Discussion

The Coalition for Improving Maternity Services:

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ABSTRACT

The *Ten Steps of Mother-Friendly Care* developed by the Coalition for Improving Maternity Services (CIMS) provides guidelines for caregivers, hospitals, birth centers, and home birth services that are committed to ensuring their services are “mother-friendly.” The evidence basis compiled by the CIMS Expert Work Group for the *Ten Steps of Mother-Friendly Care* confirms that substantial support exists for the *Ten Steps*. Furthermore, the group’s findings—along with the results from the *Listening to Mothers II* survey—support the relevance and continued importance of the *Ten Steps*, as well as the larger CIMS *Mother-Friendly Childbirth Initiative*, and suggest future direction for researchers, maternity caregivers, and childbearing women. Suggestions for ongoing research and effective advocacy on behalf of mother-friendly care practices are encouraged.

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In setting out on this project, the goal of the Coalition for Improving Maternity Services (CIMS) Expert Work Group was to provide evidence to support the *Ten Steps of Mother-Friendly Care* that would be concise, precise, and widely available to the birth community—midwives, physicians, nurses, childbirth educators, doulas, hospital administrators, and childbearing women. The group has accomