal Quality Improvement Network in the Appendix A.

**Spectrum Health Gerber Memorial**

Spectrum Health Gerber Memorial is a community hospital that does not have onsite anesthesia and resources “immediately available”, as recommended by ACOG, to perform an emergency cesarean section in the rare event of a uterine rupture. However, it did want to support mothers who want to labor for a VBAC. During prenatal visits mothers are informed about the availability of resources at Gerber Memorial and are given a referral to a tertiary hospital nearby who does have the capacity to respond “immediately” in case of complications. Collaborative care between Gerber Memorial physicians and the referral hospital gives mothers the opportunity to labor for a VBAC.

If, however a mother with a prior cesarean comes to Gerber Memorial in labor and refuses to have a routine repeat cesarean, she has a discussion with a care provider about the resources available at the hospital and is given the option of signing a Refusal for Repeat Cesarean Section Informed Decision Form. If she chooses to do so, she is admitted to the labor and delivery unit and cared for like all other mothers. The staff reviews her birth plan and respects her choices for labor and birth.

See sample copies of Specter Health Gerber Memorial in Appendix A.

1. Planned Vaginal Birth After Cesarean Section (VBAC) Education
2. Refusal of Repeat Cesarean Section Informed Decision Form
3. Birth Plan for Vaginal Delivery
4. Birth Plan for Cesarean Section

For additional information about providing care for VBAC in a community hospital, please contact Dr. Tami Michele, DO, FACOG, OB/GYN, Medical Director, Spectrum Health Gerber Memorial OB/GYN, Obstetrics and Gynecology Department Chair, at TJMichele@aol.com.

**Northern New England Perinatal Quality Improvement Network (NNPQIN)**

To increase access to safe VBAC care in community hospitals, a collaborative effort among hospitals, maternity care professionals and other stakeholders in Vermont and New Hampshire resulted in regionally defined recommendations for VBAC. The guidelines were revised to match “immediately available” resources to the individual risk status of each woman laboring for a VBAC. The patient education materials that were developed include the risks and benefits of VBAC or a repeat cesarean and define the difference between a tertiary level medical center and a community hospital. Women are then able to make an informed decision about how they want to give birth (NNPQIN, 2011).

The Northern New England Perinatal Quality Improvement Network has made these guidelines and documents available for hospitals who want to provide care for VBAC on their website, [http://www.nnepqin.org/VBAC.asp](http://www.nnepqin.org/VBAC.asp).

See sample copies of NNPQIN documents in Appendix A.

1. NNPQIN VBAC Patient Education: Birth Choices After a Cesarean Section
2. NNPQIN VBAC Guidelines Revised
3. NNPQIN VBAC Consent Form
Implications for Educators

Help your students navigate their complex and highly varied maternity care services. Policies and care practices regarding VBAC are inconsistent, not always based on evidence, and subject to medico-legal restraints that are in conflict with the best interest of mothers and babies.

Use the Educational Handout for Module 9 to clarify some of these issues with your students. They have a right to know what to expect from their caregivers and place of birth. Discussing these issues during pregnancy gives parents the time to clarify these issues and change to a care provider or birth facility that best meets their needs if it becomes necessary.

For Educators who are also part of the hospital maternity care team.

Review the sample documents from Spectrum Health Gerber Memorial and the Northern New England Perinatal Quality Improvement Network to see if you can provide safe care to support mothers who want to labor for a VBAC.

References


Module 10
Planning a VBAC In a Birth Center

For low-risk women, the midwifery-led birth center model of collaborative care achieves a minimal cesarean rate with low rates of interventions and good health outcomes for mothers and babies. A recent U.S. study of more than 15,000 mothers who planned and were eligible to give birth in a birth center at the onset of labor found that 93% had a spontaneous birth, 1% had an assisted delivery, and 6% needed a cesarean. The intrapartum fetal mortality rate was 0.47/1,000 and the neonatal mortality rate was 0.40/1,000 (Rutledge Stapleton, Osborne, & Illuzzi, 2013).

Many mothers who have had a negative hospital birth experience which ended in a cesarean section will often seek the freedom of choice, personal care, and comfort that a birth center provides. Care in a birth center supports and promotes physiologic birth and is the most likely to result in a VBAC. However, very few planned VBACs in a U.S. birth center have been studied and we don’t have enough information that tells us if it’s safe or not for women with multiple cesareans.

Based on a national study of nearly 1,500 mothers who planned a VBAC in 41 U.S. birth centers, the researchers found the risk for a baby not surviving was higher compared to VBAC labor in a hospital. There were 7 fetal/neonatal deaths. Two fetal/neonatal deaths were due to uterine rupture, and 5 of the 7 deaths occurred for women with more than one prior cesarean and for women who were at 42 weeks gestation. Based on this study, researchers recommended that women with only one prior low-transverse cesarean scar plan a VBAC in a birth center (Lieberman, Ernst, Rooks, et al., 2004).

From 2004 to 2011 birth centers accredited by the Commission for the Accreditation of Birth centers did not allow providers to care for women who wanted to plan a VBAC.
At this time, the Commission for the Accreditation of Birth Centers (CABC) recommends that birth centers provide VBAC care for women with only one prior cesarean and a documented low-transverse (side-to-side) uterine scar. However, not all birth center caregivers agree with this conclusion and mothers may choose to give birth in a birth center that is not accredited.


**History of VBACs in Birth Centers**

**A Timeline Prepared by Rosemary Senjem, CABC* and Kate Bauer, AABC**

- In the 1990’s Women began requesting VBACs in birth centers and there was very little research at the time to guide best practices. The American Association of Birth Centers (AABC), which curates the national Standards for Birth Centers, responded by launching a study about VBAC in birth centers.

- It took 10 years to get enough data logged for the study to have any statistical validity. When this study was finally published in 2004, the conclusion at that time was: “Despite a high rate of vaginal births and few uterine ruptures among women attempting VBACs in birth centers, a cesarean-scared uterus was associated with increases in complications that require hospital management. Therefore, birth centers should refer women who have undergone previous cesarean deliveries to hospitals for delivery. Hospitals should increase access to in-hospital care provided by midwife/obstetrician teams during VBACs.” [http://www.ncbi.nlm.nih.gov/pubmed/15516382](http://www.ncbi.nlm.nih.gov/pubmed/15516382)

- As a result of this study, CABC did not permit VBACs in CABC-accredited birth centers from 2004 to 2011.

- In January 2008, The AABC had a lot of pressure from birth centers to do another study, but issued a position statement about the feasibility of another study instead. [http://www.birthcenters.org/about-aabc/position-statements/vbac-study](http://www.birthcenters.org/about-aabc/position-statements/vbac-study)


- CABC proceeded with caution and in 2011 finally announced a new policy.

- Allowed VBACs in CABC-accredited birth centers meeting 8 strict risk criteria, limiting VBAC in birth centers for women who had already had a VBAC.

  - On a case-by-case basis, CABC evaluated CABC-accredited birth centers’ desiring to do primary or first time VBAC.

  - Required that CABC-accredited birth center doing VBACs to be part of a national prospective study on VBAC to maintain accreditation.

  - To put it mildly, many mothers were not happy about this, but CABC stuck to its policy, wanting to see more evidence.


*Commission for the Accreditation of Birth Centers

**American Association of Birth Centers*
In 2012, the New Jersey Hospital Association, VBAC Task Force Vision Statement relies heavily on the NIH Consensus. [http://www.state.nj.us/health/fhs/professional/documents/vbac_vision.pdf](http://www.state.nj.us/health/fhs/professional/documents/vbac_vision.pdf)

In February 2014, after conducting a literature review on the topic of VBAC, CABC also relied heavily on the NIH Consensus to update its indicators as they stand today.

**Implications for Educators**

Denial of care for hospital VBAC or VBAC care which includes several routine procedures has led many mothers to search for other settings to give birth.

Help parents to find out about licensing and accreditation requirements for birth centers in their state, they are not all the same. Encourage them to ask about the benefits of accreditation and to use the questions in their Educational Handouts for Module 10 to get the information they need to make an informed decision about giving birth in a birth center.

Many hospitals name their labor and delivery unit as the “Birth Center”, but in fact may still require routine interventions and may restrict a woman’s freedom of movement. Parents may want to look specifically for CABC accreditation to ensure they will be treated according to established national standards of evidence-based birth center care.
Module 11
Planning a Home VBAC

In 2013, 1.4% of U.S. births took place outside of a hospital. Surprisingly, 64.4% of these occurred at home. The number of women who gave birth at home, 36,080, was the highest since 1989 when reporting of home births began (Martin, Hamilton, Osterman, et al., 2015).

Home VBACs are on the rise. Women in the U.S. are often faced with the denial of hospital-based maternity care for VBAC. According to the Centers for Disease Control and Prevention, home VBACs have been increasing at the same time that hospital VBACs have been decreasing. The percentage of home VBACs in 1996 was 1% in and increased to 4% in 2008. The percentage of hospital births that were VBAC decreased from 3% in 1996 to 1% in 2008. However, the total number of home VBACs is small. About 1,000 in 2008 compared to 42,000 hospital VBACs in the same year (Macdorman, Declercq, & Mathews, 2012).

The Safety of Home Births

Planned home birth is as at least as safe as planned hospital birth for similar groups of women when four important criteria are in place.

1. Pregnant women are low risk.
2. Home was chosen as the intended place for birth.
3. The primary care provider is qualified according to professional licensing standards and trained to assist at home births.
4. A collaborative relationship with consulting physicians and a medical center exists with clear guidelines for continuity of care should a complication arise where the mother or baby would benefit from the transfer.

Based on a review of 16 years of scientific studies on home birth the Coalition for Improving Maternity Services Expert Work Group found that compared to low risk women who plan a hospital birth, low risk women who plan a home birth have similar or better outcomes with fewer medical interventions and fewer cesareans (Leslie, & Romano, 2007).

A landmark U.S. prospective study of nearly 17,000 planned home births attended by midwives between 2004 and 2009 found that overall low-risk women who plan a home birth with a midwife have safe outcomes, fewer interventions, and no increased complications for mothers or babies. Nine out of ten women had a spontaneous birth, less than 5% needed an induction of labor and an epidural for pain relief, and only 5.2% needed a cesarean. Eight out of ten babies were exclusively breastfeeding at six weeks of age. (Cheyney, Bovbjerg, Everson, et al., 2014).

What About the Safety of Home VBAC?

In the same study (Cheyney, et al., 2014) however, the outcomes for women who planned a home VBAC and went into labor on their own were not as encouraging. Although 87% of the 1,054 women who planned a home VBAC were successful, the authors point out that women who planned a VBAC were at higher-risk (as were women who had a breech) for intrapartum fetal death. The study found that for multiparous women without a cesarean scar the rate of intrapartum fetal death was 0.66/1,000 compared to 2.85/1,000 for multiparous women who planned a VBAC.

An earlier smaller prospective U.S. study of 57 women who planned a home VBAC with a nurse-midwife had similar high VBAC rates. Thirty-one of the 32 mothers who had a previous VBAC gave birth vaginally and 22 of the 25 women without a prior VBAC had a normal birth. None of the women experienced a uterine rupture, but one infant was stillborn. The death was attributed to a postdate pregnancy with meconium. The authors of this small study concluded that VBAC is not recommended in a home setting (Latendresse, Aikins, & Fullerton, 2005).

There are very few documented cases of planned home VBACs in the United States, so at this time we don’t have enough information to tell us whether planning a home VBAC is safe or not.

A Choice for Home VBAC Is Not Always Made Based on Risks and Benefits

Despite the lack of information about the safety of home VBAC, some women do choose to have home VBACs (“HBACs”).

Areas of concern are whether a skilled person would be available continuously to watch for a symptom of uterine rupture, whether the mother can be transported quickly enough to the hospital if a rupture occurred, and whether a home birth practitioner could make an effective agreement with the hospital to set up for an emergency cesarean if it were suddenly needed. These are all questions a mother considering home VBAC could be strongly encouraged to look into.

Why do some mothers choose to have their VBACs at home? Some women have experienced a profound loss of control over what was done to them in hospitals during their previous labors, and are trying to avoid repeating this scenario. Some mothers have said they simply couldn’t—not didn’t want to, but couldn’t—walk into a hospital in labor again (see Module 8, Mothers’ Feelings About Their Prior Cesarean and Why They Matter).

Some women are certain that their labor problems were caused in part by hospital customs (like immobility) or procedures (such as fetal distress after an induction or augmentation). Others simply believe that their labors will progress better in the familiar atmosphere of their homes.
Many mothers who have had a safe home VBAC have written their birth stories on VBAC-related websites or posted a video of their home VBAC on Youtube.

**Implications for Educators**

The list of questions in the Educational Handout for Module 11 are designed not to encourage a home VBAC, but to help parents reflect on all the aspects and personal responsibilities that a home VBAC implies. Home VBACs are controversial, but some mothers will make that choice if they cannot find a supportive caregiver or birth facility to care for them without imposing too many restrictions.

**If You Are Also Part of a Hospital Maternity Care Team**

If hospitals were more welcoming of mothers who want to labor for a VBAC and provided care that supported physiologic birth, more mothers with a prior cesarean would labor for a VBAC and avoid the complications of a repeat cesarean.

Encourage your colleagues to review the care you provide for mothers with a prior cesarean and find ways to provide safe care while still respecting their choices for labor and birth. See Examples of Hospital Policies and Informed ‘Consent Forms in Appendix A to find out more about how community hospitals can provide care for VBACs.

**References**


Module 12
How Do You Want to Give Birth? It’s Your Decision

It is the expectant mother who has the ultimate authority to make decisions about her care and the care of her unborn child, and which recommended drugs, interventions or procedures she will accept or refuse. As with all competent, autonomous adults, the mother has the right to choose how she wants to be cared for (ACOG, 2005, 2010).

Respect for a patient’s autonomy is defined in international human rights laws, federal directives, hospital patient rights, and in maternity care professional guidelines (Childbirth Connection, 2004, Human Rights in Childbirth, 2015).

To make an informed decision, a mother usually depends on her caregiver to provide her with evidence-based information about the benefits, risks, and alternatives to his/her recommendations. In the United States, however, it would seem that those rights are being largely ignored. A recent study in the American Journal of Obstetrics and Gynecology revealed that women in the U.S. tend to choose a VBAC or a repeat cesarean based on their provider’s preference (Bernstein, Matalon-Grazi, & Rosen, 2012).

A national survey of childbearing women found that in conversation with their caregiver about whether to plan a VBAC or a routine repeat cesarean, more than 1 in 4 expectant mothers stated that how they would give birth this time was not framed as a matter of choice. Of the care providers who expressed an opinion about VBAC or a repeat cesarean, 88% recommended a repeat cesarean. Ultimately, 93% of this group of women ended up having a repeat operation (Declercq, Sakala, Corry, et al., 2013).
Empowering Mothers to Exercise Their Rights

Module 12 helps to inform women of their right to decide for themselves how they want to give birth. It also helps them to question the, “We don’t do VBACs.” hospital policies.

What Is True Informed Consent?

To make a truly informed decision about their care, mothers need to take the time to read and understand the consent forms they are asked to sign.

Dr. Charles Mahan, former Dean and Professor Emeritus of the College of Public Health at the University of South Florida and a founder of The Lawton and Rhea Chiles Center for Healthy Mothers and Babies, wrote this about true informed consent:

Hardly any patient, man or woman, rich or poor, could tell you what was on that outpatient procedure or hospital consent form they just signed. So when the rare mother does die from a pulmonary embolus after her cesarean, it is a double shock to the family because “nobody told us she might be more likely to die after that operation compared to normal birth!” The way we currently manage so-called informed consent is generally useless as information (and in court) and very effectively hides the danger of medical procedures from patients.

When should women get these consent forms? They should get a complete set of forms at their prenatal visit. An individual form covering one of the areas at each prenatal visit starting with the cesarean form and if they are having a normal vaginal birth but have to have an unexpected emergency cesarean, should be sent home with the VBAC and repeat cesarean forms to help think about the future.

As an ob/gyn resident I was taught a valuable way to present informed consent in my opinion. The doctor or midwife sits down with the woman at a prenatal visit to cover, say, the epidural consent at this visit. They underline key positive and negative effects of the procedure, send the form home with the patient to discuss with family and friends and ask her to return with the form and any questions she may have. The discussion is noted in the chart for each of the consent forms and what the woman thinks she might prefer at that time – agreeing that she can always change her mind. This is not only true informed consent but also a great teaching opportunity which is what prenatal care is supposed to be all about, but has drifted away from recently (Mahan 2008).

Implications for Educators

In the United States, the majority of women with a prior cesarean are not informed about their rights and are not making their own informed decisions about planning a VBAC or a routine repeat cesarean. Many hospitals are denying care for healthy women who want to plan a VBAC and mothers are presented with no other choice but to have a repeat cesarean.

Provide mothers with the facts about the benefits and risks of VBAC and repeat cesarean so they have the knowledge base to have a meaningful conversation with their care provider.

Encourage mothers to get a copy of the informed consent forms they will be asked to sign in the hospital during their pregnancy. This will give them time to understand their options.

Educate mothers about their rights and find out about alternatives to a “forced” repeat cesarean in your community.

Consider offering a one-time class in your community on women’s rights in childbirth, on a bi-monthly or quarterly basis.

Write an article on the subject for the healthcare section of your community paper, or for a maternity care consumer website.

Follow-up on the list of Resources for Parents at the end of the module for additional information and educational materials for your students.
References


American College of Obstetricians and Gynecologists. (August 2010). *Vaginal birth after previous cesarean delivery*. *Practice bulletin number 115*.


Mothers with a previous cesarean who want to labor for a VBAC have a better chance of having a vaginal birth if their caregivers support and encourage normal physiologic childbirth without medically unnecessary interventions.

The *Mother-Friendly Childbirth Initiative* (MFCI) is a Ten Step, evidence-based, consensus document developed by the Coalition for Improving Maternity Services (CIMS) in 1996. It is a mother-, baby-, and family-friendly model of maternity care which focuses on prevention and wellness. The first consensus document on maternity care, the MFCI respects the normal (physiologic) process of birth and a mother’s informed choice. The evidence supporting the Ten Steps of Mother-Friendly Care was reaffirmed in 2007 in the *Journal of Perinatal Education* (Coalition for Improving Maternity Services, 2007).

The philosophical principles of the MFCI: Normalcy of the Birthing Process; Empowerment; Autonomy; Do No Harm; and Responsibility apply to births in a hospital, home, or birth center.

The MFCI is aligned with national quality improvement initiatives, state initiatives to improve maternity care, the Affordable Care Act, and legislative initiatives that promote normal birth, fewer interventions, midwifery care, and birth center options (Jukelevics, 2014).
With Mother-Friendly care there are fewer maternal and newborn complications, fewer re-
hospitalizations, increased maternal-infant attachment, improved mental well-being for mothers, 
increased breastfeeding rates, and fewer maternal and neonatal deaths.

Research, professional guidelines, state–wide health care directives, hospital systems, health 
care quality improvement initiatives and federal and state-level maternity care legislation 
have identified many aspects of the MFCI and the Ten Steps of the Mother-Friendly Childbirth 
Initiative as key factors to improving maternal-infant health outcomes.

By implementing the Ten Steps of Mother-Friendly care, mothers have a better chance of 
achieving a VBAC, establishing mother-infant attachment, and initiating breastfeeding. The 10th 
step of the Initiative encourages caregivers to strive to achieve the WHO-UNICEF “Ten Steps to 
Successful Breastfeeding.”

Implications for Educators

Personal participation in one’s health care improves outcomes. Help your students to ask for and 
expect quality maternity care. Use the CIMS pamphlet, Having a Baby? Ten Questions to Ask as a 
source of discussion (See Appendix C).

Show your students how to access and compare hospital cesarean rates, VBAC rates and 
intervention rates, on websites such as http://www.leapfroggroup.org/cp, www.cesareanrates. 

Encourage your students to seek a second opinion if their caregiver denies them care for a VBAC.

Educate your students about the benefits of birth doulas and midwifery care.

Empower mothers to stay actively involved in their maternity care and make the decision that is 
best for them.

Respect your students’ choices even if you disagree with them. Mothers make decisions based on 
their own values, preferences, availability of resources and support, and their social situation.

Implications for Hospital Staff

The MFCI is an evidence-based comprehensive model of maternity care that can be used as a 
quality improvement guide. The Coalition for Improving Maternity Services has published a 
clinical guide to help maternity care professionals provide Mother-Friendly Care. How To Become 
Mother-Friendly: Policies and Procedures for Hospitals, Birth Centers and Birth 
Practices (edited by Barbara Hotelling and Helen Gordon) is a comprehensive guide that can improve outcomes, increase 
patient satisfaction, and lower the costs of maternity services.

Helen A. Gordon, DNP, CNM, CNE, a professor of nursing at Duke University in Durham, North 
Carolina said this about the Ten Steps of Mother-Friendly Care:

- Hospitals need to embrace the 10 steps. But until nurses are given guidelines on how to do 
  that, are required to implement those guidelines by their job descriptions, and are rewarded 
  annually in their performance reviews, those needed changes will remain a pipe dream. We 
  need more than isolated and zealous nurses who believe in the 10 steps. What is required is 
  for hospital and nursing leadership to incorporate this work into the fabric of nursing care 
  delivery in every hospital that cares for mothers and babies (Hotelling & Gordon, 2014).

For information on implementing Mother-Friendly care in your facility, contact the Coalition for 

To offer a Mother-BabyFriendly workshop for the nurses in your hospital contact the International 
Childbirth Education Association (ICEA), www.icea.org.
References


Module 14
Trust Yourself To Give Birth Safely

A mother needs to feel confident, safe and supported during childbirth. She has a better chance of giving birth vaginally if she has the support and trust of her maternity care team and her family.

It’s helpful for mothers to talk with their maternity care team, family and partners to resolve any issues that may make it difficult for them to focus fully on the process of labor.

Many women approach their VBAC labor with some anxiety. Although they may have gathered the information they needed to make informed decisions, emotionally they may still question their ability to complete the process of labor and birth. It’s important to encourage mothers and remind them that they have the power and ability to give birth.

If you are using this module as the last one in a class series or at the end of a long VBAC orientation presentation to a large group of parents, showing a film where mothers labor for a VBAC will reinforce what you have taught and give mothers encouragement to prepare them for their upcoming birth.

Remind mothers that there is no one right way to give birth and they have the freedom to do what they need to have a vaginal birth. It’s their labor. Only they can give birth to this particular baby, so whatever way they do that is a major accomplishment.

Make sure you have also prepared mothers for Plan B—shared with them how they can make a cesarean, should they need one, a family-centered experience with skin-to-skin after birth and mother and baby together during the hospital stay (see Appendix A for sample forms).
Addressing the Hard Questions-Medical Ethics and VBAC

A father and physician whose wife wanted to labor after three previous VBACs contacts a VBAC website for advice:

Can a hospital have a vbac policy which states no vbacs will be labored there? what happens when a vbac arrives in labor? does the vbac policy conflict with the right of the mother to receive care during labor?... this happened to my wife. She is a dr. who practices ob, and I was the only dr available to her. I am now accused of violating the vbac policy. she got stuck at 5 cm (she did not want a cesarean), so i drove her to the next hospital 70 miles away, where she delivered with some pit. (pitocin). she had had 3 previous vbacs...Can you help me with the constitutionality of vbac policies or do you know a good lawyer? thx

ACOG's Controversial Guidelines

This confusion and anger by two physicians who were turned away from a hospital that had a “No VBACs” policy is a clear example of the current state of affairs for the majority of mothers who want to labor for a VBAC and the caregivers who want to support them. VBAC was deemed a reasonable and safe option to routine repeat cesareans decades ago. But, in recent years misinformation about its safety and lack of clear national practice guidelines have succeeded in virtually eliminating VBACs in hospitals.

This resistance to provide care for VBACs is a relatively recent phenomenon associated more with medical malpractice suites and fixed reimbursement rates for childbirth rather than solid scientific evidence. In fact laboring for a VBAC after a prior cesarean is not any more dangerous today than it was in 1981 when the U.S. Department of Health and Human Services, National Institutes of Health (NIH), concerned about the rapidly increasing cesarean rate encouraged caregivers and hospitals to provide VBAC care for healthy women with a prior cesarean. In 1978, the national cesarean rate was 15.2%, a steep increase from 1970 when 5.5% of women had a surgical delivery.

At the conclusion of a consensus conference on cesarean childbirth, the NIH found that the risk for complications when laboring for a VBAC with a prior low horizontal scar was less than 1%. It’s report stated, “hospitals with appropriate facilities, services, and staff for prompt emergency cesarean birth, a proper selection of cases should permit a safe trial of labor and vaginal delivery for women who have had a previous low segment transverse cesarean birth...”(USDHHS, 1981) The VBAC rate increased steadily until it reached its peak of 28.3% in 1996.

The American College of Obstetricians and Gynecologists supported the NIH recommendations of the consensus report, “Cesarean Childbirth,” and published the first Guidelines for Vaginal Delivery After a Previous Cesarean Birth in 1982. The ACOG guidelines were updated five more times between 1982 and 1998.

In the 1982-84 guidelines ACOG stated:

“Uterine rupture is rarely catastrophic with availability of modern fetal monitoring, anesthesia, and obstetric support services.

Trial of labor is appropriate if adequate facilities and staff are available.”

In 1988 ACOG recommended that an emergency cesarean be available within 30 minutes “as is standard for any obstetrical patient in labor.”

The 1995 guidelines affirmed:

“As with any birth, professional and institutional resources should have the capacity to respond to acute intrapartum obstetric emergencies.”

Three years later, in 1998 ACOG increased its requirements for a trial of labor:

“Rupture of the uterine scar can be life-threatening for both mother and infant. When catastrophic uterine rupture occurs, some patients will require a hysterectomy and some infants will die or will be neurologically impaired.”

ACOG did not provide any information about the odds for hysterectomy or infant deaths. But, it was clear that there was a move away from supporting care for VBAC. The 1998 guidelines included a discussion about the “reimbursement rate”, “capitation”, “increased
costs” to the physician who attends a woman in labor for a VBAC, and higher costs if a woman laboring for a VBAC ends up with a cesarean and NICU costs.

Unlike prior guidelines which recommended, “as with any birth,” and an emergency cesarean should be “readily available” when women labor for a VBAC, ACOG stated that it was a contraindication for VBAC if there was an, “inability to perform immediate emergency cesarean delivery because of unavailable surgeon, anesthesia, sufficient staff, or facility.” ACOG did not clarify the term “immediately available”, rather it recommended that it should be regionally defined. There was no evidence that having an emergency cesarean “immediately available” lowered complications or death for mothers or their babies, since even in tertiary medical centers with in-house staff and anesthesia there is no guarantee that a cesarean section can be performed “immediately.”

Many hospitals and malpractice insurance companies defined “immediately available” as having a surgeon capable of performing a cesarean and anesthesiologist to be “in house” or “on the grounds.” Malpractice insurance companies began to deny hospitals coverage for VBAC, in fact pressure hospitals not to provide care for VBAC (NNPQIN), and substantially increase premiums for physicians who wanted to provide care for VBAC.

ACOG’s recommendations and the requirements by malpractice liability insurers made it impossible for many community hospitals to comply, effectively denying hundreds of women care for VBAC (Cunningham, Bangdiwala, Brown, et al., 2010). In fact, it was almost impossible for community hospitals, even if it was financially feasible to have staff “immediately available.” A study of the State of Ohio’s capacity to provide obstetric anesthesia concluded that even if all labor and delivery units could afford to comply with ACOG’s guidelines, there were not enough anesthesiologists to meet the need (Bell, Penning, Cousineau, et al., 2000).

In 1999 and still current in 2015, ACOG has chosen not to change its “immediately available” recommendations. It has, however, left it up to women themselves to carry the burden of challenging a hospital’s denial of VBAC services, advocating for their right not to be “forced” into a medically unnecessary operation. When parents are alone they resort to searching for a VBAC-friendly provider or hospital covered by their healthcare insurance, driving several miles or sometimes moving to another town, city, or state to avoid a repeat surgical birth.

The fact that too many women cannot get appropriate care for a VBAC is a moral issue, and it matters.

Thousands of women are being denied medical care and given no choice but to “consent” to a major abdominal surgery they do not need or want. Mothers have the legal right to make their own health care decisions, but that right, more often than not, is not upheld. Malpractice insurance companies are, in some communities, dictating patient care with regard to VBAC.

Physicians have an obligation to provide optimal care for their patients, with regard to women with a prior cesarean, that means not putting them and their baby at risk for serious complications and sometimes, death by denying them care for a VBAC. But, caregivers who want to support VBAC are asked to pay malpractice premiums that are prohibitive. Hospitals have an obligation to provide medical care to their community that serves the best interest of their patients, but this is not the case when it comes to VBACs. They are more concerned with avoiding malpractice suits.

Governments have an obligation to protect their citizens’ health and well-being, especially their most vulnerable, pregnant women and babies. But, the ability of caregivers to violate a woman’s bodily integrity by performing a major surgical procedure without real “consent” has not yet been challenged by any government, state, or federal.

Some community hospitals who want to provide care for VBAC have found a way to develop policies which provide safe care for VBAC and honor a woman’s right to not have a medically unnecessary major abdominal surgery (See Module 9 and Examples of hospital policies that support VBAC in Appendix A).
Pregnant women in the crossfire

In the end, given the current status quo, it is pregnant women and their families that are dealing with the stressful situation and paying the emotional and financial costs of denial of care for VBAC. Here is what some mothers wrote to a vbac support website:

I found out at my first prenatal appointment that the hospital I plan to deliver at has changed policies regarding VBAC. I want a VBAC. I feel so scared. I don’t want this pregnancy to end so I don’t have to deal with the issue. I have dreamed of going into labor and ‘hiding’ until delivery is imminent, then chance the 40 minute drive to the hospital and delivering on the roadside. Please help me. P.S. All the hospitals in this area have the same policy.

My hospital no longer allows VBACs. I investigated what would happen if I walked in ready to deliver, what they’d do, etc. I was told that if I came in at 8+ cm, they’d let me deliver vaginally—anything less and they’d either ship me off to another hospital or push to section me then and there.

I live in W. Small hospital. No in house anesthesia. Nor VBAC unless the woman comes in advanced labor, then she labors in the OR (operating room). Documented in our practice guidelines that we don’t do VBACs (from a Certified Nurse Midwife).

As educators we can help mothers understand the complex and often, questionable health care practices they may often be faced with and help them to persevere to get the birth and care that they desire.

References


What Maternity Care Professionals Can Do to Support VBAC

What Nurses Can Do to Help Women Achieve a VBAC

Nurses play a significant role in helping women complete their VBAC labors. Women laboring for a VBAC may have more anxieties than women having first babies, and may need extra support. They are grateful for all the encouragement, validation, and labor progress suggestions you can provide. Many times, mothers have said, “My nurse was wonderful. Just when I wanted to quit and ask for another cesarean, she told me things were going just as they should be. I couldn’t have done it without her.”

The following is a list of suggestions to help nurses support women laboring for a VBAC:

- During labor, while collaborating with her caregiver avoid formally admitting them to the L & D unit until they are in active labor.
- Encourage mothers to continue taking in clear liquids and light carbohydrate snacks in the early phase of labor and liquids in the active phase.
- Remind them to use a variety of positions and ambulate during labor as long as they are comfortable.
- Suggest that the mother and her partner use a variety of comfort measures, such as heat or cold packs, lunging motions, a birth ball, a rocking chair, hydrotherapy, etc.

**Psychological interventions**

- When meeting the mother for the first time, find out how she wants to labor this time. How does her partner or family feel about a VBAC? What concerns does she have? Why did she have a cesarean? Teach her how she can do things differently this time. Verbal support and encouragement are extremely helpful, especially when nurses help to identify signs of labor progress. Remind parents that 3 out of 4 women who labor for a VBAC have a safe birth. Help her to create the birth environment she prefers (low lighting, quiet, music, no visitors, etc.).
- When laboring for a VBAC, some mothers may have anxious moments and flashbacks to their prior birth. Distressing memories of fetal distress or of laboring “for ever” and not getting anywhere. Help mothers to overcome these difficult moments and remind them that this is a different labor for a different baby and that they are strong enough to move through it. Most nurses know when a mother has gone as far as she can and that she needs to adjust to the idea of having a cesarean birth.
- Give her time, if circumstances allow it, to think about what she would like for this birth. Does she want the baby skin-to-skin after birth? Does she want her partner to go with the baby to the nursery if it’s necessary or stay by her side? Does she want her family to visit her in recovery? Involving mothers in their care and honoring their wishes, if possible, will go a long way to help them adjust to the loss of the birth they may have planned for and anticipated for months.
- Many mothers have said that they were left alone after the birth while their partner went with the baby to the nursery (when medically necessary). If a mother does not
have a doula and if you can provide one-on-one care for this period of time and talk to the mother about how she is feeling, or how the baby might be doing, she is more likely not to feel abandoned.

- Mothers, just like their newborns, need to adjust to their new life. Your support, guidance, and compassion will give mothers and babies their best start together.

What Can Doulas Do to Help Support VBAC?

Doulas have a unique opportunity to educate and support expectant parents during pregnancy, labor, and birth.

1. Use the Resources and Educational Handouts for Parents to help parents find supportive providers and make informed decisions about a place of birth. Empower the expectant parents with the most up-to-date information with which they can make the best decision for them, rather than telling them what you think they should do.

2. Share the Resources List with parents so they can find the information they need to help them make an informed decision about how and where they want to give birth.

3. Hold monthly community meetings and invite parents to learn about VBAC. Consider a panel discussion and invite maternity care professionals experienced with VBAC and former VBAC moms.

4. Offer to do an in-service for the labor and delivery nurses in your community. Demonstrate non-drug options for pain relief, how to use the birth ball, hot and cold packs, massage and pressure techniques.

Remember that each woman is unique and her needs, preferences, and values should be respected. For example, you may think that having an epidural is the worst possible choice for a mother who wants a vaginal birth, but for some, knowing that they can avoid the pain and difficulties of the prior birth that may have led to a cesarean, an epidural may be her ticket to a VBAC. (See Penny Simkin’s article, “Supporting the Woman with an Epidural” in Resources for VBAC and Physiologic Birth.)
For Doulas Who Support VBAC Clients
A Personal Perspective
Jess Larsen Jukelevics, MA, CD (DONA)

VBAC families commonly come to birth with hopes or determination for a different experience, fear of repeating some part of their first birth, and sometimes unresolved feelings about giving birth again. In short, it can often feel (for every one) that the stakes are high.

We know that labor support is associated with better outcomes (Childbirth Connection, 2013), and a doula can go a long way to alleviate the fear and anxiety a VBAC mom may experience. But it’s also critical for doulas to be capable of supporting the emotional realities of VBAC women regardless of the clinical outcome of the VBAC attempt.

So how can a doula:
1. Offer help that best supports a family’s chances of a successful VBAC?
2. Hold the space for a family no matter the outcome in a productive and healthy way?

In prenatal work together with the family:

Depending on how the family is approaching this birth, it may be helpful to plan for more time prenatally than you might with other families. Before now, they may not have had an opportunity to digest what happened last time, their feelings about it, or to get clear on what they want this time (particularly if their first child is still young). Their time with you may be the most productive and helpful time they’ve had to do that. If they need more help than you can offer, refer them to a Birth Story Medicine® session or local birth trauma workshop. These can be very healing experiences for parents.

Survey the mom’s emotional landscape. Has she needed special support as part of her recovery from the last cesarean? Did she experience it as traumatic? Or was it an uncomplicated and easy decision for her the first time? (It is likely her experience lies somewhere in the middle of those extremes.) Expect some significant shifts in how she feels as her due date gets closer.

Be aware of her support landscape as well. Does she have the support of her partner, family, friends and community in her hopes for a VBAC? Does she feel like she has to fight for what she wants? If you approach her VBAC hopes as logical, normal, and positive, you may be setting an example for others, or offering support she’s not getting privately. Also remember that it’s not your responsibility to change anyone’s mind, but to support the needs and wishes of your client as best you can. Can you refer her to a local ICAN (International Cesarean Awareness Network) chapter or Facebook/Meetup group of VBAC moms?

How about her clinical support? This is a delicate conversation for a doula. A family chooses a caregiver for many reasons, some of which you will never know. It is also true that while some caregivers indicate that they will support a VBAC in theory, their track record says otherwise. If you have a sense from your own experience that this caregiver is not likely to support a VBAC, it may be worth a careful conversation about your past experiences with this clinician. Proceed with caution: a sense that you are second-guessing or not trusting the family’s decisions will not serve anyone.

1 http://www.birthingfromwithin.com/pages/birth-story-medicine
Get the clinical and emotional facts. Ask: What happened *clinically*, to the best of their knowledge? (They may need to ask questions and clarify with caregivers and/or request their medical records to get a complete picture.) What happened *emotionally* for this family? What did that birth ask of them, and how does it linger?

Ask solution-focused questions to help them reflect and clarify what they want and need this time. For example:

- What did you learn from your cesarean birth that will help you give birth vaginally this time?
- What is it about a cesarean birth that you’re hoping to avoid this time?
- What will it mean about you as a woman or mom if you have a VBAC this time? What will it mean if you have another cesarean birth?
- Are there ways in which a VBAC could be a problem for you?

Imagine yourself birthing your next baby with confidence and clarity. What do you need this time to do that?

Ask for the father’s/partner’s perspective. Perhaps no one has ever asked the partner what the last birth was like. What is the most powerful memory from that birth? What were the turning points in that birth? What does the partner need this time to be better able to support the expectant mother?

Use thoughtful language. Phrases like “failed VBACs,” “failed inductions,” and a woman who “was sectioned” can feel hurtful to a mother. Be conscious of the ways word choices promote a failure/success dichotomy or a passive role for the mother in her own birth.

Remind the family that outcome is not everything. We know that for mothers the factors most highly associated with satisfaction in childbirth are (1) having good support and a high-quality relationship with caregivers, and (2) being involved in making decisions about their care. Having everything go “according to plan” isn’t necessary or enough. In what ways is she eager to be involved in the decisions made about her care? How could she stay emotionally present for the birth of her next child, and what small things could she do, if a repeat cesarean is necessary?

If you were the doula for her first birth, welcome constructive feedback about your role at that birth. Initiate a conversation about how it went last time, what happened, and what she would like more or less of *from you* this time. What do they need you to do differently?

During labor:

Prepare yourself and the family for a potentially long labor. If the mother labored at least to the point of active labor the first time, after 6 cm her second labor may go quickly. But if she didn’t labor at all the first time or reached a few centimeters before her cesarean birth, her labor is likely to progress like a first-time mom.

How can you support the family in letting labor begin and progress on its own? Share resources in this vein to help parents minimize their chances of an induced or augmented labor.

Use your knowledge of what happened last time to anticipate emotional and physiological benchmarks. It could be a certain point in dilation, in labor’s duration, or when something happened, (i.e. after her water broke, her baby turned posterior, or after she agreed to a particular intervention). To the mother (or her partner!) reaching those benchmarks may feel like a hurdle was overcome, or it could lead to intense flashbacks.

If the mother starts to have flashbacks, try helping her with focusing and breathing exercises that bring her back to the present moment. (Finding a rhythm with guided visualization, counting her breath patterns aloud, guided body scans, or shifting her attention to each of her senses one at a time may be helpful.)
If the mother finds it helpful, **point out ways that this experience is already different** from the last time. Notice aloud what you see, what you see her doing, and any small reminders that this is an entirely new and different birth. This practice may be helpful for anyone that was at her first birth: her partner or husband, any family members present, and even you!

**Remember that you are not there to “save” this mother or her family from another cesarean birth.** Her birth outcome is ultimately not within your control. The key: helping this family respond in the moment to what’s unfolding and what’s needed, and validating their ability to make the best choices for themselves.

**If it starts to look like a repeat cesarean is going to happen,** encourage the family to have all their questions answered. If time permits, help them try everything they can do. If the cesarean is not imminent give them a moment to digest what happened. This space and time, and the knowledge that they did everything in their power, may help them later.

**In early postpartum work together with the family:**

Don’t assume you know how the mother feels about her birth yet. Ask open-ended questions to give you a sense of how her experience is affecting her, and remember how quickly birth stories can change. (What was the most powerful moment of this birth for you? What is your strongest memory?) Even a hoped-for VBAC may bring up conflicted feelings. If possible, have information on hand for peer support groups in your area.

Supporting a family through a VBAC or a repeat cesarean can be among the most demanding, meaningful, and poignant experiences in a doula’s career. Likewise, the families you serve benefit greatly from your grounded presence. To that aim, please don’t overlook the nurturing and self-care that is required for you to come to each birth with curiosity, humility, and care. Your families deserve it, and so do you!

**References**

1. Create separate informed consent/refusal forms for each intervention and provide the information to women during pregnancy, in childbirth class, in the office, during a prenatal visit and on your facility’s website. Include forms on:
   - Benefits and risks of VBAC
   - Induction of labor (different methods)
   - Epidurals for labor pain
   - EFM
   - Amniotomy
   - Episiotomy
   - Forceps or vacuum extractor
   - Drugs available for pain relief

2. Provide appropriate copies of the Educational Handouts for Parents.

3. Schedule an in-service on positions in labor and birth, benefits of doula care, comfort measures to ease the pain of labor, and Mother-Friendly nursing.

4. Conduct a Needs Assessment of your birthing unit to determine which written policies need to be revised, added or discarded so you can provide optimal care for women laboring for a VBAC.

5. Sponsor a monthly community presentation, “Mothers’ Tea”, to educate the public on the benefits of VBAC. Show a film on VBAC, invite mothers who have had a VBAC and/or a maternity care staff member for a Q & A. Distribute appropriate Educational Handouts for Parents.

6. Nurses should consider taking a workshop on non-pharmacologic pain relief measures.

7. Develop weekly VBAC education classes for women who have had a cesarean.

8. Include a booth on VBAC if your facility sponsors a community Health Fair.

9. Labor and delivery nurses may want to consider applying for Mother-Friendly Nurse Recognition from the Coalition for Improving Maternity Services (CIMS). The web link is included in the Resources for VBAC and Physiologic Birth.

10. Sponsor a conference on VBAC for maternity care professionals.

Take the lead.
   - Start with “ripe for change” practices first.
   - Which change do you want to implement?
   - Where are you now?
   - Where do you want to be?
   - How will you get there?
   - Who will be your collaborative partners?
Appendix A

Examples of Hospital Policies that Support VBAC, Family-Centered Cesarean, and Informed Choice
I understand:

1. I have had one or more prior Cesarean-section(s) and have refused a repeat c-section to attempt a vaginal delivery. Spectrum Health Gerber Memorial does not offer vaginal deliveries for women who have had previous cesarean sections because it does not have the surgery and anesthesia staff on site at all times.

2. Approximately 60-80% of women who attempt to delivery vaginally after Cesarean Section will deliver vaginally.

3. The benefits of an uncomplicated VBAC include decreased blood loss, decreased post-delivery complications, and a shorter recuperative period.

4. The risk of a uterine rupture during VBAC in someone like me who has had a prior incision in my uterus is approximately 1% or 1 in 100 VBAC deliveries.

5. VBAC poses a higher risk of harm to my baby than to me. In the event of a uterine rupture, the baby may suffer brain damage or death, if not immediately delivered by emergency C-section.

6. If my uterus ruptures during my VBAC, I understand there may not be sufficient time to operate and prevent death or permanent brain injury to my baby.

7. The risk of death or permanent brain damage to the baby when the uterus ruptures is uncertain, but has been reported to be generally less than 1%, or 1 in 100 uterine ruptures.

8. The risks of harm to me if my uterus ruptures include: hysterectomy (loss of the uterus), blood transfusion, infection, injury to internal organs (bowel, bladder, ureter), blood clotting problems, or death (which is rare).

9. My doctor has determined that transfer to a hospital that provides VBAC is not recommended because the risk of transfer outweighs the benefit.

10. During my VBAC, the use of oxytocin (Pitocin), a hormone to make my uterus contract, may be necessary to assist me in my vaginal delivery. This may cause long contractions and increased pain during contractions and increase the possibility of uterine rupture, abnormal position of the baby, and fetal distress, which will increase the need for an emergency Cesarean section.

11. If I choose a VBAC, but require an emergency Cesarean-section during labor, I have a greater risk of problems than if I had an elective repeat Cesarean-section.
By signing below, I confirm I have reviewed this information, have discussed it with my doctor, and have had all my questions answered.

**CONSENT FOR EMERGENCY TREATMENT**

By signing this form, I give my consent to all appropriate treatment in the event of a uterine rupture or other complications including, emergency cesarean section, hysterectomy, blood transfusion for me and/or my baby, and emergency resuscitation.

**REFUSAL OF CESAREAN SECTION**

I understand that by signing this form, I am refusing a repeat Cesarean-section. By signing this form I am choosing to attempt a vaginal birth after cesarean at a small hospital that does not offer this option.

Patient signature: ___________________________ Date: _______________

Witness signature: ___________________________ Date: _______________

Physician signature: __________________________ Date: _______________
Spectrum Health Gerber Memorial
Planned Vaginal Birth After Cesarean Section (VBAC) Education

After having a cesarean section, you must decide between a repeat cesarean section or a vaginal birth after cesarean (VBAC) for the birth of your baby. Research has determined that a VBAC is a reasonable option for many women with success rates of 60-80%. Because both routes of delivery have risks, we want to help you understand the risks and benefits of both options. Additionally, your OB provider will discuss with you any individual factors that may affect your decision.

Spectrum Health Gerber Memorial does not have the resources necessary to offer VBAC deliveries. However, if you choose to attempt a vaginal birth after cesarean section, your OB provider will work with you to plan your delivery at a hospital that offers VBAC as a delivery option.

What are my chances for a successful VBAC?
Your OB provider will help to determine the likelihood that you will have a successful VBAC. Factors include:
• If you ever delivered vaginally from 37 weeks to 41 weeks of pregnancy
• The reason you had a c-section
• The kind of incision you had for your c-section
• The length of your previous labor
• The shape of your pelvis
• The size of your baby
• How far you got in labor last time

What are the benefits of VBAC compared to planned cesarean birth?
• Faster time to heal after birth
• Shorter hospital stay
• Less chance of need for blood transfusion
• Less risk of infection after delivery
• Less risk the baby will have breathing problems
• Quicker return to normal activities, as there is no pain from abdominal surgery
• Greater chance of vaginal birth in later pregnancies

VBAC is a reasonable option for many women with success rates of 60-80%.
What are the risks of VBAC?

Risks to the mother:
- Tear or opening in the uterus—occurs in 7 to 10 out of 1000 low risk women who try VBAC (0.7% to 1%) If there is a tear in the uterus there are more possible risks:
  - Blood loss and the need to give you blood
  - Need to remove your uterus (hysterectomy). This means you will never be pregnant again.
  - Damage to your urinary bladder
  - Infection
  - Blood clots may develop in your legs
  - Death, which is rare
- Any of the following may increase your risk of tearing your uterus during labor:
  - Labor that does not start on its own (labor induction)
  - Location of uterine scar
  - More than one cesarean section
  - Less than 18 months since your last cesarean delivery
  - Need for medicine during labor to increase your contractions
  - Other unknown risks. These are still being studied.
- If your trial labor does not work your doctor must perform a cesarean section to deliver your baby. The risks of a cesarean delivery are higher when it is done as an emergency. This may double the risk of infection if done after labor.

Risks to the baby:
- Normal risks of a vaginal birth which could include shoulder dystocia and cord compression.
- A tear in the uterus may harm your baby. A tear in the uterus causes brain damage or death to a small percentage of babies (5 to 10 babies out of 10,000 VBAC attempts).

What are the risks of a planned cesarean birth, if that is my choice?
- Tear or opening in the uterus. The chance of this is about 5 in 1000 cesarean sections (0.5%). You will always have a risk for a tear in your uterus. This is because there is a scar on your uterus from the cesarean section you had before. The tears usually occur during labor. Risks to you and the baby are the same as if the uterus tore during VBAC.
- Blood loss with possible need to give you blood
- More scars on your uterus and inside your abdomen
- Infection
- Injury to organs inside your body
- Problems with anesthesia (drugs that make you numb and take away the feeling of pain)
- Blood clots in your legs
- Problems with the placenta (organ that nourishes your baby in your uterus) in later pregnancies
- Death, which is very rare
Why doesn’t Spectrum Health Gerber Memorial offer VBAC?

At Spectrum Health Gerber Memorial we want to make the birth of your baby as safe as possible. The American College of Obstetricians and Gynecologists (ACOG) has recommended that hospitals that offer VBAC have anesthesia staff, a doctor or both, and operating room services immediately available to provide emergency care. Although Spectrum Health Gerber Memorial has a process for assembling needed staff in emergency situations, there are times when certain staff are not on-site at the hospital and must be called in to provide emergency care. This means that it may take longer for staff to arrive than at a hospital that offers VBAC, where these staff are on site and immediately available.

If I can’t deliver by VBAC at Spectrum Health Gerber Memorial, where can I have my baby?

Your OB provider will work with you to arrange for your delivery at a hospital that offers VBAC. Your OB provider can continue to manage your prenatal care and will work together with the doctor who plans to deliver your baby.

By signing this form I agree:

- I read this form or had it explained to me in words I can understand.
- I understand there are risks associated with both planned cesarean section and VBAC.
- I had time to read the patient education material.
- I had time to speak with my OB provider about repeat cesarean section and VBAC. My OB provider answered my questions.
- If I choose to try VBAC for delivery of my baby, I will work with my OB provider to plan my delivery at a hospital that offers VBAC.
- If I choose a VBAC, I understand my doctor may still need to deliver my baby by cesarean section.

Patient signature: ___________________________ Date: _______________ Time: __________
We welcome you to the Gerber Memorial Health Services Family Birth Center. While the safety and well-being of you and your baby are the top priority, we will strive to meet as many of your expectations as possible. We look forward to sharing your upcoming birth with you.

Patient Name_________________________________________________
Date of birth_________________________________________________
OB provider__________________________________________________
Support person’s name_________________________________________
Due Date_____________________________________________________
Expecting: boy   girl   unknown
Doula _______________________________________________________
Baby’s name _________________________________________________
Baby’s doctor________________________________
Did you attend childbirth or refresher classes? Yes  No
Family and friends I would like present during labor and delivery: (maximum of 4) __________________________________________

You may choose as many as you like under each category

During labor I’d like:
□ To stay home as long as possible.
□ Lights dimmed.
□ Flameless candles.
□ Music, will bring my own.
□ Music, will use hospital relaxation collection.
□ The room as quiet as possible.
□ Standing, walking, position changes.
□ A birth ball.
□ Lying down, mobility not important since I am planning on epidural.
□ Bag of waters to break naturally.
□ To wear my own clothes.
□ To wear hospital gown.
□ To be informed of all procedures and discuss options when time allows.
□ If labor is not progressing, discuss most natural methods to help.
□ Pictures taken by: __________________________________________

Spectrum Health Gerber Memorial: Birth Plan Vaginal Delivery 1 of 4
Monitoring:
- I prefer minimal monitoring.
- I prefer monitoring that allows me to be mobile.
- I prefer continuous monitoring.

Hydration:
- IV on admission in preparation for pain medicine, epidural, and/or antibiotics if Group B Strep is positive.
- IV access site.
- IV only if medically necessary.

Pain Relief:
- Aromatherapy - we offer lavender/clary sage mixed.
- Massage
- Hypnosis techniques
- Breathing techniques
- Relaxation techniques
- Hot or cold packs
- Distraction
- TENS unit
- Sterile water papules
- Acupressure
- Water therapy using whirlpool or shower
- Medicine injection if no IV.
- IV medicine
- Only medicine if I request.
- Would prefer no medicines, I will ask, don’t ask me.
- Would like to avoid epidural.
- Epidural only if IV medicine isn’t effective.
- Epidural

During pushing I would like:
- Semi-recline in bed.
- Use a squatting bar on bed.
- Use a birth stool.
- Be side lying.
- Be on hands and knees.
- Deliver in any position I choose.
- Wait to push until I feel the urge.
- Push without a time limit as long as mom and baby are safe.

At the time of birth I would like:
- A mirror to watch delivery.
- To touch the baby’s head.
- To reach down and take the baby.
- To let my partner help catch the baby.
- OB provider to use oil and/or hot compresses for comfort and to help avoid tearing.
- Immediate skin to skin holding of baby.
- Do not want skin to skin.

**Umbilical Cord:**
- Cut the cord after it stops pulsating and the baby has received all the blood from the placenta.
- Cut the cord as soon as possible for cord blood donation. I will bring the kit.
- Dad will cut the cord.
- Dad does not want to cut the cord, do not ask him.
- I will cut the cord myself.
- _______________________________will cut the cord.

**Immediately after birth:**
- I will breastfeed as soon as the baby desires.
- Delay routine hospital procedures until after the baby has breastfed.
- Routine Pitocin to prevent hemorrhage.
- Pitocin only if necessary (required if not breastfeeding).
- I would like to see the placenta.
- Do not show me the placenta.
- I would like to take the placenta home.

**Newborn preferences:**
- I would like all routine medications and immunizations for my baby.
- Other_________________________________________________
- Breastfeeding
- Bottle feeding
- 24 hour rooming in is our practice. If your preference is different, explain.
- If a boy, circumcision.
- I do not want my baby boy circumcised

**If Cesarean becomes necessary - during delivery:**
- I would like music softly playing. My favorite type is _______________
- I plan to take pictures in the operating room.
- I plan to wait on pictures until I am in my room after the surgery
- I would like to have the surgery explained as it is happening
- Please do not talk about the surgery, I would rather think about other things
- I would like the surgical drape lowered so I can see the baby
- I do not want the surgical drape lowered
- I would like delayed cord clamping
- I would like the cord left long so dad can cut the cord
- Other thoughts: ________________________________
After the Delivery
I would like the baby brought to me:
☐ Immediately for skin to skin contact
☐ After being cleaned up and wrapped in a blanket

I prefer routine baby procedures:
☐ Delayed until after the surgery so I can have my baby immediately
☐ To be completed before the baby is brought to me
☐ I would like all routine newborn medications and immunizations
☐ Other: ________________________________

If the baby needs medical attention and cannot be with us immediately:
☐ I would like dad/support person to go to the nursery if the baby has to leave the room
☐ Dad/support person will stay with me. Please update us with the baby’s condition

Family and Friends
☐ May come in immediately after my recovery period, approximately 1 hr.
☐ May come in after some time alone with the baby

Preferences for Pain Management
☐ I am interested in the option of an abdominal nerve block (TAP block)
☐ Please give me whatever my anesthesia provider or doctor feels is necessary
☐ I am sensitive to medications and desire the least amount possible

Medications that have worked well for me in the past:
________________________________________________________________________

Medications that have caused problems for me in the past:
________________________________________________________________________

Time: _______________ Date: _______________ Mother’s signature: ____________________________
Epidural Anesthesia
Gerber Memorial Hospital
Epidural Education Form

Expected Results
A temporary decrease or loss of feeling and or movement to lower part of the body, which may provide relief from pain during a prolonged or difficult labor. This type of anesthesia/analgesia does not alter the mental status as occurs with IV or injection pain medications. Occasionally the anesthesia does not completely take away the pain, or only provides numbness on one side.

Technique
Medication is injected through a needle, and a catheter is placed outside the spinal canal in the epidural space.

Risks
Risks for mother:
• **HIGH SPINAL BLOCK:** you could experience shortness of breath, respiratory depression or respiratory/cardiac arrest. You may need an emergency cesarean section and resuscitation.
• **ADVERSE REACTION TO ANESTHETIC AGENT:** May lead to respiratory paralysis, cardiac arrest, brain damage, heart attack, convulsions, stroke or death.

Risks to the baby:
• Reduced blood supply to the placenta may cause fetal distress, brain damage, or death.

Other Considerations:
• Continuous electronic fetal monitoring will be used to check for signs of fetal stress.
• Epidural anesthesia/analgesia may cause slow, less effective labor contractions. Pitocin may have to be added to the IV to stimulate stronger contractions. More epidural medicine may be needed to relieve the pain of stronger Pitocin induced contractions. Pitocin can cause more risk to the baby. Arrested labor may result in cesarean section, which is a major abdominal surgery and poses increased risk for the mother.
• If an epidural is given in early labor, it increases the chance that the baby is in the wrong position as it comes into the pelvis. This may increase the need for a cesarean delivery.
• Epidural anesthesia decreases the mother’s ability to push and increases the need for forceps, vacuum, or cesarean section. Forceps or vacuum assisted deliveries have a greater need for an episiotomy and deep tears into the perineal muscle. This can increase the pain and healing time after giving birth.
• Back strain or injury to the hips and knees may occur due to the inability to feel if the body is in an awkward position.
• The mother cannot respond naturally to labor cues, and may not feel as much control over the birth process.
• You will not be able to walk around, or use the tub, shower, or toilet.
• The epidural may cause the mother’s temperature to rise requiring additional tests for you and the baby to evaluate for possible infections.
• You may need a catheter inserted into your bladder if you are unable to urinate.
• You will be limited to a clear liquid diet only after an epidural because of increased surgical risk if a cesarean is needed.
• You will be monitored often for vital signs after an epidural, so a blood pressure cuff will be placed on your arm, a pulse oximeter will be placed on a finger, and you will receive intravenous fluids.

Postpartum Effects:
• Epidurals may cause severe headaches, migraines, temporary or permanent nerve damage, muscle weakness in legs, numbness or tingling sensation, and long term backache.

Newborn Effects:
• The epidural may decrease the newborn baby’s ability to nurse well for the first 12-72 hours.

All forms of anesthesia or medications have some risk, and rare unexpected complications other than what is listed here may occur.

I understand that it is my choice to choose the type of pain relief method I feel is appropriate for my baby’s birth including an epidural, IV pain medications, or comfort measures as listed on my birth plan.

If I choose an epidural, I understand that every effort will be made to get an epidural administered in a timely manner. I understand an epidural may not be appropriate if the labor is advancing quickly and the procedure cannot be done safely.

If a cesarean delivery becomes necessary, the epidural may be adequate anesthesia for surgery but general anesthesia may be necessary if complete pain relief is not achieved.

I have had the opportunity to ask my OB physician or midwife questions regarding pain relief methods for labor and delivery.

I understand this is NOT A CONSENT FORM FOR THE PROCEDURE OF THE EPIDURAL, but is confirmation that I have been educated on the effects of an epidural which may affect the obstetrical care I receive from my physician or midwife. If I choose to have an epidural during my labor, the anesthesia provider who will be administering the epidural will also inform me of risks associated with the procedure.

Please initial the above statements, and sign below.

Patient signature: ___________________________ Date: ________________

OB Provider signature: ______________________ Date: ________________
Spectrum Health Gerber Memorial
Birth Plan for Cesarean Section Delivery

We welcome you to the Gerber Memorial Health Services Family Birth Center. While the safety and well-being of you and your baby are the top priority, we will strive to meet as many of your expectations as possible. We look forward to sharing your upcoming birth with you.

Name_______________________________________________________
OB provider__________________________________________________
Person who will be with me during surgery________________________
Relationship__________________________________________________
Due Date_____________________________________________________
Expecting: boy   girl   unknown
Baby name ___________________________________________________
Baby doctor________________________________
I plan to: Breast Feed    Bottle Feed
Did you attend childbirth or refresher classes? Yes  No

You may choose as many as you like under each category

During the Delivery:
□ I would like music softly playing. My favorite type is _______________
□ I plan to take pictures in the operating room.
□ I plan to wait on pictures until I am in my room after the surgery
□ I would like to have the surgery explained as it is happening
□ Please do not talk about the surgery, I would rather think about other things
□ I would like the surgical drape lowered so I can see the baby
□ I do not want the surgical drape lowered
□ I would like delayed cord clamping
□ I would like the cord left long so dad can cut the cord
□ Other thoughts: ______________________________________________

After the Delivery
I would like the baby brought to me:
□ Immediately for skin to skin contact
□ After being cleaned up and wrapped in a blanket

I prefer routine baby procedures:
□ Delayed until after the surgery so I can have my baby immediately
□ To be completed before the baby is brought to me
□ I would like all routine newborn medications and immunizations
□ Other: ______________________________________________________
If the baby needs medical attention and cannot be with us immediately:
□ I would like dad/support person to go to the nursery if the baby has to leave the room
□ Dad/support person will stay with me. Please update us with the baby’s condition
□ If your trial labor does not work your doctor must perform a cesarean section to deliver your baby. The risks of a cesarean delivery are higher when it is done as an emergency. This may double the risk of infection if done after labor.

Family and Friends
□ May come in immediately after my recovery period, approximately 1 hr.
□ May come in after some time alone with the baby

Preferences for Pain Management
□ I am interested in the option of an abdominal nerve block (TAP block)
□ Please give me whatever my anesthesia provider or doctor feels is necessary
□ I am sensitive to medications and desire the least amount possible

Medications that have worked well for me in the past:
___________________________________________________________

Medications that have caused problems for me in the past:
___________________________________________________________

Patient signature: ______________________________ Date: ______________ Time: ______________
The following guidelines are intended only as a general educational resource for hospitals and clinicians, and are not intended to reflect or establish a standard of care or to replace individual clinician judgment and medical decision making for specific healthcare environments and patient situations.

VBAC Guidelines
Revised December 2011

This document represents collaboration among the hospitals in Vermont and New Hampshire. It outlines NNEPQIN’s collective recommendations for VBAC care, based upon thorough and thoughtful review of the literature. It incorporates ACOG guidelines, and presents a regional definition of provider’s “immediate availability” based upon patient risk status. The goal is to maintain the availability of VBAC services throughout the region, while ensuring patient and provider safety. These recommendations apply to VBAC candidates only, and recognize the need to adapt care to the unique circumstances of each case.

Unit Structure:
Each hospital should develop policy and procedure guidelines that reflect the resources and ability of the delivery unit to respond to emergent situations that may develop for patients attempting VBAC. These guidelines should include a description of informed consent, notification, availability of key providers, facilities, and the typical response times for emergency cesarean section.

Each hospital needs to have a system in place for competency review and protocol verification. This can be accomplished in several ways, including but not limited to:
• periodic emergency cesarean drills for staff
• ongoing individual review of emergency cesarean section cases
• regular staff training in the interpretation of fetal heart rate monitoring

These activities will provide ongoing opportunities for quality improvement.
Definitions:

- **Labor**: Regular and painful uterine contractions that cause cervical change.
- **Active Labor**: The cervix is 4-5 cm dilated and there are regular and painful uterine contractions.
- **Adequate Labor**: Contractions every 3 minutes with a 50 torr rise above baseline or contractions every 3 minutes lasting at least 45 seconds that palpate strong.
- **Provider capable of performing a cesarean section**: An obstetrician, surgeon, or family practitioner who is credentialed to perform a cesarean delivery.
- **Admission**: Occurs when labor has been diagnosed, or when decision is made to deliver the patient. Observation to determine if the patient is in labor is not considered admission.
- **Anesthesia**: Refers to a CRNA or anesthesiologist who is privileged by the hospital.
- **OR Team**: One person competent to scrub for a cesarean section and one person competent to circulate during a cesarean section. These may be OR technicians, LNA, CNA, LPN, or RN.

Risk Assessment:

- Each patient should be evaluated for risk factors associated with decreased VBAC success and uterine rupture. (See tables.)
- The association of factors related to an increased risk of uterine rupture has not been able to be translated into the reliable prediction of uterine rupture (1, 2). Patients without risk factors may experience uterine rupture.
- Previous vaginal delivery is associated with higher rates of VBAC success and lower risk of uterine rupture.
- There is limited data on outcomes for women with multiple risk factors present. Some studies suggest that even when multiple risk factors are present, VBAC success rates are often at least 50% or higher (3). All patients should receive counseling about the assumed relative risk for VBAC success and uterine rupture. Management plans for these outcomes should be reviewed with the patient.

The Maternal Fetal Medicine Unit Network recently performed a large multi-center trial evaluating VBAC. Based on the data from this study, a nomogram was created to predict VBAC success. A calculator based on this nomogram can be found at the George Washington University Biostatistics Center web site. It may be useful for individualizing the counseling given to patients about VBAC.

http://www.bsc.gwu.edu/mfmu/vagbirth.html
### Factors Associated With Decreased VBAC Success

<table>
<thead>
<tr>
<th>Factor</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labor induction (3, 4)</td>
<td></td>
</tr>
<tr>
<td>Labor augmentation (3, 4)</td>
<td></td>
</tr>
<tr>
<td>Short inter-pregnancy interval (3, 4)</td>
<td></td>
</tr>
<tr>
<td>Birth weight &gt;4000 gm (3, 4)</td>
<td></td>
</tr>
<tr>
<td>Gestational age 41 weeks or greater (3, 4)</td>
<td></td>
</tr>
<tr>
<td>Excess maternal weight gain, variously defined (3, 4)</td>
<td></td>
</tr>
<tr>
<td>Recurrent indication for initial cesarean delivery (3, 4)</td>
<td></td>
</tr>
<tr>
<td>Unfavorable cervical status at admission (3, 4)</td>
<td></td>
</tr>
<tr>
<td>Non-white ethnicity (3, 4)</td>
<td></td>
</tr>
</tbody>
</table>

### Factors Associated With Uterine Rupture

<table>
<thead>
<tr>
<th>Factor</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labor induction (5, 6, 7)</td>
<td></td>
</tr>
<tr>
<td>Labor augmentation (8, 9, 10)</td>
<td></td>
</tr>
<tr>
<td>Short inter-pregnancy interval (16, 17, 18)</td>
<td></td>
</tr>
</tbody>
</table>

### Data insufficient to demonstrate consistent association.

<table>
<thead>
<tr>
<th>Factor</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gestational age 41 weeks or greater (14, 15)</td>
<td></td>
</tr>
<tr>
<td>Birth weight &gt;4000 gm (11, 12, 13)</td>
<td></td>
</tr>
<tr>
<td>Previous single layer closure of the uterus (19, 20)</td>
<td></td>
</tr>
<tr>
<td>Maternal obesity, variously defined (21)</td>
<td></td>
</tr>
<tr>
<td>Recurrent indication for initial cesarean delivery (1)</td>
<td></td>
</tr>
<tr>
<td>Unfavorable cervical status at admission (1)</td>
<td></td>
</tr>
<tr>
<td>Non-white ethnicity (1)</td>
<td></td>
</tr>
<tr>
<td>3 or more prior cesarean sections (23, 24)</td>
<td></td>
</tr>
</tbody>
</table>
Low Risk Patient: Risk for uterine rupture approximately 0.3-0.7%.
- 1 or 2 prior low transverse cesarean section(s)
- Spontaneous onset labor
- No need for augmentation
- No repetitive FHR abnormalities
- Patients with a prior successful VBAC are especially low risk. However, their risk status escalates the same as other low risk patients.

Medium Risk Patient: Risk for uterine rupture is likely greater than 0.7%.
- Induction of labor
- Oxytocin augmentation
- <18 months between prior cesarean section and current delivery.
- 3 or more prior low transverse cesarean sections.

High Risk Patient: Patients who have intra-partum signs or symptoms that may be associated with uterine rupture or failure of vaginal delivery (4).
- Recurrent clinically significant deceleration (variable, late or prolonged fetal heart rate decelerations) not responsive to clinical intervention
- Significant bleeding of uterine origin
- New onset of intense uterine pain
- 2 hours without cervical change in the active phase despite adequate labor

Prenatal Management:
- Records of prior delivery reviewed, including type of uterine incision and method of closure. Evaluate history of previous uterine surgery.
  - VBAC may be attempted in some cases where documentation of the previous uterine scar is not available, as long as there is not a high suspicion of a classical uterine incision. (4) (Level B)
  - Patients with a previous classical uterine incision, previous extensive transfundal surgery or prior uterine rupture are not candidates for VBAC. (4) (Level B)
- Appropriate patient education brochure given to patient and reviewed with patient (NNEPQIN sample available).
- Appropriate VBAC consent reviewed during prenatal care and signed (NNEPQIN sample available). Informed consent should include a discussion of the following.
  - A description of the process of risk assessment.
  - The ability of the institution to care for the patient, based on her risk level.
  - The process of transfer of care, should it become necessary based on risk factors.
  - Institutional management plans for uterine rupture.
- Anesthesia consultation/evaluation per institution guidelines.
- If the primary OB provider cannot perform a cesarean section, consultation with provider privileged to perform a cesarean section.
Basic Intra-partum Care Recommendations for all VBAC Patients:

- Review with the patient the risks/benefits of proceeding with VBAC on admission. Determine if the patient’s risk level has changed, or patient choice has changed. This review should be documented in the medical record.

- Lab/Blood Bank Preparation
  - Type and Screen, or Type and Cross depending on the institution’s blood bank availability in off hours

- Anesthesia personnel notified of admission.

- Pediatric personnel notified of admission.

- OR Team notified of admission and plan in place if cesarean delivery needed.
  - Does not mean an OR is kept open for patients at low risk.

- In Active Labor (4-5 cm dilated).
  - Continuous Electronic Fetal Monitoring.
  - Place 18 gauge IV.
  - Provider on hospital campus who is credentialed to perform a cesarean section.
    - If the primary obstetric provider is not credentialed to perform a cesarean section, the cesarean delivery provider will be consulted.

- All patients attempting VBAC should have their labor progress monitored carefully to ensure adequate progress. Arrest of labor is associated with decreased VBAC success and uterine rupture. Patients with a macrosomic fetus (EFW > 4000 gm), especially those with no previous vaginal birth, are more likely to experience outcomes related to arrest of labor, and require careful monitoring.

Intra-partum Management:

Each hospital should evaluate the resources that they typically have available for the care of laboring women with prior cesarean deliveries. Women should be counseled as to their anticipated risk status and the institutional resources. Cesarean section may be recommended if a woman’s risk status increases and provider services cannot be increased and maintained until delivery.

ACOG states: “Respect for patient autonomy supports the concept that patients should be allowed to accept increased levels of risk, however, patients should be clearly informed of such potential increase in risk and management alternatives...In settings where the staff needed for emergency cesarean section are not immediately available, the process for gathering needed staff when emergencies arise should be clear, and all centers should have a plan for managing uterine rupture.” (4) (Level C)
Low Risk Patient:
- No additional interventions other than those listed above.
- Cesarean delivery provider may have other acute patient care responsibilities.

Medium Risk Patient:
- Cesarean delivery provider in the hospital during the active phase of labor. Cesarean delivery provider may have other acute patient care responsibilities.
- An open and staffed operating room is available or there is a plan in place if immediate delivery is required. This may be a room where there is adequate lighting, instruments, and general anesthesia can be administered if needed.
- An anesthesia provider is present in the hospital during the active phase of labor.
- Anesthesia staff may have other acute patient care responsibilities.
- There is an established back up protocol for anesthesia services during busy times.

High Risk Patient:
- The cesarean delivery provider is present in the hospital and does not have other acute patient care responsibilities
- Anesthesia staff is present and does not have other acute patient care responsibilities.
- An open and staffed operating room is available.

Caveats:
- Misoprostil is associated with a high rate of uterine rupture and should not be used when a living fetus is still in-utero (4) (Level A). It may be used after delivery for uterine atony.
- There are limited data regarding the safety of a trial of labor in women with more than 2 prior cesarean sections. The degree of increase in risk of uterine rupture is unclear.
- Single layer closure of the uterus with an interlocking chromic type suture has been reported to be associated with an increased risk of uterine rupture. Operative records should be reviewed for the method of closure.
- Transfer during the active phase of labor typically holds little benefit for the patient as access to timely delivery is not present during transport.
- Attempting VBAC with twin gestation carries a similar risk as for those women with singleton pregnancies. Women without other risk factors, who have twins and are candidates for vaginal delivery, may be considered candidates for attempting VBAC. (4) (Level B)
• Women may present to hospitals that have chosen not to offer VBAC services. Transfer to a hospital providing VBAC services necessitates evaluation of the patient, to determine safety, and must comply with federal and state law. Hospitals not offering VBAC services should meet the following standards:
  • Protocol in place for women with prior cesarean sections who present in labor
  • Institution complies with ACOG Guidelines for Prenatal Care and JACHO Standards for Obstetrical Care.
  • Referral and counseling practices established so that women desiring VBAC may be referred to an appropriate center based upon their risk status.
  • Meets NRP Guidelines for infant care.

**Proposed Performance Measure:**

The percentage of patients for whom there is documented risk status at the time of admission, and documented change in risk status during labor, should that occur.
Complication Rates Associated With VBAC and Planned Cesarean Birth
(Includes preterm and term births). (22)

<table>
<thead>
<tr>
<th>Complication</th>
<th>VBAC Attempt</th>
<th>Planned Cesarean Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uterine Rupture</td>
<td>468/100,000</td>
<td>26/100,000</td>
</tr>
<tr>
<td>Maternal Death</td>
<td>4/100,000</td>
<td>13/100,000</td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>No significant difference</td>
<td>No significant difference</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>No significant difference</td>
<td>No significant difference</td>
</tr>
<tr>
<td>Maternal Infection</td>
<td>No significant difference</td>
<td>No significant difference</td>
</tr>
<tr>
<td>Infant Infection</td>
<td>Insufficient information</td>
<td>Insufficient information</td>
</tr>
<tr>
<td>Infant Bag and Mask Ventilation Required</td>
<td>5,400/100,000</td>
<td>2,500/100,000</td>
</tr>
<tr>
<td>Transient Tachypnea of the Newborn (TTN)</td>
<td>3,600/100,000</td>
<td>4,200/100,000</td>
</tr>
<tr>
<td>Infant with Brain Injury</td>
<td>Insufficient information</td>
<td>Insufficient information</td>
</tr>
<tr>
<td>Infant death in pregnancy or within 7 of birth (Perinatal Death Rate)</td>
<td>130/100,000</td>
<td>50/100,000</td>
</tr>
<tr>
<td>Infant death within 30 days of birth (Neonatal Death Rate)</td>
<td>110/100,000</td>
<td>60/100,000</td>
</tr>
</tbody>
</table>

References:


24. Tasheen F, Griffiths M: Vaginal birth after two caesarean sections (VBAC-2)—a systematic review with meta-analysis of success rate and adverse outcomes of VBAC-2 versus VBAC-1 and repeat (third) caesarean sections. BJOG 2010;117:5-19 (Level II-B)
Studies were reviewed and evaluated for quality according to the method outlined by the U.S. Preventative Services Task Force

I  Evidence obtained from at least one properly designed randomized controlled trial.
II-1 Evidence obtained from well-designed controlled trials without randomization.
II-2 Evidence obtained from well-designed cohort or case-control analytic studies, preferably from more than one center or research group.
II-3 Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments also could be regarded as this type of evidence.
III  Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Based on the highest level of evidence found in the data, recommendations are provided and graded according to the following categories:

Level A—Recommendations are based on good and consistent scientific evidence.
Level B—Recommendations are based on limited or inconsistent scientific evidence.
Level C—Recommendations are based primarily on consensus and expert opinion.
Patient Education:
Birth Choices After a Cesarean Section

(Your Hospital: Insert Name)

This document was created by obstetric doctors, midwives, and nurses from hospitals across Northern New England. It is based upon thorough and thoughtful review of medical studies on vaginal birth after cesarean section (VBAC). It is a collection of everyone’s understanding of these studies. Our goal is to give you a fair review of the risks and benefits of attempting vaginal delivery after a cesarean delivery. We believe vaginal birth after a cesarean section is a good choice for many women.

Your Hospital wants to give you the best care possible. Taking part in choices about your delivery is an important part of this care. Because you had a cesarean birth before, you come to this delivery experience with further choices to make. We will give you information so that you can make choices that are best for you and your family. The goal is a healthy mother and baby, whether the birth is vaginal or cesarean.

What are the benefits of VBAC compared to a planned cesarean birth?

- Faster time to heal after birth
- Shorter hospital stay
- Less risk of infection after delivery
- No chance of problems caused by surgery (infection, injury to bowel or urinary tract, or blood loss)
- Less risk that the baby will have breathing problems
- Quicker return to normal activities because there is no pain from surgery.
- Greater chance of having a vaginal birth in later pregnancies
- Less risk of problems with how the placenta attaches in future pregnancies.

VBAC means Vaginal Birth After Cesarean Section.
Can all women with previous cesarean birth attempt VBAC?

Some women should not try VBAC. If the cesarean scar is in the upper part of the uterus, where contractions occur, the risk of the uterus tearing (also called uterine rupture) is high. These women should have repeat cesarean births and avoid labor. Women with a scar in the lower part of the uterus have a lower risk of the uterus tearing and VBAC is considered safe. The type of scar you have in your skin may not be the same type of scar you have in your uterus. Your doctor or midwife will review the records of your previous birth to find the location of your uterine scar. If you have had three or more cesarean births and no vaginal births, the risk of the uterus tearing during labor may increase and VBAC may not be recommended. Your doctor or midwife will review these risks with you.

What are the risks of VBAC?

• A tear or opening in the uterus (womb) occurs in 5 to 10 women out of every 1,000 low risk women who try VBAC (0.5% to 1.0%).

• Risks to the mother if there is a tear in the uterus include:
  • Blood loss that may need transfusion
  • Damage to the uterus that may need hysterectomy (removal of the uterus)
  • Damage to the bladder
  • Infection
  • Blood clots
  • Death, which is very rare.

• Risks to the baby if there is a tear of the uterus are brain damage and death. Not all tears in the uterus harm the baby. About 7% of the time the baby is harmed when the uterus tears. In other words, 5 to 10 babies out of every 10,000 VBAC tries will suffer brain damage or death (0.05% to 0.1%) due to uterine rupture.

• The normal risks of having a vaginal birth are also present for VBAC.

• The risk of your uterus tearing during labor is increased with any of the following:
  • Labor that is induced (does not start on its own)
  • More than 1 cesarean section
  • Less than 18 months since your last cesarean delivery
  • Need for medicine during labor to increase contractions

• If a vaginal birth cannot occur, then a cesarean birth must be done. Overall, 70-80% of attempted VBAC are successful. A cesarean section after attempting vaginal delivery has the same types of risks as a planned cesarean delivery. However, the risk of infection, transfusion, blood clots and needing hysterectomy is increased.
How can I reduce risks to my baby and me?

- Regular prenatal care is very important in reducing all risks in pregnancy.
- Having labor occur naturally, rather than using medications to start labor, brings down the risk of a tear in the uterus. Your doctor or midwife will talk to you about this, taking into account your own situation.
- Having at least 18 months time between the date of your last cesarean birth and the due date of this pregnancy helps insure the strength of the uterus during this pregnancy.

What are the risks of a planned cesarean birth, if that is my choice?

- The risk that the uterus will tear before a planned cesarean birth is very low. Because you have a scar on your uterus from your prior cesarean birth, you will always be at risk for having a tear in your uterus. The tears usually occur during labor. The risks to the baby and you are the same as if the uterus tore during a VBAC.
- Blood loss
- More scars developing on the uterus
- Infection
- Scarring inside the abdomen
- Injury to organs inside the body
- Problems with anesthesia
- Blood clots
- Risk in later pregnancies of problems with the placenta
- Death, which is very rare

If I choose a repeat cesarean birth, what can I expect in my recovery?

Each woman has her own special experience with cesarean delivery and recovery. Many women talk about their recovery from their second cesarean as easier than their recovery from their first cesarean. This may be due to knowing what to expect in a second cesarean and feeling less tired because you did not have labor. Still, recovering from any type of childbirth takes time.

Overall, how do the risks of VBAC compare to repeat cesarean birth without labor?

- The risk of the uterus tearing during a low risk VBAC is 5 in 1,000 (0.5%). Because you have a scar on your uterus from your prior cesarean birth, you will always be at risk for having a tear in your uterus. The tears usually occur during labor. The risk that the uterus will tear before a planned cesarean birth is very low. The risks to the baby and you are the same as if the uterus tore during a VBAC.
- Overall, the risk of blood transfusion, hysterectomy, blood clots and infection are increased in women who attempt vaginal delivery. These increased risks are from the women who are not successful in vaginal delivery.
• The risk of your baby dying or being seriously injured during VBAC is the same as during a first labor. There is a higher risk of the baby dying or being injured with VBAC compared to a planned repeat cesarean birth. The overall risk with VBAC is about 11 out of 10,000 (0.1%) and with a planned repeat cesarean birth 6 out of 10,000 (0.06%).

### Complication Rates Associated With VBAC and Planned Cesarean Birth (Includes Preterm and Term Births).

<table>
<thead>
<tr>
<th>Complication</th>
<th>VBAC Attempt</th>
<th>Planned Cesarean Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uterine Rupture</td>
<td>468/100,000 (0.5%)</td>
<td>26/100,000 (0.026%)</td>
</tr>
<tr>
<td>Maternal Death</td>
<td>4/100,000 (.004%)</td>
<td>13/100,000 (0.013%)</td>
</tr>
<tr>
<td>Hysterectomy</td>
<td>No significant difference</td>
<td>No significant difference</td>
</tr>
<tr>
<td>Blood Transfusion</td>
<td>No significant difference</td>
<td>No significant difference</td>
</tr>
<tr>
<td>Maternal Infection</td>
<td>No significant difference</td>
<td>No significant difference</td>
</tr>
<tr>
<td>Infant Infection</td>
<td>Insufficient information</td>
<td>Insufficient information</td>
</tr>
<tr>
<td>Infant breathing problems requiring immediate interventions</td>
<td>5,400/100,000 (5.4%)</td>
<td>2,500/100,000 (2.5%)</td>
</tr>
<tr>
<td>Infant breathing problems which last 6-48 hours</td>
<td>3,600/100,000 (3.6%)</td>
<td>4,200/100,000 (4.2%)</td>
</tr>
<tr>
<td>Infant with Brain Injury</td>
<td>Insufficient information</td>
<td>Insufficient information</td>
</tr>
<tr>
<td>Fetal/Infant Death during pregnancy or the first 7 days after birth</td>
<td>130/100,000 (0.13%)</td>
<td>50/100,000 (0.05%)</td>
</tr>
<tr>
<td>Infant death within 30 days of birth</td>
<td>110/100,000 (0.11%)</td>
<td>60/100,000 (0.06%)</td>
</tr>
</tbody>
</table>

What is the chance that trying a VBAC will result in a vaginal birth?

- 60%-80% of women who try a VBAC have a vaginal birth. There is no perfect way to say who will deliver vaginally. A number of factors increase the chance of success. However, even if none of these factors are present, the chance of vaginal delivery is at least 50%. Factors that predict success are:
  - Cesarean birth for a reason that is not likely to happen again (i.e. breech presentation)
  - Having a vaginal birth in the past
  - Labor that occurs naturally
  - The length of the pregnancy is less than 40 weeks
  - A cervix that is at least 2 cm dilated and very thin when admitted to the hospital

How do women make a choice about a VBAC?

- Having a vaginal birth is very important to some women. For many women, the benefits of trying a vaginal birth outweigh the risks. Women who deliver vaginally have less postpartum discomfort, shorter hospital stays, and describe a feeling of wellness sooner than women recovering from cesarean section.
- Other women choose cesarean birth because they do not want to go through labor. They may be more concerned about the risk of the uterus tearing and the risks of vaginal delivery than the risks of cesarean birth.
- There may be added benefits and risks, some of them emotional, with either choice. We want you to discuss these with your provider and family.
- Future Child Bearing: If a woman is very certain in her desire to have no more children, then the VBAC benefit of less uterine scarring and a better place for the placenta to attach is not present and a repeat cesarean section may be best. However, if there is even a small chance of another pregnancy, a low risk VBAC may be the better choice.
- The purpose of this pamphlet is to help you make the choice that is best for YOU.

If I select VBAC, what can I expect during prenatal care and at the hospital?

- You will be asked to sign a consent form showing that you understand the risks and benefits of your choice. The form will ask you to give your choice.
- Your doctor or midwife will talk with you when to call or come in for labor.
- You may meet with an anesthesiologist before your labor.
- Constant fetal heart rate and contraction monitoring during active labor (when your cervix is 4-5 cm dilated).
• You will have an IV so that fluids and medications may be given to you if needed.
• Blood samples will be taken.
• You options for pain medication during labor are not affected by your prior cesarean section.
• A doctor able to perform a cesarean birth will be on the hospital grounds during the active phase of labor.

What is my hospital’s experience with VBAC?

[Your Hospital] has been performing VBAC for (Insert # of yrs) years. In Northern New England, 60-80% of women who try VBAC have a vaginal birth. [Your hospital] has anesthesia staff, a doctor for the baby and operating room services available 24 hours per day. Your risk of a tear in the uterus and how far along you are in labor determine if all these people are present in the hospital. In cases of tear in the uterus, injury to the baby may occur. The risk of injury to the baby increases with the time it takes to deliver the baby and the damage to the placenta. We have specific plans to respond once a problem is detected. However, there is risk associated with every pregnancy. Risk cannot be completely removed. We share the same goal as you: a healthy baby delivered to a healthy mom. We will make every effort to ensure this.

You also have the choice of having your birth at a hospital where anesthesia, operating room staff and doctors for the baby are always present in the hospital. This may lower the risk to the baby if there is a tear in the uterus, but not in all cases. However, delivery at another hospital may mean travel during labor and having your baby away from your local community and support system. You may want to talk to your doctor or midwife about the risks and benefits of planning to deliver at such a hospital. Changing care from one hospital to another during labor may be of little benefit and may increase the risk of harm to you and your baby.

What if I change my mind?

If during the VBAC process you have questions about continuing, we encourage you to talk with your doctor or midwife. You may change your mind about VBAC. However, if delivery is about to happen, a cesarean section may not be possible.

Am I comfortable with making the decision?

Each woman’s decision is personal. Your doctor or midwife is your best source of information. She or he will guide you and your family in deciding how you have your baby. The overall goal is a healthy mother and baby, whether the delivery is by vaginal or cesarean birth.
Spectrum Health Gerber Memorial
Refusal of Repeat Cesarean Section Form

I understand:

1. I have had one or more prior Cesarean-section(s) and have refused a repeat c-section to attempt a vaginal delivery. Spectrum Health Gerber Memorial does not offer vaginal deliveries for women who have had previous cesarean sections because it does not have the surgery and anesthesia staff on site at all times.

2. Approximately 60-80% of women who attempt to delivery vaginally after Cesarean Section will deliver vaginally.

3. The benefits of an uncomplicated VBAC include decreased blood loss, decreased post-delivery complications, and a shorter recuperative period.

4. The risk of a uterine rupture during VBAC in someone like me who has had a prior incision in my uterus is approximately 1% or 1 in 100 VBAC deliveries.

5. VBAC poses a higher risk of harm to my baby than to me. In the event of a uterine rupture, the baby may suffer brain damage or death, if not immediately delivered by emergency C-section.

6. If my uterus ruptures during my VBAC, I understand there may not be sufficient time to operate and prevent death or permanent brain injury to my baby.

7. The risk of death or permanent brain damage to the baby when the uterus ruptures is uncertain, but has been reported to be generally less than 1%, or 1 in 100 uterine ruptures.

8. The risks of harm to me if my uterus ruptures include: hysterectomy (loss of the uterus), blood transfusion, infection, injury to internal organs (bowel, bladder, ureter), blood clotting problems, or death (which is rare).

9. My doctor has determined that transfer to a hospital that provides VBAC is not recommended because the risk of transfer outweighs the benefit.

10. During my VBAC, the use of oxytocin (Pitocin), a hormone to make my uterus contract, may be necessary to assist me in my vaginal delivery. This may cause long contractions and increased pain during contractions and increase the possibility of uterine rupture, abnormal position of the baby, and fetal distress, which will increase the need for an emergency Cesarean section.

11. If I choose a VBAC, but require an emergency Cesarean-section during labor, I have a greater risk of problems than if I had an elective repeat Cesarean-section.
By signing below, I confirm I have reviewed this information, have discussed it with my doctor, and have had all my questions answered.

**CONSENT FOR EMERGENCY TREATMENT**

By signing this form, I give my consent to all appropriate treatment in the event of a uterine rupture or other complications including, emergency cesarean section, hysterectomy, blood transfusion for me and/or my baby, and emergency resuscitation.

**REFUSAL OF CESAREAN SECTION**

I understand that by signing this form, I am refusing a repeat Cesarean-section. By signing this form I am choosing to attempt a vaginal birth after cesarean at a small hospital that does not offer this option.

Patient signature: ___________________________  Date: ________________

Witness signature: ___________________________  Date: ________________

Physician signature: ___________________________  Date: ________________
Protocol For
Trial Of Labor After
Cesarean Section (TOLAC)
Against Medical Advice

This protocol is applicable to the following sites:

**Applicability Limited to:** N/A
**Reference #:** 0
**Version#:** 1
**Effective Date:** February 26, 2014
**Functional Area:** { Functional Areas > Values (by comma) }

1. **Purpose**
   This Hospital does not possess the required staff or facilities to provide VBAC deliveries. Women who desire VBAC should be instructed to present to a hospital with staff and facilities to provide VBAC in accordance with ACOG guidelines. The purpose of this policy is to address those instances in which a woman presents to the Hospital in active labor with viable fetus with history of a previous cesarean section and refuses a repeat cesarean section delivery and the risk of transfer to a facility that provides VBAC deliveries outweighs the benefit of transfer.

2. **Definitions**
   - **Labor:** Regular uterine contractions that cause progressive cervical change.
   - **Hospital:**
   - **Immediately Available:** Present on hospital campus
   - **TOLAC:** Trial Of Labor After Cesarean
   - **VBAC:** Vaginal Birth After Cesarean
   - **NRP:** Neonatal Resuscitation Program
   - **ACOG:** American College of Obstetricians and Gynecologists
   - **AIC:** Anesthesia In-Charge

3. **Responsibilities**
   Regular uterine contractions that cause progressive cervical change.
   - OB Provider, OB Registered Nurse (RN), Nursing Administrative Supervisor (NAS), OB Clinical Manager, Certified Registered Nurse Anesthetist (CANA), Anesthesia In Charge (AIC), Surgery Staff and Pediatrician.
4. Protocol

A. A pregnant woman, greater than 20 weeks, presenting to the Hospital, will be assessed for labor by a qualified medical provider per EMTALA policy (RM16ADM)-Emergency Medical Condition/Transfer Policy (Emergency Medical Treatment and Active Labor Act EMTALA)

B. For patients in active labor, the OB provider will determine the plan of care. If the laboring patient has had a previous cesarean section and refuses a repeat c-section delivery, the patient will be informed of the risks of refusing a repeat cesarean section and attempting TOLAC at this hospital, including the lack of Immediately Available obstetrics, pediatrics, anesthesia, and surgical staff.

C. If the patient continues to refuse a repeat C-section, the OB provider will review the Refusal of Repeat Cesarean Section Form with the patient and obtain the patient’s signature evidencing the patient’s informed refusal of c-section and decision to proceed with TOLAC against medical advice.

D. IN THE EVENT THE PATIENT REFUSES C-SECTION AND PROCEEDS WITH TOLAC; THE ATTENDING OB PHYSICIAN WILL REMAIN ONSITE UNTIL THE PATIENT HAS DELIVERED.

E. Intrapartum trial of labor management will be provided by the nursing staff and OB providers according to standard practice for obstetrical patients, with the following exception:

   Cytotec (misoprostol) is not to be used in women with a previous cesarean. It may be used after the birth for uterine atony.

5. Documentation (as a result of using the protocol)

A. Documentation of patient’s counseling of the risks of a TOLAC.

B. Refusal of Repeat Cesarean Section Form.

6. Revisions

This Hospital reserves the right to alter, amend, modify or eliminate this protocol at any time without prior written notice and in compliance with Administrative Policy: Policy and Procedure Structure, Standards and Management.

7. References


D. National Institutes of Health Consensus Development Conference


8. Protocol Development and Approval

Document Owner: ____________________________________________

Writer(s) (formerly Author): ________________________________

Reviewer(s): _____________________________________________

Approver: _______________________________________________

9. Keywords

No set
Policies and Procedures for Skin-to-Skin After a Cesarean Section

Brookings Health System
South Dakota

Procedure for our cesarean section patients are as follows:

- We have an RN go to the OR with the patient. Her only job is to care for infant in the delivery room, recovery room, and transfer to the floor.
- This nurse assists with skin-to-skin as soon as mother and baby are stable after delivery. Most babies go directly to mother after a two minute assessment on warmer.
- Baby stays skin-to-skin as mother travels to recovery room. More often than not, even though skin-to-skin we do not see baby initiate breastfeeding until mother is in recovery room.
- The PAR nurse takes care of mother in recovery room while the OB nurse takes care of baby, assists with skin-to-skin, and gives any breastfeeding assistance as needed.
- After mother is stable and ready to be transferred to the postpartum unit, the PAR nurse and OB nurse accompany mother and baby to room per cart.
- Mother is transferred to the postpartum bed while holding baby. We have one staff member watching baby to ensure a safe transfer.
- This procedure of keeping baby and mother together in OR, PAR, and transfer to postpartum floor has made our patients very satisfied. Patients that have had a prior c/s without this process are so grateful for the change in policy.
- If the patient has a volunteer doula, the doula is welcome to come to OR with the patient. The doula continues to be a necessary support in the delivery process even if cesarean section is done.

Mother-Baby Contact in the Immediate Postpartum Period (Step 4)

1. Mother and newborn couples, unless infant or mother is unstable, and regardless of feeding preference, will be:
   a. Offered skin-to-skin (STS) contact immediately after birth for at least an hour.
   i. Definition of skin-to-skin contact or skin-to-skin care refers to contact between the newborn infant and its mother (although in the case of incapacitation of the mother, another adult such as the baby’s father or grandparent may hold the baby skin-to-skin). Baby should be placed naked against mother’s naked ventral surface. The baby may wear a diaper and/or hat, but no other clothing should be between the mother’s and baby’s bodies.
   ii. Documentation of STS contact will be placed in infant’s EMR.
   iii. All mothers of cesarean section delivery should be given their infant to hold STS as soon as the mother is safely able to hold and respond to her baby.
b. Routine newborn procedures are postponed until after the first feed during the initial period of STS contact, and should be conducted, when feasible, at the mother’s bedside.

c. Routine assessments are performed while infant STS contact with mother.

d. Implementation of newborn procedures
   1. Infant dried and placed skin-to-skin prone on mother’s chest
   2. Infant covered with warm, dry blanket
   3. May suction if necessary while in STS
   4. Assess and assign APGARS
   5. Replace damp blankets as needed
   6. STS contact begins immediately after birth and continues for at least 1 hour.
   7. Newborn Vitamin K and prophylactic eye antibiotic to prevent ophthalmia neonatorum may be delayed for the first hour of birth to allow uninterrupted mother-infant contact and breastfeeding. (ABM Clinical Protocol #5, pg 130)

e. Delivery and/or nursery nurse will offer assistance to assess baby’s readiness for feeding within one hour of birth.

f. STS contact will continue, uninterrupted, until baby completes the first feeding.

g. If STS contact is interrupted for clinical reasons, it should be resumed as soon as mother and infant are able.

2. Mothers whose babies are being cared for in the nursery due to acute care needs:

   a. Acutely ill infants being cared for in the nursery will be placed STS with their mother when clinically stable.
   
   b. Mothers will be encouraged to remain with their baby as much as feasible.
   
   c. Frequent STS contact will be encouraged.
   
   d. Mothers will be educated and assisted with breastfeeding when infant is clinically stable to nurse.
Appendix B
ICEA Position Papers
The International Childbirth Education Association (ICEA) recognizes that birth is a unique and synergistic process between mother and fetus. While the use of technology in maternity care worldwide increases, maternal/infant morbidity/mortality rates have not shown significant improvements. ICEA defines physiologic birth as a birth where the baby is birthed vaginally following a labor which has not been modified by medical interventions.

Introduction
Whereas comparisons of maternal/infant morbidity and mortality rates between countries requires caution due to different risk factors, there is consensus that childbirth is a safe and natural human event. Currently, there is confusion and disagreement on the definitional differences between “normal birth”, “natural birth” and “childbirth”. It is the purpose of this position paper to identify the parameters of healthy, safe, normal human physiologic childbirth.

Many entities have contributed to a definition of physiologic birth. The World Health Organization (WHO) defines birth as “spontaneous in onset, low-risk at the start of labour and remaining so throughout labour and delivery. The infant is born spontaneously in the vertex position between 37 and 42 completed weeks of pregnancy. After birth, mother and infant are in good condition.”

The Society of Obstetricians and Gynaecologists of Canada (SOGC) include six recommendations for SOGC and its partners regarding maternity health care. These include development of national practice guidelines on normal childbirth; development of interdisciplinary committees to implement standardized unit policies on normal childbirth; promotion among childbirth educators and maternity care providers of knowledge about and experience with the birth process and evidence-based practices so that women and families can be informed about normal birth; promote expert knowledge and skills in normal childbirth among health care practitioners/professionals providing intrapartum care; and creation of collaborative education opportunities on normal childbirth for maternity care providers (Society of Obstetricians and Gynaecologists of Canada/AWHONN Canada, et al., 2008).

The 2012 consensus statement (Albers, Sedler, Bedrick, Teaf, & Peralta, 2006) issued by the American College of Nurse-Midwives (ACNM), the Midwives Alliance of North America (MANA) and the National Association of Certified Professional Midwives (NACPM) defines birth as a compilation of the three stages of labor, the newborn transition and the first hour after birth. The consensus statement goes further to identify the characteristics of a normal physiologic childbirth.

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Normal Physiologic Childbirth

- is characterized by spontaneous onset and progression of labor;
- includes biological and psychological conditions that promote effective labor;
- results in the vaginal birth of the infant and placenta;
- results in physiological blood loss;
- facilitates optimal newborn transition through skin-to-skin contact and keeping the mother and infant together during the postpartum period; and
- supports early initiation of breastfeeding.

Based upon the above criteria, it is also logical to extrapolate that normal physiologic birth is one that is without interference, complications and in line with normal body functions (World Health Organization, 1996).

Factors Influencing Physiologic Birth

For most women, physiologic birth is an achievable outcome of pregnancy. The mother’s health status and education are two of the most important factors.

A mother’s complicated health history and/or pregnancy may warrant interference with the normal physiologic process in order to improve health outcomes for the woman or baby. A mother’s confidence, autonomy, and personal knowledge surrounding labor and birth may be directly influenced by the amount of education she has prior to the birth. Access to a primary maternity care provider skilled in physiologic care, attendance at a childbirth education class that is focused on normal physiologic birth, as well as individual education (reading and internet exploration) impacts the informed decision-making process.

As previously mentioned, access to a collaborative health care team is an important factor influencing normal physiologic birth. Care providers need the education, knowledge and skill to support physiologic labor and birth as well as an infrastructure supportive to physiologic birth (Society of Obstetricians and Gynaecologists of Canada/AWHONN Canada, et al., 2008). Goer and Romano define physiologic care as the use of supportive care practices and low-technology techniques that facilitate the normal biological process of birth. It comprises optimal care for healthy women experiencing uncomplicated labor (Dixon, Fullerton, & Begley, et al., 2011).

Benefits of Physiologic Birth

Birth without medical intervention may have many benefits (Romano & Lothian, 2008). The following are some that have been suggested by writers on the subject:

- less postpartum pain;
- quicker physical recovery from the birth;
- increase in self-esteem as a result of the birth;
- enhanced bonding with the baby;
- reduced likelihood of post-natal depression;
- a calmer, more settled baby;
- an easier breastfeeding experience;
- effective respiratory transition for the baby; and
- more effective gut colonization that prevents allergies in the baby.

Additional benefits of physiologic birth include a reduction in genital tract trauma/need for suturing (Albers, Sedler, Bedrick, Teaf, & Peralta, 2006) as well as triggering the production of certain proteins in a newborns’ brain that may improve brain development (Dominguez-Bello, et al., 2010).

Supporting Physiologic Birth

Entities such as the Queensland (Australia) Government’s Maternity and Neonatal Clinical Guideline (Queensland Maternity and Neonatal Clinical Guidelines Program Statewide Maternity and Neonatal Clinical Network, 2012) provide guidelines for supporting a normal physiologic birth. These guidelines include a positive philosophy of care, clear communication,
continuity of care programs, providing continuous support, one-to-one midwifery care, providing a suitable environment for birth, maintaining the minimal level of intervention which is compatible with safety, freedom of movement, food and fluid intake, and enabling the woman’s choice of positions during labor and pushing.

Intervening in a normal physiologic birth process, where there are no complications, increases the risk of complications for the mother and her baby. Six evidence-based care practices that promote physiologic birth were created by Lamaze International and outline changes in labor care: avoiding medically unnecessary induction of labor, allowing freedom of movement for the laboring woman, providing continuous labor support, avoiding routine interventions and restrictions, encouraging spontaneous pushing in non-supine positions, and keeping mothers and babies together after birth without restrictions on breastfeeding (Lamaze International, 2009).

Therefore, a collaborative effort between expectant parents and care providers places the woman at the center of her care in physiologic birth care. That is, the mother and baby form a dyad and all subsequent decisions take both mother and baby into account (Goer & Romano, 2012; See ICEA FCMC Position Paper 2013). To facilitate this collaboration is the childbirth educator, providing evidence-based information and teaching techniques to prepare parents for a physiologic birth experience.

Implications for Practice

Physiologic birth is evidence-based and optimal care for mothers and babies.

Expectant parents can optimize their chances for a physiologic birth by becoming educated in childbirth education classes with the latest research (Zwelling, 2008). Women need to be aware of the benefits to mothers and babies of physiologic birth as well as the risks of interventions.

Childbirth educators may act as advocates for and promote the research on physiologic birth in their classes, hospital in-service education, conferences/meetings and through social media. Our teaching should not only reflect current evidence-based information but also the concept of best practice. Informed decision making must be at the forefront of our presentation of physiologic childbirth. The goals of prenatal (childbirth) education are to build women’s confidence in their own ability to give birth, to provide knowledge about normal birth, and to help women develop individualized birth plans that provide a road map for keeping birth as normal as possible even if complications occur (Kavanagh, et al., 2012).

Providing positive sources of media information, such as television shows or web information, can assist expectant parents in their quest for knowledge. Referrals to such out-of-classroom materials become necessary especially when limitations are placed on the dissemination of class information.

Maternity care providers can become knowledgeable about the physiology of, and skilled in coping techniques that facilitate physiologic birth. Nurses can evaluate their personal philosophies about childbirth and become advocates for childbirth education classes and doula support (Zwelling, 2008). Keeping policies, procedures and practice guidelines updated and evidence-based also contributes to an environment that honors and facilitates normal physiologic birth.

References


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ICEA Position Paper

Comfort Measures

Position

The laboring woman’s perception of labor events and her response is a priority concern for healthcare professionals. Labor management to include the promotion of comfort measures must be available to all laboring women within an evidence-based practice. All practice that facilitates comfort measures as non-medical therapies should be deeply seeded in sound scientific knowledge. Risk factors for application or ingestion of chemicals or herbal products are unwelcome in an evidence-based practice setting. In keeping with a family centered maternity care philosophy, and in recognition of the client-centered bill of rights, healthcare organizations support the utilization of comfort measures in labor. It is recognized that they contribute to a holistic approach to care. Informed decision making is magnified as a focal point in childbirth education programs. Supplementing a woman’s knowledge and understanding of the importance of comfort measures in labor is pivotal role for the Childbirth Educator (ICEA, 2013; Simkin, 2007).

Introduction

Comfort measures are those actions a laboring woman initiates or requests to facilitate positive reactions, responses, and or emotions during labor and delivery. Her sense of smell, touch, taste, and sound are supported by comfort measures in labor. Acupuncture aromatherapy, freedom of movement, hydration and sustenance, hydrotherapy, massage and therapeutic touch, music and song, and support are commonly used comfort measures. Comfort measures help laboring women maintain control of her labor progress. Contrast to medical interventions, comfort measures and complementary therapies are gaining recognition (Briggs, 2012; Roman, 2012; Wagner, 2012).

A supportive partner and empathetic healthcare team work in concert to energize the laboring woman. Their united efforts enhance her sense of wellbeing within a safe therapeutic milieu. The woman and her partner can be assisted during marked periods of stress by a Doula or Montrice. Comfort measures are implemented based on the woman’s expressed desires as she adjusts and adapts to her labor process.

The Childbirth Educator facilitates knowledge and understanding of comfort measures, their advantages, disadvantages, and potential for adverse effects. All information provided should be designed with focused attention on healthcare literacy skills. The role of the Educator advances the philosophy of ICEA in recognition of “…the pregnant woman’s right to make informed choices based on knowledge of benefits, risks, and alternatives…” (ICEA, 2013).”

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Comfort Measures

Acupuncture

An ancient remedy for a long list of ailments and disease processes. Primarily used in Asian cultures, the practice is gaining world-wide acceptance and has been incorporated in maternity settings to alleviate some discomforts of pregnancy. As reported by Wilson & Wilson, (2012), the use of acupuncture in labor and delivery has not been supported by a large number of large scale research studies. These authors report that although there is a limited amount of scientific evidence to support its practice it is “…a safe intervention in labor, and we need more options for pain management that do not increase risk for the mother or baby (Wilson & Wilson, 2012, p.50). The role of the Childbirth Educator is to “…provide accurate and factual information based on current research (ICEA, 2013).”

Aromatherapy

The sense of smell is one of the most affective mechanisms for those experiencing distress. Some women in labor who experience the fight or flight response to the stress of labor benefit from the pleasing aroma of an essential oil. The olfactory nerve transmits calming signals in response to scents such as lavender and sweet almond. Aromatherapy can initiate a sense of wellbeing by creating a calm and relaxing environment. Smith (2012) reports that additional research is needed to substantiate the efficacy of the use of aromatherapy in labor. This author’s report provides a wellresearched and referenced article for Childbirth Educators to access in preparation for “…determining content and teaching strategies…” related to aromatherapy (Smith, 2012).

Freedom of Movement, Therapeutic Touch and Massage

When the laboring woman has freedom of movement her sense of balance and homeostasis is maintained. Muscle strength and stability is realized as she stretches in preparation for the delivery process (Adams, 2012). In their randomized trial, Silva Gallo, Santana, Jorge Ferreira, Marcolin, Polineto, Duarte, & Quintana, (2013) found that a 30 minute lumbar massage reduced pain in labor.

Effleurage, a light touch and massaging like movement over the pregnant abdomen is a comfort measure that is frequently practiced by many women without conscious effort. This movement sends signals to nerve endings on the surface of the skin initiating a sensation of comfort and relief. Exteroceptors are close to the body surface and are specialized to detect sensory information from the external environment (such as visual, olfactory, gustatory, auditory, and tactile stimuli). Receptors in this class are sensitive to touch (light stimulation of the skin surface), pressure (stimulation of receptors in the deep layers of the skin, or deeper parts of the body), temperature, pain, and vibration. Nerve endings known as proprioception function within a neuroanatomical structure that conveys information from the muscular skeletal system to the central nervous system (Patestas, & Gartner, 2013).

Hydration and Sustenance

Labor and delivery requires an energy store to sustain the powers of labor and delivery. Assessment of thirst, adequate fluid intake, skin turgor, edema, and urination are indicators of hydration, vascularity, and circulation. Women who choose to drink fluids like water, juices, and herbal teas are acting in recognition of their knowledge gleaned from prepared childbirth education classes. Maintenance of her electrolyte balance is essential to uterine muscle contractility, blood pressure regulation, and maternal-fetal-placental circulation. Small light meals may be requested to provide the needed calories to fuel and sustain oxygenation and cellular metabolism (McCance, Huether, 2006; Tyree, Baker, & Weatherspoon, 2012).

In a national review of midwifery practices pertaining to the use of herbal preparations for labor augmentation, induction, and cervical ripening, the authors McFarlin, Gibson, O’Rear, and Harman reported that herbal remedies were preferred for their “natural” effects. Three questionnaires were excluded due to incomplete data or blank questionnaires. No significant differences were noted in relations to geographical region, midwifery education, or highest level of ed-

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ucation between the CNM respondents who did and those who did not use alternative methods to stimulate labor. Of the CNMs who used herbal preparations to stimulate labor, 64% used blue cohosh, 45% used black cohosh, 63% used red raspberry leaf, 93% used castor oil, and 60% used evening primrose oil. CNMs who used herbal preparations to stimulate labor were younger (43 versus 45 years, P < .01) and more likely to deliver at home or in an in-hospital or out-of-hospital birthing center (P < .0006), than CNMs who never used herbal preparations to stimulate labor (McFarlin, Gibson, O’Rear, and Harman, 1999, p. 205).

The Childbirth Educator informs about the risks associated with some herbal preparations as found in a variety of beverages marketed as homeopathic remedies. Risks can be associated with uterine overstimulation, rupture, or birth defects. An advantage to some herbal beverages is their mineral content needed for muscle fiber contractility and the immune response. Research and documentation to support safe decision making about the use of herbal remedies during labor is available on the National Institute of Health website (NIH, 2013).

“Herbs with the potential to cause uterine stimulation and miscarriage are blue and black cohosh, feverfew, aloe, ephedra, Epsom salts, and Chinese tea rose” (Harris, 2012, p. 95). “While homeopathic remedies are frequently confused with herbs, they are different in their legal status and side effects. Herbs are categorized by the U.S. FDA as a food product, while homeopathic remedies are categorized by the U.S. FDA under the Homeopathic Pharmacopoeia of the U.S. (HPUS)” (Zimmerman, 2012, p. 20).

**Hydrotherapy**

Immersion in a warm water bath during labor is reported by many women as an experience that releases the sensations of pain and pressure in the abdomen and pelvis. As reported by Cluett, Nikodem, McCandlish, & Burns, 2009 in the Cochrane review…, “Women who used water immersion during the first stage of labour reported statistically significantly less pain than those not labouring in water (40/59 versus 55/61) (OR 0.23, 95% CI 0.08 to 0.63, one trial).”

**Music and Song**

Most women in labor will incorporate one or two comfort measures at the same time. They will perform effleurage while moving about freely, slowly swaying back and forth to enhance gravity’s force upon fetal descent. Music, song, and dance are three practices akin to cultural celebration, a time to welcome a change. A research study conducted in Western Iran reported the differences between laboring woman in regard to pain relief while exposed to either massage or music therapy. The researchers reported that of a population of 101 first time mothers who were randomly stratified into two groups a significant difference (p=0.001) was observed in terms of pain severity after the initiation of (music, n=50) or (massage, n=51) therapies. The women in the massage group reported the lowest pain levels. A small sample size and the only statistical reference is to a (p level) limit the generalizability of this study (Taghinejad, Delpisheh, Suhrabi, 2011).

**Support from a Doula or Monitrice**

The ICEA (2013) philosophy encourages all Educators to recognize that collaborative efforts within family-centered care are essential to promote the health and wellbeing of the laboring women. The practice setting for the Childbirth Educator is one that provides for the “…encouragement for the optional participation of labor support person(s) of the woman’s choice…” The authors of a Cochrane review on the significance of support of women in labor found that of 15,061 women who were enrolled in the study those who received continuous support among other things, were more likely to deliver vaginally (RR 1.08, 95% CI 1.04 to 1.12), shorter labors (mean difference -0.58 hours, 95% CI -0.86 to -0.30), and less medical intervention (Hodnett, Gates, Hofmeyr, Sakala, Weston, 2011).

**Implications for Practice**

Comfort measures are incorporated in childbirth education classes to emphasize the significance of support, healthcare provider assistance, and self-regulation of labor discomfort, anxiousness, and pain.

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Comfort measures may be used in combination with medical interventions to enhance and facilitate rest and relaxation. They (comfort measures) are used to help laboring women to conserve energy and to decrease or eliminate anxiety, fear, and painful sensations.

As childbirth educators, it is important that class participants are informed about comfort measures from an evidence-based research practice that includes both risk and benefits associated with acupuncture, aromatherapy, hydration and sustenance, freedom of movement, therapeutic touch, and massage, music and song, and the support from a doula or Montrice. ICEA childbirth educators teach to inform pregnant women and their partners; teach to inform and to increase knowledge and understanding of alternatives within the ICEA’s philosophy of family-centered maternity care.

References


ICEA Position Paper

Pain in Labor

Position

The International Childbirth Education Association (ICEA) takes the position that client-centered care of women experiencing pain during labor and delivery emphasizes informed decision making about pain relief and management strategies. The ultimate choice resides with the individual. Her decision must be based on a thorough understanding of the advantages, disadvantages, risk, and benefits as they relate to her health and that of her fetus. Information pertaining to pain should be made available to her in writing and verbal instruction during childbirth education sessions. Childbirth Educators recognize that the neuro-anatomy and physiology of pain is complex. All instruction should be designed with focused attention on healthcare literacy.

Introduction

The laboring woman’s perception and response to pain during labor and delivery is a priority concern for healthcare professionals and childbearing families. Pain management and pain relief must be provided to all laboring women within an evidence-based practice. All practice that facilitates medical and nonmedical pain management should be deeply seeded in sound scientific knowledge. In keeping with a family centered maternity care philosophy, and in recognition of the client-centered bill of rights, several prestigious healthcare organizations have conducted extensive research to support and inform a woman’s decision to utilize a combination of pain management options (ICEA, 2013).

Pain experienced during labor and delivery is an intermittent physical sensation originating from uterine muscle contractions, fetal descent, pressure of the fetus on nerve pathways, and the healing process of postpartum (Goodard, 1962; Helms & Barone, 2008; Jangsten, Bergh, Mattsson, Lars-Ake, Hellstrom, Berg, 2011; Loudermilk, 2011; Maguire, 2008; Walsh, 2007). It is perceived by most women as an acute sensation ranging from mild to extreme in intensity. According to the International Association for the Study of Pain (IASP), pain is defined as: “An unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage (IASP, 2013).” Labor pain sensations arise from somatic and visceral nerve pathways that innervate the uterine muscle, pelvic, lumbar, and sacral vertebrae during intermittent uterine contractions. Tissue damage can result from pressure, oxygen deprivation (ischemia), uterine muscle rupture, vascular insufficiency, perineal lacerations and infection (Lawrence, Fullilove, Borders, Manocchio, Albers, & Rogers, 2009). Damage from these events may generate a painful inflammatory response that travels through muscle fibers, connective tissue, ligaments, and the integumentary surrounding the thoracic, lumbar, and sacral regions (T10-S4) (McCance & Huether, 2007). In addition to the physical sensation some women acknowledge that cultural, psychological, spiritual and environmental factors influence their pain tolerance and response (Green, 2012; McNeil & Jomeen, 2010; Talbot, 2012). (T10-S4) (McCance & Huether, 2007).
Origin of Pain

Physical pain in labor is related to intermittent uterine contraction, fetal position and descent, pelvic floor distension, and the healing processes of postpartum. The psychological component to pain in labor is intertwined within the neuroendocrine complex. Factors associated with nutrition, muscle strength, the pelvic structure, ligaments, soft tissue, and the peripheral, autonomic, and central nerve pathways are instrumental in the development of pain in labor. In combination, all of these factors are activated and provide the signals and responses to help women describe and characterize their pain.

The central nervous system (CNS) consists of the brain and spinal cord, enclosed within the protective cranial vault and vertebrae, respectively. The peripheral nervous system (PNS) is composed of the cranial nerves, which project from the brain and pass through foramina (openings in the skull, and the spinal nerves, which project from the spinal cord and pass through intervertebral foramina of the vertebrae. Clinically, the PNS can be divided into the somatic nervous system and the autonomic nervous system. The somatic nervous system consists of motor and sensory pathways regulating voluntary motor control of skeletal muscle. The autonomic nervous system (ANS) also consists of motor and sensory components and is involved with regulation of the body’s internal environment (viscera) through involuntary control of organ systems (McCance, Huether, 2006, p. 411-412).

Pain Classifications

Pain is classified as either nociceptive or neuropathic. Nociceptive pain results from tissue, muscle, or bone injury. It is labeled as visceral and/or somatic with sensations described as dull, aching, burning, stretching, or throbbing. Nociceptive pain is generally transmitted via myelinated nerve fibers. Nerve fibers that are myelinated have a protective or insulating coating that enables rapid transmission and response to pain. (Bergstrom, Man, Sadosky, Parsons, Schaefer, Baik, et al., 2012; IASP, 2013; Polamaro, Buckenmaier, Galloway, & Kerns, 2012).

Neuropathic pain occurs when nerve, vascular, and/or tissue damage has been inflicted. It can be chronic when conditions such as numbness, tingling, and burning, three descriptors for peripheral neuropathy are present. Glutamate and Gamma-aminobutyric acid (GABA) two chemical mediators found in the nervous system contribute to neuropathic pain perception. Glutamate is excitotoxic. It is released when the nerve pathways are over stimulated. Over stimulation of nerve fibers can result in damage operationalized as a burned-out state (Moore, Costello, Wieczorek, Shah, Taddio, & Carvalho, 2011; Stahl, 2008, p. 274). The neurotransmitter (GABA) has a role that is to quiet nerve excitability while its anxiolytic actions assist in the psychological response to pain. Pain is a warning signal and should not be ignored.

Pathologic pain is a warning sign. It can advise against complications of pregnancy, labor and delivery. Uterine rupture, placenta abruption, deep vein thrombosis (DVT), perineal hematoma, amniotic fluid embolism, and pulmonary embolism have painful indicators leading to further investigation and anticipation of serious consequences. Subtle signs such as acute onset of panic, chest pain, shortness of breath, and leg cramps inform about amniotic fluid embolism or pulmonary embolism. Severe, sharp knife-like stabbing sensations in the abdomen direct the mother and care provider toward potentially catastrophic conditions such as placental abruption and or uterine rupture. Pitocin, a synthetic form of oxytocin when used to augment labor contractions can increase risk for uterine complications (Beilin, Mungall, Hassain, & Bodian, 2009; Zhang, Branch, Ramirez, Laughon, Reddy, Hoffman, et al., 2011). Painful sensations described as excruciating, unrelenting, and horrible throbbing have been related to perineal hematoma (Distefano, Casarella, Amoroso, DiStasi, Scambia, & Traneano, 2013; Esker, Salt, Kitzsimmons, & MacGillivray, 2012; Pallais, Blake, & Dishpande, 2012; Tamagawa, & Weaver, 2012).

Understanding the differences between visceral and somatic pain helps the woman identify the location and describe the severity of conditions associated with painful sensations in labor. Prior to the onset of labor women are encouraged to recognize intuitive factors and cultural heritage as they contribute to pain responses in labor. (Green, 2012).

Physical Pain Response: Visceral Pain

Early in the labor process, pain arises primarily from the internal organs within the abdominal and pelvic cavities. It can radiate to other areas and be referred along a complex network of nerve pathways.

Painful sensations felt in these areas transit within unmyleinated nerve fibers. Sensations traveling these routes are slower than those in myelinated fibers. During the first stage of labor, intermittent uterine contractions become regular and increase in frequency, intensity, and duration. The uterine muscle fibers stretch and relax, the cervix effaces and dilates and an inflammatory response is triggered as small blood vessels innervating the lining of the vaginal and cervical walls rupture.

The inflammatory response activates chemical and mechanical mediators generating a surge of elements that initiate the tissue repair process. (Duggal, Mercado, Daniels, Bujor, Caugghey, El-Sayed, 2008; Jonsson, Ellafi, Rudhstrom, & Herbst, 2008; Landy, Laughon, Bailit, Kominiarek, Gonz-
Somatic Pain

Somatic pain in labor originates from “connective tissue, muscle, bone, and skin” and is frequently described as a sharp pain that has an obvious and easily identified origin. This type of painful sensation is related to nociception impulses that are transmitted along A-delta nerve fibers. These fibers transmit sensation generating a fast response along peripheral nervous system tracts. Generally experienced during the second stage of labor, somatic pain is the result of ligament stretching, and cartilage and bone relaxation. The inflammatory response related to electrolyte fluctuations and vascular changes are also initiated as painful sensations are transmitted along the pudendal and perinatal nerve pathways in the lower sacral region (S2-S4). Nociception impulses that are transmitted along A-delta nerve fibers. These fibers transmit sensation generating a fast response along peripheral nervous system tracts. Generally experienced during the second stage of labor, somatic pain is the result of ligament stretching, and cartilage and bone relaxation. The inflammatory response related to electrolyte fluctuations and vascular changes are also initiated as painful sensations are transmitted along the pudendal and perinatal nerve pathways in the lower sacral region (S2-S4). The effect of hormone and electrolyte fluctuation increases bone, muscle, and vascular activity. The hormone relaxin facilitates loosening of collagen fibers in the pelvis to accommodate fetal engagement and descent. The effects of relaxin can result in pelvic re-alignment along nerve pathways in the lumbar and sacral regions (Kelly, Shelton, & Davidson, 2001; Soh, Tiwari, Mahendroo, Conrad, & Perry, 2012; Teichman, Unemori, Teerlink, Cotter, & Metra, 2012). These pathways send painful signals from the peripheral nervous system to the central nervous system. In some women, sciatic pain may be a result of pelvic re-alignment.

The risk for ischemic muscle pain is reduced as estrogen levels fluctuate while increasing vascularity and oxygenated blood flood. Simultaneously decreasing progesterone levels increase excitability of the uterine muscle. (Genazzani, Stomati, Fernardi, Monteleone, Casarosa, Gallo, & Salvestroni, 2000).

Regulation of the electrolytes calcium, magnesium, sodium, potassium, and chloride facilitate muscle contractility, frequency, and intensity of uterine pain. Maintaining hormonal and electrolyte balance in labor and delivery is a basic technique utilized by women to reduce painful sensations in labor. Oxygenation, adequate hydration and calorie consumption prior to and during the stages of labor are essential to nourish the regularity in muscle fiber contractility and progress in labor (Weatherspoon, 2011).

Somatic pain in the soft tissue of the perineum has been investigated by Leeman, Fullilove, Borders, Manocchio, Albers, and Rogers, (2009). Their findings indicate that explosive forceful delivery, through lacerations, and or the use of instrumentation for fetal head rotation are three factors contributing to major perineal trauma. In their study, the painful sensations associated with these three factors were described and rated on a Likert scale. “When women were dischotomized into groups with no or mild pain versus discomforting, distressing, or horrible pain on the Likert scale, discomforting perineal pain was associated with the presence of major perineal trauma versus minor or no trauma. (55% vs 35%, p <0.001) (p.286).” This descriptor was reported as the painful sensation at the time of hospital discharge. Childbirth educators instruct pregnant women about the causes, locations, and the various types of pain associated with labor and delivery. Their instruction provides for anticipation of painful sensations and contributes to informed decision when pain management techniques are indicated. (Green, 2012). % vs 35%, p <0.001 (p.286)."

Psychological Pain Response

Pain in labor is not limited to physical sensation. Psychological pain can be manifested in fear, anxiety, and panic. (Simkin, 2011; Stahl, 2008). These emotional responses to pain can be triggered by the connectivity within the endocrine, nervous, and reproductive systems. They can also be the result of lack of preparation, knowledge, and understanding of the birth process. Childbirth Educators teach that a complete pain assessment begins with recognition that both physical and psychological factors are indicated. The educator along with all healthcare providers recognizes that multiple factors impact the perception of pain. The perception of pain is experienced in association with cultural, spiritual, developmental and environmental factors. Encouraging the pregnant woman to examine these factors in responses to pain is a
The perception of pain and behavioral responses originate in various regions of the brain. The cortex, along with the neurotransmitters, serotonin, dopamine, norepinephrine, and acetylcholine contribute to the woman’s ability to perceive and remember pain (Stahl, 2008). These brain regions and specific functions within the amygdala, hippocampus, and the limbic system contribute to anxiety, fear, and panic. Influencing factors that trigger these emotions are the integration of endocrine, nervous, immune, and vascular systems (Haines, Rubertsson, Palant, & Hildingsson, 2012; Kalin, Shelton, & Davidson, 2004). Prolonged exposure to painful stimuli induces the stress response and activates the hypothalamic, pituitary adrenal axis (HPA) whereby stress hormones are released. The release of catecholamines, oxytocin, and cortisol amplify the cycle of pain and stress (Friedrich, 2013; Godfrey, 2005; Khajehei & Doherty, 2012; Zang, Branch, Ramirez, Laughlon, Reddy, Hoffman, et al. 2011). Influencing factors that trigger these emotions are the integration of endocrine, nervous, immune, and vascular systems (Haines, Rubertsson, Palant, & Hildingsson, 2012; Kalin, Shelton, & Davidson, 2004).

Psychological responses frequently triggered when the fear of the unknown is coupled with painful sensations. These responses can be manifested as the woman’s pain threshold is reached without the administration of adequate and timely pain relief mechanisms. Perceiving pain in labor as a condition to “endure” may have cultural significance (Gitahun, Yeshi, & Roberts, 2012; Green 2012; van der Westhuizen, 2011). Assisting the pregnant women to be able to interpret their pain tolerance based on prior experiences is one method that the educator can incorporate into childbirth education classes to increase knowledge and the ability to recognize when pain control mechanisms are indicated. Recognizing and understanding the significance of neuroanatomical and physiologic factors increases the Childbirth Educator’s ability to teach about the difference between physical and psychological pain during the stages of labor. The origin of pain in labor involves a highly complex interconnected network of anatomical and physiologic structures and functions (Melzack, 1987; Melzack & Wall, 1965; Zhang, Troendle, Mikolajczyk, Sundaram, beaver, & Frazer, 2010).

Theoretical Perspective

The theoretical assumptions and scientific rational attributed to the Gate Control Theory (Melzack and Wall, 1965) is introduced early in Childbirth Education classes. Although since its first introduction by the Gate Control Theory has been challenged by some healthcare professionals. Additional work completed by Melzack has contributed to greater understanding of the propositions and perspective (Melzack, 1987). Many women who are taught and understand the theoretical assumptions and the scientific rational are empowered through their knowledge. They are prepared to anticipate and adapt to painful sensations in labor with the belief that they can regulate pain impulses and block, or “close the gate” to ascending central nervous system pathways. Confidence in their ability to control painful sensations and to regulate responses is paramount to their success from a mind-body perspective. (Mishra, Singh, & Singh, 2012; Peng, 2012; Weatherspoon, 2011). Many pregnant women accept that pain medication is an option but that dynamic physiologic mechanisms within a woman’s physical and psychological control can modulate her pain response. When incorporated into a daily routine, breathing and relaxation techniques can assist with decreasing pain in labor. In addition, many women believe that their mind-body connection and response to pain are controlled by metaphysical or spiritual aspects of her life. Knowledge of alternative pain management techniques and the freedom to choose in collaboration with healthcare providers is fundamental to ICEA’s mission, vision, and philosophy. (ICEA, 2013). control can modulate her pain response. When incorporated into a daily routine, breathing and relaxation techniques can assist with decreasing pain in labor. In addition, many women believe that their mind-body connection and response to pain are controlled by metaphysical or spiritual aspects of her life. Knowledge of alternative pain management techniques and the freedom to choose in collaboration with healthcare providers is fundamental to ICEA’s mission, vision, and philosophy. (ICEA, 2013).

Learned responses to pain are stored in the memory regions of the hippocampus and recalled when similar experiences, smells, sounds, and timing, are recognized. Similarity environmental conditions surrounding painful experiences can generate negative pain reactions. Gazellig a concept germane to Dutch culture is described as an environment that is “cozy” or conducive to relaxation and well-being. When routinely practiced, women who have incorporated relaxation techniques in a hospitable environment claim to maintain greater control. Aerobic exercise, yoga, acupuncture, massage, and a variety of other non-medical interventions to include creating an environment conducive to calm, can activate endogenous opiates. Endogenous opiates are inhibitory neurotransmitters located in the hypothala-
Implications for Practice

The goals of the certified childbirth educator are to promote and facilitate client centered care by providing knowledge and promoting understanding of pain in labor. Client centered care, enforced by the client's bill of rights, is the standard of care in the classroom and delivery setting. Educator goals are to inform clients about the origin of pain how it is defined, described, characterized, and classified. Many women and their partners lack the knowledge and understanding of how nerve impulses, brain chemistry, hormones, and inflammatory processes influence the pain response. An educational goal is to ensure information about pain in labor, and influencing factors are provided. Facilitating the client's knowledge base is maximized within a therapeutic relationship that emphasizes open and honest communication.

The Childbirth Educator informs the pregnant women and her partner about the anatomical, physiological, psychological, cultural, and spiritual aspects of pain in labor. The Educator teaches that the pain process is complex and is managed as a team effort while maximizing the woman's control of her labor process. The healthcare team ensures that the mother is at the center of the care plan and facilitates positive labor and birth outcomes within a family centered maternity care system. “An individual treatment plan that focuses on both the psychological and physical components is necessary” (Buttar, Trybulski, Bailey, & Sandberg-Cook, 2008, p. 81).

The Childbirth Educator facilitates understanding and empowers the pregnant women to communicate all aspects of her pain. They are encouraged to actively participate in their client-focused assessment therefore, contributing to a more accurate pain management plan (Hassett, Wasserman, Goeling, Rakovits, Boorang, & Brummet, 2012). “Pain is often managed inadequately because of poor clinical assessment” (Buttar, Trybulski, Bailey, & Sandberg-Cook, 2008, p. 81). Persistent low back pain in the postpartum period was found to have a multifactorial origin in research studies. “It has been recommended that pain should be analyzed from a biopsychosocial perspective. Pain is not merely a specific condition but is a complex perceptual experience that involves, sensory, and cognitive components” (Olsson, Groolen, Nilsson-Wikmar, Harms-Ringdahl, and Lundberg, 2012, p. 49).

References


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ICEA Position Paper

Water Labor & Water Birth

Position

It is well established in the research that maternal relaxation during labor may reduce the perception of pain, shorten the phases of labor and may reduce the need for medical interventions such as analgesia and anesthesia. The International Childbirth Education Association (ICEA) believes that for those women whose pregnancies are low-risk and where water immersion is not contraindicated, water labor and water birth may provide an environment for a gentle, physiologic birth.

Background

In nearly every culture, water signifies peace, calm and relaxation. From ancient times to the present, humans have used a warm bath to ease tension, quiet aching muscles and relieve pain. The therapeutic use of water, also called hydrotherapy, during labor and birth is also not new. Historically, Japanese women made use of warm labor pools to reduce labor pains and British midwives use warm water as a source of pain relief. France was the site of the first recorded waterbirth in 1805, however several individuals such as Igor Charkovsky, Dr. Michel Odent, Dr. Michael Rosenthal, and Dr. Grantly Dick-Read introduced it officially in Russia, France, England and the US respectively (Avery, 2013; Sprague, 2011). Odent published his results of the first hundred waterbirths in the Lancet in 1983. His findings were that anxiety and pain trigger a stress response that leads to a reduction in uterine activity. Laboring in water could overcome this stress response by aiding relaxation, increasing endorphin release and reducing the perception of pain (Mollamahmutoglu, 2012).

Review of the Literature

Hydrotherapy expert Michel Odent outlined his research at the maternity unit at Pithiviers, recording a definite change in labor contractions after immersion – sometimes before immersion. This lead Odent and his staff to believe that hydrotherapy not only actually worked, but the anticipatory feelings of pain relief may also release endorphins (Sprague, 2011). This may be the cause of the prominent benefit of birth satisfaction seen with waterbirths (Avery, 2013).

Women who utilize hydrotherapy for labor and birth should be deeply immersed in the water to cover the belly and up to the breast. “Full immersion” promotes optimum physiologic responses, primarily the stimulation of oxytocin and vasopressin (Avery, 2013; Sprague, 2011). Entering the pool between 3-5 cm cervical dilation and staying approximately 2 hours (120 minutes) allows for optimum relaxation and labor progression. Some women who step out of the pool for 30 minutes and return, often experience enhanced dilation. Recommended temperature for the birth pool water is between 98° F and 101° F. Some resources recommend 95° F – 97.5 °F in order to

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maintain an optimal core temperature for mother and baby. A baby with hyperthermia may show signs of distress (Avery, 2013; Sprague, 2011).

**Benefits of Water Labor/Birth: Maternal**

Several studies have found significant benefits of water labor/birth for mothers. These benefits include:

- Increased satisfaction with the birth (Sprague, 2011);
- Reduction in the perception of pain (Mollamahmutoglu, 2012);
- Increased endorphin release and increased relaxation (Mollamahmutoglu, 2012; Sprague, 2011);
- Reduction in the need for pharmacologic pain relief (Cluett, 2009; Mollamahmutoglu, 2012; Sprague, 2011);
- More ease for assuming various labor/birth positions (due to buoyancy) that leads to increased functional diameter of the true pelvis (Avery, 2013; Dahlen, 2013; Mollamahmutoglu, 2012);
- Shorter first and second stage of labor due to a reduction in stress hormones and catecholamines, which inhibit oxytocin and labor progress (Cluett, 2009; Cortes, 2011; Mollamahmutoglu, 2012);
- Less perineal trauma (Dahlen, 2013; Henderson, 2014);
- Less postpartum hemorrhage (Dahlen, 2013).

**Benefits of Water Labor/Birth: Fetal**

Promotes positive maternal/infant bonding behaviors such as skin-to-skin contact (Sprague, 2011).

**Safety of Water Birth: Baby**

**Apgar Scores**

Authors of several studies have stated that there was no evidence of increased adverse effects with water labor/water birth for the newborn. There were no differences in NICU admissions or Apgar Scores (Avery, 2013; Cluett, 2009; Dahlen, 2013; Nutter, 2014; Mollamahmutoglu, 2012).

**Breathing/Drowning**

There are several factors that inhibit the baby from inhaling water during the birthing process. Barbara Harper, Director of Waterbirth International, explains the factors in this way:

“Approximately 24 to 48 hours before the onset of spontaneous labor, the fetus experiences a notable increase in the prostaglandin E2 levels from the placenta, which causes a slowing down or stopping of the fetal breathing movements (FBM). With the work of the musculature of the diaphragm and intercostal muscles suspended, there is more blood flow to vital organs, including the brain. You can see the decrease in FBM on a biophysical profile, as you normally see the fetus moving these muscles about 40% of the time. When the baby is born and the prostaglandin level is still high, the baby’s muscles for breathing simply don’t work, thus engaging the first inhibitory response. A second inhibitory response is the fact that babies are born experiencing acute hypoxia or lack of oxygen. It is a built in response to the birth process. Hypoxia causes apnea and swallowing, not breathing or gasping. If the fetus were experiencing severe and prolonged lack of oxygen, it may then gasp as soon as it was born, possibly inhaling water into the lungs. If the baby were in trouble during the labor, there would be wide variabilities noted in the fetal heart rate, usually resulting in prolonged bradycardia, which would cause the practitioner to ask the mother to leave the bath prior to the baby’s birth. The reduced temperature differential is another factor thought by many to inhibit the newborn from initiating the breathing response while in water. Finally, the reflex to begin breathing is only initiated after innervations of the trigeminal

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nerves in the face, nose and mouth are stimulated with a combination of room air and complete removal from the water. Once activated, the pulmonary circulation begins for the first time with oxygen rich blood flowing into the lungs and carbon dioxide removed” (Harper, 2012).

Cord Avulsion

Cord avulsion or snapping of the umbilical cord is a rare phenomenon but may occur during a waterbirth. During a waterbirth, there may be a strong instinct to bring the baby above the level of the water immediately after the birth. This may cause rapid cord traction with a higher tension than a land birth. Risk factors for cord avulsion in both land births and water births include cord abnormalities such as abnormal insertion of the cord into the placenta, limited length of the cord, tumors or hematomas. Cues that a cord avulsion has occurred include a sudden change in the color of the water to deep red (due to a gush of blood), sudden release of cord tension, visual confirmation of a detached cord, snapping sound as newborn is lifted from the water, and signs of neonatal hemorrhagic shock. With increased professional and parent education, the incidence of cord avulsion can be greatly reduced (Schafer, 2014).

Reduced Group B Strep

The literature demonstrates a GBS rate of 1 in 4432 for waterbirths and 1 in 1450 for land births. Theories for the rate phenomenon, according to Cohain, includes (1) inoculating the baby with mother’s intestinal flora at birth protects against GBS infection; (2) water washes off the GBS bacteria acquired during the descent through the vagina; (3) the water dilutes the GBS bacteria and mixes it with a multitude of other intestinal bacteria that compete with GBS; (4) early onset GBS is elicited by complications and interventions at birth, which occur less often at waterbirths; (5) kangaroo care at birth promotes healthy newborns; (6) GBS and antibiotic-resistant GBS are more prevalent in hospital environments, where waterbirths are not an option; (7) a higher rate of underreporting of adverse events at waterbirths compared to dry births; and/or (8) a massively successful international campaign has covered up the reporting of all deaths and disease from GBS after waterbirths. GBS is not a contraindication to waterbirth (Avery, 2013; Cohain, 2010).

Contraindications for Waterbirth

The research shows that contraindications for waterbirth include mothers desiring a VBAC (vaginal birth after a cesarean), Pitocin augmentation/induction or where telemetric EFM is not available. Maternity units may elect to add to the list of contraindications the use of analgesia or anesthesia, multi-fetal gestation, and gestational age less than 37 weeks (Avery, 2013; Harding, 2012).

Implications for Practice

According to Avery, warm water stimulates large, high-velocity afferent nerve fibers, blocking smaller, slower pain fiber impulses, thus reducing the amount of painful stimuli reaching the reticular activating system in the cerebral cortex (The Gate Control Theory). Coupled with the hydrostatic pressure decreasing muscular tension and the buoyancy of the water enabling mothers to assume optimal positions, water labor and birth are highly beneficial with the least amount of risks to either mother or baby (Avery, 2013).

For those mothers seeking a physiologic birth with minimal interventions, water labor and water birth are safe options and provide comfort in labor and relief of labor pain using a convenient non-pharmacologic method.

Waterbirth Workshops are available world-wide to provide childbirth educators, doulas, nurses, midwives and physicians, with further research data to instill confidence, explore procedures, and reduce fear (Russell, 2014).
The Need for More Research in the Future

A joint statement was published from the American Academy of Pediatrics (AAP) Committee on Fetus and Newborn and the American College of Obstetricians and Gynecologists (ACOG) Committee on Obstetric Practice assessing the use of water as a part of labor and birth, relieving or shortening labor and adding to maternal satisfaction (ACOG, 2014).

The report from the committees concluded that “immersion in water may be appealing to some and may be associated with decreased pain or use of anesthesia and decreased duration of labor”. The report went further to state, “there is no evidence that immersion in water during the first stage of labor otherwise improves perinatal outcomes.”

However, a Cochrane Review of the literature included 12 trials (3243 women). Water immersion during the first stage of labor significantly reduced epidural/spinal analgesia without adversely affecting labor duration, operative delivery rates or neonatal well-being. One trial showed that immersion in water during the second stage of labor increased women’s reported satisfaction with their birth experience (Cochrane, 2009).

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ICEA Position Paper

Skin-to-Skin Contact

Position

The International Childbirth Education Association (ICEA) recognizes the benefits of early and frequent skin-to-skin care in the first hours and days after the birth of a baby. Decades of research demonstrate the benefits of skin-to-skin care for both mother and baby including optimal adaptation to extra-uterine life for the newborn. The International Childbirth Education Association encourages education on the benefits and practices supporting skin-to-skin care being included in basic birth education curriculum.

When in the appropriate habitat, the developing organisms are physically capable & neurobehaviorally programmed to behave in such a way as to provide for its own needs (warmth, food, & nurturance) (Bergman, 2006).

Introduction

In the ideal birth scenario, early skin-to-skin contact/care (SSC) begins immediately after the birth of the baby. The naked newborn is placed prone on the mother’s bare chest, with no diaper, hat or hospital gown (mother’s) hindering total skin contact. Research demonstrates that extra tactile, odor and thermal cues provided by SSC may stimulate babies to initiate breastfeeding more successfully.

Benefits of Skin-to-skin Care

Immediate Skin-to-skin Care

- thermoregulation and temperature maintenance;
- temperature synchrony between mother and newborn;
- cardio-respiratory stability;
- facilitates self-attachment for breastfeeding;
- higher blood glucose levels;
- infant’s hands & feet warmed within 90 minutes of initiating skin-to-skin care.

Skin-to-skin Care in the Postpartum Period

For Mother:

- infant cries 10 times less and for shorter periods than infants in cribs;
- increased maternal affectionate/nurturing behaviors;
- enhances effective breastfeeding;
- less maternal requested time in the nursery;
- sleep synchronized with newborn.

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For Newborn:

- Apnea reduction;
- Less initial weight loss;
- Positively influences state organization (moving from sleep to awake & back) and motor system modulation (smoothness of movement);
- More restful natural sleep cycles and more quiet sleep;
- Reduced stress reaction to painful procedures.

"Swaddling was more stressful and potentially harmful than allowing the infant to remain skin-to-skin with his mother" (Kennell & McGrath, 2003).

Kangaroo Mother Care

Kangaroo Mother Care is defined as early and continuous skin-to-skin contact, usually with the mother, to provide the habitat for optimal early adaptation to extra-uterine life. This practice is often used for premature newborns but can also be beneficial healthy full term infants.

Long Term Benefits of Kangaroo Mother Care for Infants and Children

- Fewer infections at 6 & 12 months;
- Smiles more often at 3 months;
- Ahead in social, linguistic, fine/gross motor indices at 1 year;
- Earlier urinary continence;
- Earlier stubbornness;
- Mothers & children were smiling and laughing more in free play;
- Mothers more encouraging and instructing towards children;
- Improved brain maturation;
- Promotes self-regulation;
- Better emotional and cognitive regulatory abilities and more efficient arousal at 3 & 6 months;
- Improved attachment;
- Twice as likely to breastfeed compared to incubator care;
- Shorter length of stay in the NICU.

Obstacles to Skin-to-skin Care

- Lack of parental education on benefits of skin-to-skin care;
- Lack of staff education on importance and techniques;
- Staff buy-in and discomfort with non-technical support;
- Inadequate policies and procedures to support skin-to-skin care;
- Documentation availability in the electronic medical record;
- Disruption with visitors;
- Cultural barriers, i.e., fear of cold, need for rest.

Implication for Practice

"Dr. Bergman challenges us to face the facts and restore newborns to their rightful place: their mothers chest … This contact has remarkable effects. Breast-feeding is essential for the baby, from the first hour of life and onwards. The key message: Never separate mother and her newborn. The benefits are even more crucial for a premature baby." —Dr. Nils Bergman, 2007

Teaching best practices in labor and birth are an integral part of basic education to expectant and new parents. Presentations based on the risk-benefit-alternative principle are effective in helping parent make informed decisions. When educating on skin-to-skin care the above benefits can be discussed, the risks are minimal when care procedures are followed and the alternative which is standard open crib care, carries the risk of separation-stress reaction of crying, unstable vital signs, low blood sugar and increased somatostatin and cortisol levels.
The “how-to’s” of skin-to-skin care education includes:

- placing the naked newborn directly on the unclothed chest of the mother;
- for initial skin-to-skin care the baby should be dried while on the chest;
- both mother and baby covered with dry blankets;
- initial vital signs and procedures can be accomplished while skin-to-skin;
- if the mother is unable, the father or support person can do skin-to-skin care;
- infants can be transferred to other areas while skin-to-skin.

Later skin-to-skin care can include a diaper on the newborn. Keeping mother and baby skin-to-skin for at least 60-90 minutes facilitates breastfeeding in the first days. Mothers can also use skin-to-skin care for calming in the first weeks and months.

References

Current Research


Classic Research


continued on next page


The Healthy Children Project. The Magical Hour DVD/Book. www.HealthyChildren.cc
ICEA Position Paper

Induction

Position

The International Childbirth Education Association (ICEA) finds that spontaneous, physiologic labor provides benefits to babies and mothers. Induction of labor is a process utilizing various chemical and mechanical methods to initiate uterine contractions before the onset of spontaneous labor with the goal of accomplishing a successful birth. Augmentation of labor is initiated when spontaneous labor has either slowed, contractions are hypotonic, or labor progress has stopped. This position paper will focus solely on induction of labor.

Background

The use of labor induction in the U.S. has risen from less than 10% to more than 22% between 1990 and 2006. Other studies show induction rates higher than 22%. An analysis of 230,000 medical records of U.S. women birthing from 2002-2008 in a 19 hospital consortium reported an induction rate of 44% among women planning vaginal birth (Goer and Romano, 2012).

According to the American College of Obstetricians and Gynecologists (ACOG), induction of labor is indicated when the benefits to the mother and/or the fetus outweigh the risks of continuing the pregnancy (ACOG, 2009). Some examples in which labor induction is indicated include (but are not limited to) gestational or chronic hypertension, preeclampsia, eclampsia, diabetes, premature rupture of membranes, severe fetal growth restriction, and post-term pregnancy. Controversy regarding the exact definition of post-term or postdates pregnancy still looms.

Evaluating Readiness for Induction: The Bishop Score

In 1964, Bishop developed a pelvic scoring system to predict inducibility by evaluating the position of the cervix as it relates to the vagina, the cervical consistency, dilation, effacement and station of the presenting part (Bishop, 1964).

The higher the score, the more favorable the cervix with a clinical trial showing a score of 6-7 or more associated with successful inductions.

Bishop Scoring System

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dilation (cms)</td>
<td>0 1 2 3 4 5 6</td>
</tr>
<tr>
<td>Effacement (%)</td>
<td>0-30 40-50 60-70 80</td>
</tr>
<tr>
<td>Station</td>
<td>-3 -2 -1 +1, +2</td>
</tr>
<tr>
<td>Consistency</td>
<td>Firm Med Soft +1, +2</td>
</tr>
<tr>
<td>Position</td>
<td>Posterior Mid Anterior</td>
</tr>
</tbody>
</table>

In nulliparous women with prolonged pregnancy, the Bishop Score predicts the need for cesarean section better than the ultrasonographic assessment of the cervix (Uzun, et al, 2013).

During the 1990s and 2000s, the U.S. saw a 30% increase in preterm births (before 37 completed weeks gestation, reaching an all-time high of 12.8% in 2006 (March of Dimes, 2006).

In 2012, the Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN) identified more pregnant women were electing to induce labor before term and thus putting their babies at risk for significant health issues (AWHONN, 2012).

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The health risks for infants associated with an elective early term birth include:

- Greater chance of dying early;
- More likely to need care in the neonatal intensive care unit;
- Problems breathing, including needing a ventilator;
- Problems feeding, including coordinating sucking and swallowing; and
- Increased need for special educational interventions later in life.

AWHONN urged nurses to help improve health outcomes for mothers and babies through education and intervention:

- Asking hospital-based and other childbirth educators to include fetal development and early term birth health risk information in childbirth classes;
- Providing information about the risks of early term birth to the pregnant women for whom they provide care; and
- Educating women and healthcare providers alike about the health benefits of normal spontaneous birth and the prevention of unnecessary elective induction delivery.

**Indications for Induction**

Election to induce has not been identified as a clinical indication for induction. Since 1982, the American College of Obstetricians and Gynecologists (ACOG) have had specific guidelines in place that recommend against elective inductions in early term or before 39 weeks. However, they do maintain “Guideline Suggestions for Elective Labor Induction” on their website. ACOG issued a joint statement in 2013 with the Society for Maternal-Fetal Medicine titled “Early Deliveries Without Medical Indications: Just Say No” (ACOG, 2013). AWHONN and the March of Dimes (AWHONN, 2012; March of Dimes, 2006) have made the public aware that babies should be growing inside the Mother’s uterus for as long as possible through various initiatives. Election to induce includes but is not limited to request for induction because a woman is “tired of being pregnant”, a family member will only be in town for a certain length of time, the family would like the baby born on a certain date, or the “favorite” physician is going out of town.

Clinical indications for induction (ACOG, 2009) include:

- Abruptio placenta;
- Chorioamnionitis;
- Fetal demise;
- Gestational hypertension;
- Preeclampsia, eclampsia;
- Premature rupture of membranes;
- Postterm pregnancy;
- Maternal medical conditions (e.g., diabetes mellitus, renal disease, chronic pulmonary disease, chronic hypertension, antiphospholipid syndrome); and
- Fetal compromise (e.g., severe fetal growth restriction, isoimmunization, oligohydramnios).

Contraindications for labor induction (ACOG, 2009) includes:

- Vasa previa or complete placenta previa;
- Transverse fetal lie;
- Umbilical cord prolapse;
- Previous classical cesarean delivery;
- Active genital herpes infection; and
- Previous myomectomy entering the endometrial cavity.

**Methods of Induction**

The non-pharmacologic alternative approaches for cervical ripening and inducing labor can be safe, less-invasive, and more cost-effective than their pharmacological counterparts. Non-pharmacological methods may include acupuncture, sexual intercourse, nipple stimulation, herbal preparations, evening primrose oil, or castor oil. These methods require less clinical supervision; however, their effectiveness is less-documented in scientific literature. These alternative methods may require a longer period to ripen the cervix and initiate labor; therefore, time may be the determining factor in deciding which method to choose. The most important criteria for ripening the cervix and inducing labor is safety, for both the woman and her fetus. Nonpharmacological alternative methods are shown to be safe (Goer and Romano, 2012; NHS/NICE, 2008).

Pharmacologic or mechanical induction of labor include membrane stripping, Foley Balloon Catheter, or laminaria tents, cervical ripening agents, Pitocin/Syntocinon, Misoprostol/Cytotec, and Artificial Rupture of Membranes (AROM) via an amnihook (amniotomy).

A randomized controlled trial (RCT) of 123 women undergoing induction of labor with singleton pregnancies at 24 weeks gestation or greater with an unfavorable cervix ( Bishop score 6 or lower). Women with fetal malpresentation, multifetal gestation, spontaneous labor, contraindication to prostaglandins, nonreassuring fetal heart rate tracing, intrauterine growth restriction, abnormal fetus, fetal demise, or previous cesarean delivery or other significant uterine surgery were excluded. The primary outcome measure was induction-to-delivery time. Secondary outcomes were mode of delivery, tachysystole with fetal decelerations, terbutaline

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Complications of Induction

Even in low risk women, induction of labor, regardless of the method used, is associated with a higher risk of postpartum hemorrhage than spontaneous labor (Khireddine, et al, 2013). Additionally, in multiparous women, the risk of cesarean delivery following induction increases with previous preterm delivery, short maternal height, and limited dilatation at the start of induction (Verhoeven, et al, 2013). Careful titration of oxytocin is necessary to avoid uterine tachysystole (Kunz, et al, 2013). A common complication, tachysystole, may be reduced by removal of induction agent.

Induction of labor has been associated with a shorter duration of any breastfeeding (Bai, 2013).

An increase in maternal/neonatal infections has been reported with laminaria and other hygroscopic dilators. Foley catheters also can cause significant vaginal bleeding in women with a low-lying placenta (ACOG, 2013).

Childbirth Connection asserts that although the public and professional perception that induction of labor is convenient and cost-effective, the reality is that (elective) induction of labor can result in neonatal intensive care admission and can increase the length of the hospital stay and the overall cost of care. In addition, elective induction, especially in first-time mothers, frequently results in c-section which exposes mothers to the risks of surgery, requires a longer recovery, and affects choices, outcomes, and costs in future pregnancies (Childbirth Connection, 2011).

Labor inductions should, therefore, be performed for specific indications and women should be fully informed of the possible risks, including failed induction leading to cesarean delivery (Glantz, 2010).

Implications for Practice

There are numerous choices of induction methods that range from alternative to conventional; from noninvasive to invasive; and from non-pharmacologic to pharmacologic. ICEA takes the position that obstetrical intervention and technology should only be used in the presence of medically valid criteria and early induction methods should only be performed when a thorough medical assessment has been documented.

ICEA supports the focus on uncomplicated vaginal births and recommends that childbirth classes emphasize self-help strategies.

Since the pattern of labor is unpredictable and is subject to change, it would be desirable for every pregnant couple to participate in an education program where the many options and alternatives for all medical procedures are discussed. ICEA recommends childbirth educators teach from a Risk/Benefit position and childbirth education curricula consist of the following information concerning the induction of labor:

- Information is presented in an unbiased format.
- Information presented should reflect the common practices in their communities and prepare the learner accordingly.
- Participants are educated on the rights of expectant parents and informed consent.
- Learners are provided with the tools to obtain information to help in their decision-making process.
- Printed materials reflect a risk/benefit approach that is well-referenced.
- Information is provided for each procedure.
- Expected restrictions that might be imposed by various induction methods are discussed.
- Pregnant couples are informed of other medical interventions that might be involved such as intravenous infusion, blood pressure monitoring, rupture of membranes, and the risk for a possible cesarean delivery.
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Appendix C

The Coalition for Improving Maternity Services (CIMS)
The Mother-Friendly Childbirth Initiative

The First Consensus Initiative of the Coalition for Improving Maternity Services

Mission

The Coalition for Improving Maternity Services (CIMS) is a coalition of individuals and national organizations with concern for the care and wellbeing of mothers, babies, and families. Our mission is to promote a wellness model of maternity care that will improve birth outcomes and substantially reduce costs. This evidence-based mother-, baby-, and family-friendly model focuses on prevention and wellness as the alternatives to high-cost screening, diagnosis, and treatment programs.

Preamble

Whereas:

• In spite of spending far more money per capita on maternity and newborn care than any other country, the United States falls behind most industrialized countries in perinatal* morbidity* and mortality, and maternal mortality is four times greater for African-American women than for Euro-American women;
• Midwives attend the vast majority of births in those industrialized countries with the best perinatal outcomes, yet in the United States, midwives are the principal attendants at only a small percentage of births;
• Current maternity and newborn practices that contribute to high costs and inferior outcomes include the inappropriate application of technology and routine procedures that are not based on scientific evidence;
• Increased dependence on technology has diminished confidence in women’s innate ability to give birth without intervention;
• The integrity of the mother-child relationship, which begins in pregnancy, is compromised by the obstetrical treatment of mother and baby as if they were separate units with conflicting needs;
• Although breastfeeding has been scientifically shown to provide optimum health, nutritional, and developmental benefits to newborns and their mothers, only a fraction of U.S. mothers are fully breastfeeding their babies by the age of six weeks;
• The current maternity care system in the United States 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;

Therefore,

We, the undersigned members of CIMS, hereby resolve to define and promote mother-friendly maternity services in accordance with the following principles:

Principles

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.

* see glossary, next page
**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.

These principles give rise to the following steps (see next page), which support, protect, and promote mother-friendly maternity services:

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**Glossary**

- **Augmentation**: Speeding up labor.
- **Birth Center**: Free-standing maternity center.
- **Doula**: A woman who gives continuous physical, emotional, and informational support during labor and birth—may also provide postpartum care in the home.
- **Episiotomy**: Surgically cutting to widen the vaginal opening for birth.
- **Induction**: Artificially starting labor.
- **Morbidity**: Disease or injury.
- **Oxytocin**: Synthetic form of oxytocin (a naturally occurring hormone) given intravenously to start or speed up labor.
- **Perinatal**: Around the time of birth.
- **Rupture of Membranes**: Breaking the “bag of waters.”

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—. Guidelines for vaginal delivery after a previous cesarean birth. ACOG Committee Opinion 1988; No 64.


Bureau of Maternal and Child Health. Unity through diversity: a report on the Healthy Mothers Healthy Babies Coalition Communities of Color Leadership Roundtable. Healthy Mothers Healthy Babies, 1993. (A copy may obtained by calling (202) 821-8993 ext. 254. Dr. Marston Wagner also provided maternal mortality statistics from official state health data.)


Ten Steps of the Mother-Friendly Childbirth Initiative
For Mother-Friendly Hospitals, Birth Centers,* and Home Birth Services

To receive CIMS designation as “mother-friendly,” a hospital, birth center, or home birth service must carry out the above philosophical principles by fulfilling the Ten Steps of Mother-Friendly Care.

A mother-friendly hospital, birth center, or home birth service:

1. Offers all birthing mothers:
   • Unrestricted access to the birth companions of her choice, including fathers, partners, children, family members, and friends;
   • Unrestricted access to continuous emotional and physical support from a skilled woman—for example, a doula,* or labor-support professional;
   • Access to professional midwifery care.

2. Provides accurate descriptive and statistical information to the public about its practices and procedures for birth care, including measures of interventions and outcomes.

3. Provides culturally competent care—that is, care that is sensitive and responsive to the specific beliefs, values, and customs of the mother’s ethnicity and religion.

4. Provides the birthing woman with the freedom to walk, move about, and assume the positions of her choice during labor and birth (unless restriction is specifically required to correct a complication), and discourages the use of the lithotomy (flat on back with legs elevated) position.

5. Has clearly defined policies and procedures for:
   • collaborating and consulting throughout the perinatal period with other maternity services, including communicating with the original caregiver when transfer from one birth site to another is necessary;
   • linking the mother and baby to appropriate community resources, including prenatal and post-discharge follow-up and breastfeeding support.

6. Does not routinely employ practices and procedures that are unsupported by scientific evidence, including but not limited to the following:
   • shaving;
   • enemas;
   • IVs (intravenous drip);
   • withholding nourishment or water;
   • early rupture of membranes*;
   • electronic fetal monitoring;
   • other interventions are limited as follows:
     • Has an induction* rate of 10% or less;†
     • Has an episiotomy* rate of 20% or less, with a goal of 5% or less;
     • Has a total cesarean rate of 10% or less in community hospitals, and 15% or less in tertiary care (high-risk) hospitals;
     • Has a VBAC (vaginal birth after cesarean) rate of 60% or more with a goal of 75% or more.

7. Educates staff in non-drug methods of pain relief, and does not promote the use of analgesic or anesthetic drugs not specifically required to correct a complication.

8. Encourages all mothers and families, including those with sick or premature newborns or infants with congenital problems, to touch, hold, breastfeed, and care for their babies to the extent compatible with their conditions.


10. Strives to achieve the WHO-UNICEF “Ten Steps of the Baby-Friendly Hospital Initiative” to promote successful breastfeeding:
    1. Have a written breastfeeding policy that is routinely communicated to all health care staff;
    2. Train all health care staff in skills necessary to implement this policy;
    3. Inform all pregnant women about the benefits and management of breastfeeding;
    4. Help mothers initiate breastfeeding within a half-hour of birth;
    5. Show mothers how to breastfeed and how to maintain lactation even if they should be separated from their infants;
    6. Give newborn infants no food or drink other than breast milk unless medically indicated;
    7. Practice rooming in: allow mothers and infants to remain together 24 hours a day;
    8. Encourage breastfeeding on demand;
    9. Give no artificial teat or pacifiers (also called dummies or soothers) to breastfeeding infants;
    10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from hospitals or clinics.

† This criterion is presently under review.
The Mother-Friendly Designation

When The Mother-Friendly Childbirth Initiative (MFCI) was drafted, the authors envisioned hospitals, birth centers, and home birth services as being able to fulfill all of the Ten Steps over time. Over the years, our nation’s health care system became more complex and included a greater number of stakeholders. In turn, it became evident that providing optimal care for mothers and babies did not rest solely in the hands of the dedicated professionals and administrators. CIMS encourages hospitals, birth centers, and home birth services to work towards implementing the Ten Steps of the MFCI as they are able to for improved childbirth outcomes.

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Endorse The Mother-Friendly Childbirth Initiative

Since ratification in 1996, the principles and Ten Steps of the Mother-Friendly Childbirth Initiative have been endorsed by hundreds of individuals and organizations. For a complete list of endorsers, or to add your name or your organization’s name, please visit our Web site at www.motherfriendly.org.

Help Circulate The Mother-Friendly Childbirth Initiative

Free copies of this document, as well as the consumer version, “Having a Baby? Ten Questions to Ask,” can be downloaded from the CIMS Web site at www.motherfriendly.org. Bulk quantities are available for purchase. Visit our Web site, or contact us, for pricing and ordering information.

Organizations (names of organizations’ officers may have changed since ratification):

- Academy of Certified Birth Educators (Diathe, KS), Linda M. Herrick, RNC, BSN, CCE, CD; and Sally Riley, BS, Ed, CCE, CD, & Judie C. Wiha, RNC, MSN, CNM, CCE, Co-Directors
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Having a Baby?

10 Questions to Ask

Have you decided how to have your baby? The choice is yours!

First, you should learn as much as you can about all your choices. There are many different ways of caring for a mother and her baby during labor and birth.

Birthing care that is better and healthier for mothers and babies is called “mother-friendly.” Some birth places or settings are more mother-friendly than others.

A group of experts in birthing care came up with this list of 10 things to look for and ask about. Medical research supports all of these things. These are also the best ways to be mother-friendly.

When you are deciding where to have your baby, you’ll probably be choosing from different places such as:

- birth center,
- hospital, or
- home birth service.

Here’s what you should expect, and ask for, in your birth experience. Be sure to find out how the people you talk with handle these 10 issues about caring for you and your baby. You may want to ask the questions below to help you learn more.

Ask, “Who can be with me during labor and birth?”

Mother-friendly birth centers, hospitals, and home birth services will let a birthing mother decide whom she wants to have with her during the birth. This includes fathers, partners, children, other family members, or friends.

They will also let a birthing mother have with her a person who has special training in helping women cope with labor and birth. This person is called a doula or labor support person. She never leaves the birthing mother alone. She encourages her, comforts her, and helps her understand what’s happening to her.

They will have midwives as part of their staff so that a birthing mother can have a midwife with her if she wants to.

Ask, “What happens during a normal labor and birth in your setting?”

If they give mother-friendly care, they will tell you how they handle every part of the birthing process. For example, how often do they give the mother a drug to speed up the birth? Or do they let labor and birth usually happen on its own timing? They will also tell you how often they do certain procedures. For example, they will have a record of the percentage of C-sections (Cesarean births) they do every year. If the number is too high, you’ll want to consider having your baby in another place or with another doctor or midwife.

Here are numbers we recommend you ask about.

- They should not use oxytocin (a drug) to start labor for more than 1 in 10 women (10%).

- They should not do an episiotomy (ee-peezee-AH-tummy) on more than 1 in 5 women (20%). They should be trying to bring that number down. (An episiotomy is a cut in the opening to the vagina to make it larger for birth. It is not necessary most of the time.)

- They should not do C-sections on more than 1 in 10 women (10%) if it’s a community hospital. The rate should be 15% or less in hospitals which care for many high-risk mothers and babies.

A C-section is a major operation in which a doctor cuts through the mother’s stomach into her womb and removes the baby through the opening. Mothers who have had a C-section can often have future babies normally. Look for a birth place in which 6 out of 10 women (60%) or more of the mothers who have had C-sections go on to have their other babies through the birth canal.

Ask, “How do you allow for differences in culture and beliefs?”

Mother-friendly birth centers, hospitals, and home birth services are sensitive to the mother’s culture. They know that mothers and families have differing beliefs, values, and customs.

For example, you may have a custom that only women may be with you during labor and birth. Or perhaps your beliefs include a religious ritual to be done after birth. There are many other examples that may be very important to you. If the place and the people are mother-friendly, they will support you in doing what you want to do. Before labor starts tell your doctor or midwife special things you want.

Ask, “Can I walk and move around during labor? What position do you suggest for birth?”

In mother-friendly settings, you can walk around and move about as you choose during labor. You can choose the positions that are most comfortable and work best for you during labor and birth. (There may be a medical reason for you to be in a certain position.) Mother-friendly settings almost never put a woman flat on her back with her legs up in stirrups for the birth.

Ask, “How do you make sure everything goes smoothly when my nurse, doctor, midwife, or agency need to work with each other?”

In mother-friendly settings, you can ask your doctor or midwife what kind of birthing care they give. They will tell you how they handle every part of the birthing process. For example, how often do they give the mother a drug to speed up the birth? Or do they let labor and birth usually happen on its own timing? They will also tell you how often they do certain procedures. For example, they will have a record of the percentage of C-sections (Cesarean births) they do every year. If the number is too high, you’ll want to consider having your baby in another place or with another doctor or midwife.

Here are numbers we recommend you ask about.

- They should not use oxytocin (a drug) to start labor for more than 1 in 10 women (10%).

continued on next page
Mother-friendly places and people will have a specific plan for keeping in touch with the other people who are caring for you. They will talk to others who give you birth care. They will help you find people or agencies in your community to help you. For example, they may put you in touch with someone who can help you with breastfeeding.

Ask, “What things do you normally do to a woman in labor?”

Experts say some methods of care during labor and birth are better and healthier for mothers and babies. Medical research shows us which methods of care are better and healthier. Mother-friendly settings only use methods that have been proven to be best by scientific evidence.

Sometimes birth centers, hospitals, and home birth services use methods that are not proven to be best for the mother or the baby. For example, research has shown it’s usually not helpful to break the bag of waters.

Here is a list of things we recommend you ask about. They do not help and may hurt healthy mothers and babies. They are not proven to be best for the mother or baby and are not mother-friendly.

- They should not keep track of the baby’s heart rate all the time with a machine (called an electronic fetal monitor). Instead, it is best to have your nurse or midwife listen to the baby’s heart from time to time.
- They should not break your bag of waters early in labor.
- They should not use an IV (a needle put into your vein to give you fluids).
- They should not tell you that you can’t eat or drink during labor.
- They should not shave you.
- They should not give you an enema.

A birth center, hospital, or home birth service that does these should not be used without a special medical reason.

Would you like to give this information to your doctor, midwife, or nurse?

This information is taken from the Mother-Friendly Childbirth Initiative written for health care providers. You can get a copy of the Initiative for your doctor, midwife, or nurse by mail, e-mail, or on the Internet.

To Get a Copy by Mail
For a copy of both this brochure and the Mother-Friendly Childbirth Initiative by mail, send a stamped, self-addressed envelope with $5 (US) to help cover the costs ($6 Canada or Mexico, $10 all others). Bulk prices are available. Mail to:
Coalition for Improving Maternity Services
1500 Sunday Drive, Suite 102
Raleigh, NC 27607

To Get a Copy on the Internet
Log on to www.motherfriendly.org

Contact CIMS
Tel: 888-282-CIMS (2467) • Fax: 919-787-4916
E-mail: info@motherfriendly.org
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The Risks of Cesarean Section

A Coalition for Improving Maternity Services Fact Sheet

Cesarean section is the most common major surgical procedure performed in the United States. The Coalition for Improving Maternity Services (CIMS) is concerned about the dramatic increase and ongoing overuse of cesarean section. The surgical procedure poses short- and long-term health risks to mothers and infants, and a scarred uterus poses risks to all future pregnancies and deliveries. For these reasons, CIMS recommends that cesarean surgery be reserved for situations when potential benefits clearly outweigh potential harms. The cesarean rate can safely be less than 15 percent and 11 percent or less in low-risk women giving birth for the first time, yet, in 2007 the U.S. cesarean rate was 32 percent. When cesarean surgery rates rise above 15 percent health outcomes for mothers and babies worsen, and increasing numbers of scheduled cesareans are contributing to the rising number of late-preterm births.

Cesarean rates have been rising for all women in the United States regardless of medical condition, age, race, or gestational age, and while the number of first cesareans performed without medical indication is increasing, no evidence supports the beliefs that these elective cesareans represent maternal request cesareans or that the rise in elective first cesareans has contributed significantly to the overall increase in cesarean rates. Elective first cesarean at physician request may, however, play a significant role, and the rise in elective repeat surgeries, which has climbed by more than 40 percent in the last ten years, certainly does. Although 70 percent of women or more who plan a vaginal birth after cesarean (VBAC) can birth vaginally and avoid the complications of repeat cesarean surgeries, almost all women today have a repeat operation because most doctors and many hospitals refuse to allow VBAC.

A cesarean can be a life-saving operation, and some babies would not be born vaginally under any circumstances; however, it is still major surgery. Women have a legal right to know the risks associated with their treatment and the right to accept or refuse it. CIMS encourages childbearing women to take advantage of their rights and to find out more about the risks of cesarean section so they can make informed decisions about how they want to give birth.

What are the potential harms of cesarean surgery compared with vaginal birth? Health outcomes after a cesarean may be worse because medical problems may lead to surgery. This fact sheet, however, is based on research that determined excess harms arising from the surgery itself. In other words, women with a healthy pregnancy who have a cesarean rather than a vaginal birth are at increased risk for the following complications as are their babies:

**Potential Harms to the Mother**

Compared with vaginal birth, women who have a cesarean are more likely to experience:

- Accidental surgical cuts to internal organs.
- Major infection.
- Emergency hysterectomy (because of uncontrollable bleeding).
- Complications from anesthesia.
- Deep venous clots that can travel to the lungs (pulmonary embolism) and brain (stroke).
- Admission to intensive care.
• Readmission to the hospital for complications related to the surgery.18,28
• Pain that may last six months or longer after the delivery.19 More women report problems with pain from the cesarean incision than report pain in the genital area after vaginal birth.19
• Adhesions, thick internal scar tissue that may cause future chronic pain, in rare cases a twisted bowel, and can complicate future abdominal or pelvic surgeries.19
• Endometriosis (cells from the uterine lining that grow outside of the womb) causing pain, bleeding, or both severe enough to require major surgery to remove the abnormal cells.27
• Appendicitis, stroke, or gallstones in the ensuing year.18,46,47,50 Gall bladder problems and stroke may be because high-weight women and women with high blood pressure are more likely to have cesareans.
• Negative psychological consequences with unplanned cesarean. These include:
  o Poor birth experience, overall impaired mental health, and/or self-esteem.12
  o Feelings of being overwhelmed, frightened, or helpless during the birth.20
  o A sense of loss, grief, personal failure, acute trauma symptoms, posttraumatic stress, and clinical depression.37
• Death.12,22

**Potential Harms to the Baby**

Compared with vaginal birth, babies born by cesarean section are more likely to experience:

• Accidental surgical cuts, sometimes severe enough to require suturing.1,28
• Being born late-preterm (34 to 36 weeks of pregnancy) as a result of scheduled surgery.6
• Complications from prematurity, including difficulties with respiration, digestion, liver function, jaundice, dehydration, infection, feeding, and regulating blood sugar levels and body temperature.25,26 Late-preterm babies also have more immature brains,63 and they are more likely to have learning and behavior problems at school age.25,26
• Respiratory complications, sometimes severe enough to require admission to a special care nursery, even in infants born at early term (37 to 39 weeks of pregnancy).28 Scheduling surgery after 39 completed weeks minimizes, but does not eliminate, the risk.31,32
• Readmission to the hospital.25
• Childhood development of asthma,3,78 sensitivity to allergens,61 or Type 1 diabetes.11
• Death in the first 28 days after birth.51

**Potential Harms to Maternal Attachment and Breastfeeding**

Failure to breastfeed has adverse health consequences for mothers and babies. Breastfeeding helps protect mothers against postpartum depression, Type 2 diabetes, high blood pressure, heart disease, ovarian and pre-menopausal breast cancer, and osteoporosis later in life.36,71 Breastfeeding helps protect babies against ear infections, stomach infections, severe respiratory infections, allergies, asthma, obesity, Type 1 and Type 2 diabetes, childhood leukemia, sudden infant death syndrome (SIDS), and necrotizing enterocolitis (a severe, life-threatening intestinal infection).15,36

• Women who have unplanned cesareans are more likely to have difficulties forming an attachment to their babies.23
• Women who have cesareans are less likely to have their infants with them skin-to-skin (cradled naked against their bare chest) after the delivery.20 Babies who have skin-to-skin contact interact more with their mothers, stay warmer, and cry less. When skin-to-skin, babies are more likely to be breastfed early and well, and to be breastfed for longer. They may also be more likely to have a good early relationship with their mothers, but the evidence for this is not as strong.16,57
• Women are less likely to breastfeed.21,44
Potential Harms to Future Pregnancies

With prior cesarean, women and their babies are more likely to experience serious complications during subsequent pregnancy and birth regardless of whether they plan repeat cesarean or vaginal birth. The likelihood of serious complications increases with each additional operation.28

Compared with prior vaginal birth, prior cesarean puts women at increased risk of:

- Uterine scar rupture. Planning repeat cesarean reduces the excess risk, but it is not completely protective.8,49,55,75
- Infertility, either voluntary (doesn’t want more children) or involuntary (can’t have more children).7,12,56,70,74,79,80
- Cesarean scar ectopic pregnancy (implantation within the cesarean scar), a condition that is life-threatening to the mother and always fatal for the embryo.67
- Placenta previa (placenta covers the cervix, the opening to the womb), placental abruption (placenta detaches partially or completely before the birth), and placenta accreta, (placenta grows into the uterine muscle and sometimes through the uterus, invading other organs), all of which increase the risk for severe hemorrhage and are potentially life-threatening complications for mother and baby.17,28,85
- Emergency hysterectomy.42,53
- Preterm birth and low birth weight.6,40,65,73,76
- A baby with congenital malformation or central nervous system injury12 due to a poorly functioning placenta.
- Stillbirth.28,29,40,65,76

Cesarean Surgery and Pelvic Floor Dysfunction

Cesarean proponents claim that cesarean surgery will prevent pelvic floor dysfunction, but it offers little or no protection once healing is complete and no protection in later life.12 Moreover, risk-free measures such as engaging in exercises to strengthen the pelvic floor or losing weight can often improve or relieve stress urinary incontinence (loss of urine with pressure on the pelvic floor such as with exercise, laughing, sneezing, or coughing).9,12

- Cesarean surgery does not protect against sexual problems,4,33,41 gas or stool incontinence,10,59 or urge urinary incontinence (loss of urine after sudden need to void).10,13,24,62,82
- Cesarean surgery does not protect against severe stress urinary incontinence.62,82 As many as one more woman in six having vaginal birth may experience stress urinary incontinence of some degree, mostly minor, at six months or more after birth.10,13,24,62,82
- Perhaps one more woman in twenty having vaginal birth will experience symptomatic pelvic floor prolapse (muscle weakness causes the internal organs to sag downwards).45,66,77,81 With three or more vaginal births, this number may be as high as one more woman in ten.66 However, many other factors, including smoking, hysterectomy, hormone replacement therapy, constipation, irritable bowel syndrome, and urinary tract infections are also associated with pelvic floor prolapse.

Cesarean Section, Care Providers and Place of Birth

To reduce the risk of cesarean surgery, CIMS encourages women to seek providers and hospitals with low cesarean rates (15% or less) and those that support VBAC. Women can access this data from their state health departments. They can also access hospital-specific cesarean rates and rates for other birth interventions for several states at www.thebirthsurvey.com and a listing of hospitals that do or do not support VBAC from the International Cesarean Network at http://ican-online.org/vac-ban-info.
Healthy women at low risk for complications should also know that choosing midwifery care or giving birth in a birth center or at home can lower their risk for cesarean section.\textsuperscript{34} Having a doula reduces the likelihood of a cesarean as well.\textsuperscript{34}

This fact sheet was co-authored by Henci Goer, BA and Nicette Jukelevics, MA, ICCE.
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References:


Birth is a normal, natural, process and the vast majority of women can have safe, normal, vaginal births. There are health conditions where a cesarean birth is necessary for the well being of the mother or her baby. However, more and more mothers these days are giving birth by cesarean section for non-medical reasons. A cesarean poses risks as well as benefits for mother and baby, and should not be undertaken lightly. This educational material is provided by the Coalition for Improving Maternity Services (CIMS) to help all expectant parents become better informed about the risks of cesarean section.

To give the expectant mother time to reflect on this information and consider the impact of cesarean surgery on her health and the health of her baby, care providers are encouraged to introduce and discuss this evidence-based information throughout pregnancy and no later than at 32-34 weeks. The expectant mother is encouraged to take the form home, read and initial the statements, discuss the information with her partner, and raise any questions or concerns she may have with her care provider. The form may then be placed in her chart.

Expectant Mother’s Name: ____________________________________________

Care Provider’s Name: ________________________________________________

A cesarean section is an operation by which a baby is born by making a cut in the mother’s lower abdominal wall (abdominal incision) and a cut in her uterus (uterine incision). I understand that a cesarean operation may be more dangerous than a vaginal birth for my baby and me.

POSSIBLE PROBLEMS FOR ME WITH A CESAREAN AS COMPARED TO A VAGINAL BIRTH:
1. _____ I am more likely to have more blood loss and a longer recovery time.
2. _____ I am more likely to have accidental surgical cuts to my bladder, bowel, or gastrointestinal tract.
3. _____ I am more likely to have a serious infection in my incision, uterus, or bladder.
4. _____ I am more likely to have thick scarring (adhesions) inside my abdomen that may cause chronic pain years after my cesarean. This scarring can make any future abdominal operation I may need more difficult.
5. _____ I may have uncontrolled bleeding and need an emergency hysterectomy (removal of the uterus) if the bleeding cannot be stopped.
6. _____ I am more likely to have complications from anesthesia.
7. _____ I am more likely to develop serious and life-threatening blood clots that can travel to my lungs (pulmonary embolism) or my brain (stroke).
8. _____ I am more likely to be admitted to intensive care.
9. _____ I am more likely to need to return to the hospital for complications from the cesarean operation.
10. _____ I am more likely to feel pain and/or numbness at the site of the operation for several months after my surgery.
11. _____ I am less likely to breastfeed successfully. I may lose out on the health benefits of breastfeeding for myself, including: weight loss, reduced risks of cancers, heart disease, diabetes, and osteoporosis.
12. _____ I am less likely to have a satisfactory birth experience. I am more likely to have emotional problems such as post-partum depression and post-traumatic stress. Many women experience a profound sense of happiness after a normal birth that flows naturally into bonding with the baby and breastfeeding.
13. _____ I am more likely to die.
POSSIBLE PROBLEMS WITH A CESAREAN FOR ME WITH A FUTURE PREGNANCY AS COMPARED TO A VAGINAL BIRTH:

14. _____ I am more likely to have trouble becoming pregnant again.

15. _____ I am more likely to have complications in a future pregnancy due to the scar in my uterus. If the new placenta attaches over my previous scar, it is more likely to cause serious problems, including: serious bleeding, placenta coming in front of the baby (placenta previa), placenta growing into or even through the wall of the womb (placenta accreta), miscarriage, or pre-term birth.

16. _____ I am more likely to have a baby with a congenital malformation, central nervous system injury, or low birth weight due to problems with the placenta.

17. _____ I am more likely to have a stillbirth.

18. _____ I am more likely to require major surgery to remove cells from the lining of my uterus that may grow outside my womb (endometriosis).

19. _____ Since it is difficult to find a physician or hospital supportive of a vaginal birth after a cesarean (VBAC), I am more likely to have a repeat cesarean for the birth of all my future children, although a vaginal birth after a cesarean birth is usually safe. Each additional operation I have increases the odds for complications.

20. _____ Research shows that having a cesarean will not protect me from urine, gas, or stool incontinence in the future, or from future sexual problems.

21. _____ I may not be able to get healthcare coverage since some insurance providers consider a cesarean to be a pre-existing condition.

POSSIBLE PROBLEMS FOR MY BABY:

1. _____ My baby is more likely to be born prematurely if the cesarean surgery is performed anytime before labor begins. A premature baby is more likely to experience the following:
   • -admission to the intensive care nursery
   • -trouble breastfeeding, digesting food, and regulating body temperature
   • -developing jaundice
   • -brain development problems and difficulties in learning in school

2. _____ My baby is more likely to face complications from anesthesia and postpartum pain medication.

3. _____ My baby is more likely to be accidentally cut during surgery.

4. _____ My baby is more likely to have breathing difficulties since labor contractions clear the lungs.

5. _____ If I agree to a scheduled cesarean, it is normally best to wait for labor to begin before performing the operation.

6. _____ My baby is more likely to have difficulty breastfeeding. My baby is less likely to benefit from skin-to-skin contact with me and is less likely to get the health benefits from breastfeeding including: reduced risk for asthma, allergies, respiratory infections, Type 1 diabetes, childhood leukemia, and SIDS (sudden infant death syndrome). If I do have a cesarean, I can request special care to help me and my baby breastfeed successfully before I am discharged from the hospital.

I have read and discussed this information with my care provider.

Expectant Mother’s Signature: _______________________________ Date: ________________

Care Provider’s Signature: _______________________________ Date: ________________

This information is provided for expectant mothers and their care providers by the Coalition for Improving Maternity Services (CIMS). CIMS strongly recommends that cesarean surgery be reserved for situations when potential health benefits clearly outweigh the risks. Please see the *The Risks of Cesarean Section, a CIMS Fact Sheet* for the references that support this form, available as a free download from [www.motherfriendly.org](http://www.motherfriendly.org).
The World Health Organization (WHO), health care associations, and government health agencies affirm the scientific evidence of the clear superiority of human milk and of the hazards of artificial milk products. The WHO and the American Academy of Pediatrics recommend that mothers exclusively breastfeed their infants for the first six months, and continue for at least a year and as long thereafter as mother and baby wish.¹

*Human milk provides optimal benefits for infants, including premature and sick newborns. Human milk is unique. Superior nutrients and beneficial substances found in human milk cannot be duplicated. Breastfeeding provides optimum health, nutritional, immunologic and developmental benefits to newborns as well as protection from postpartum complications and future disease for mothers.*

A U.S. Healthy People 2010 goal is to have three-quarters of mothers initiate breastfeeding at birth, with half of them breastfeeding until at least the 5th or 6th month, and one-fourth to breastfeed their babies through the end of the first year.² In 2007 only four states met all five Healthy People 2010 targets for breastfeeding.³

**Maternity Care Practices Greatly Affect Breastfeeding**

Labor, birth, and postpartum practices can facilitate or discourage the initiation, establishment, and continuation of breastfeeding.⁴,⁵,⁶,⁷ According to the U.S. Centers for Disease Control and Prevention (CDC), many birth facilities have policies and practices that are not evidence-based and are known to interfere with breastfeeding in the early postpartum period and after discharge.⁸ The World Health Organization,⁹ the American Association of Pediatrics,¹⁰ the American Academy of Family Physicians,¹¹ and the Academy of Breastfeeding Medicine¹² recommend that maternity health professionals provide birth and postpartum care that is supportive of breastfeeding.

The World Health Organization has identified the following intrapartum mother-friendly childbirth practices as supportive of breastfeeding:

- minimizing routine procedures that are not supported by scientific evidence;
- minimizing invasive procedures and medications;
- providing emotional and physical support in labor;
- freedom of movement and choice of positions during labor and birth;
- staff trained in non-drug methods of pain relief and who do not promote the use of analgesics or anesthetic drugs unless required by a medical condition;
- no unnecessary induction or augmentation of labor, instrumental delivery, and cesarean section.¹³
The quality of care provided in the first 24 hours after birth is critical to the successful initiation and continuation of breastfeeding. Hospitals and birth centers which encourage and support breastfeeding are more likely to care for mothers and newborns in the following ways:

- Provide mothers with comprehensive, accurate, and culturally appropriate breastfeeding education and counseling.
- Encourage skin-to-skin contact for at least thirty minutes between mother and baby within one hour of an uncomplicated vaginal birth or within two hours for an uncomplicated cesarean birth.
- Give mothers the opportunity to breastfeed within one hour of uncomplicated vaginal birth and two hours of an uncomplicated cesarean birth.
- Encourage newborns to receive breast milk as their first feeding after both uncomplicated vaginal birth and cesarean birth.
- Perform routine newborn procedures while keeping mother and baby skin-to-skin.
- Help mothers with breastfeeding and teach parents how to recognize and respond to their baby’s feeding cues.
- Encourage rooming in and help the mother to be comfortable with baby care in her own room.
- Avoid separations of healthy mothers and babies, and encourage continuous skin to skin contact. Promote as much skin to skin contact of sick babies with mothers as possible.
- Do not give pacifiers to breastfeeding newborns, or any other supplements, formula, water or glucose water to healthy babies.
- Do not give mothers discharge gift bags with formula samples or formula discount coupons.
- Provide mothers with breastfeeding support after hospital or birth center discharge. Support may include: a home visit or hospital postpartum visit, referral to local community resources, follow-up telephone contact, a breastfeeding support group, or an outpatient clinic.14

**Benefits of Breastfeeding for Children**

Enhanced Immune System and Resistance to Infections

- The infant’s immune system is not fully mature until about 2 years of age. Human milk contains an abundance of white blood cells that are transferred to the child, acting to fight infections from viruses, bacteria, and intestinal parasites.
- Human milk contains factors that enhance the immune response to inoculations against polio, tetanus, diphtheria, and influenza.15
- Breastfeeding reduces the incidence and/or severity of several infectious diseases including respiratory tract infections, ear infections, bacterial meningitis, pneumonia, urinary tract infections, and greatly reduces the incidence of infant diarrhea.
- After the first month of life, rates of infant mortality in the U.S. are reduced by 21% in breastfed infants.
- Breastfed infants are at lower risk for sudden infant death syndrome (SIDS).16
Protection Against Chronic Disease

- Exclusive breastfeeding for a minimum of four months decreases the risk of Type I diabetes (insulin-dependent diabetes mellitus) for children with a family history of diabetes, and may reduce the incidence of Type 2 diabetes later in life.
- Breastfed children are less likely to suffer from some forms of childhood cancer such as Hodgkin’s disease, and leukemia.
- Breastfeeding reduces the risk for obesity, high blood pressure, and high cholesterol levels later in life.\(^\text{17}\)
- Human milk contains anti–inflammatory factors that lower the incidence of bowel diseases such as Crohn’s disease and ulcerative colitis.\(^\text{18}\)
- The incidence of asthma and eczema are lower for infants who are exclusively breastfed for at least 4 months, especially in families at high risk for allergies.\(^\text{19}\)

**Breastfeeding Premature and High-Risk Infants**

- Breastfeeding and banked human milk are protective and beneficial for preterm infants.
- Hospitals and physicians should recommend human milk for premature and other high risk infants.\(^\text{20}\)
- Breast milk lowers the premature infant’s risk for gastrointestinal and infectious disease and reduces the incidence of necrotizing enterocolitis (inflammation with possible tissue death and perforation of the small intestines and colon).\(^\text{21}\)
- Human milk enhances brainstem maturation. Compared to premature babies who receive formula, preterm infants who receive breast milk score higher on future I.Q. tests.
- Breastfeeding the premature infant reduces hospital costs and the length of hospital stay significantly.\(^\text{22}\)

**Benefits of Breastfeeding for the Mother**

- Women who breastfeed benefit from an increased level of oxytocin, a hormone that stimulates uterine contractions lowering the risk for postpartum bleeding. Women recover better with less blood loss at birth.
- Exclusive breastfeeding frequently but not always delays the return of a woman’s ovulation and menstruation for a variable 20 to 30 weeks or more. This provides a natural means of child spacing for many.
- Breastfeeding may enhance feelings of attachment between mother and baby.
- Breastfeeding lowers a mother’s risk for developing ovarian and pre-menopausal breast cancer and heart disease, and may decrease the risk of osteoporosis later in life. The benefits increase the longer she breastfeeds.\(^\text{23}\)
- Breastfeeding women without a history of gestational diabetes are less likely to develop Type 2 diabetes later in life.\(^\text{24}\)

**The Cost of Not Breastfeeding**

- Private and government insurers spend a minimum of $3.6 billion dollars a year to treat medical conditions and diseases that are preventable by breastfeeding.\(^\text{25}\)
- Since children who are not breastfed have more illnesses, employers incur additional costs for increased health claims, and mothers lose more time from work to care for sick children.\(^\text{26}\)
References


For more references on breastfeeding, visit:
- US Breastfeeding Committee: www.usbreastfeeding.org
- Centers for Disease Control: www.cdc.gov/breastfeeding
- La Leche League International: www.llli.org
- International Lactation Consultant Association: www.ilca.org

This fact sheet was co-authored by Nicette Jukelevics, MA, ICCE, and Ruth Wilf, CNM, PhD.

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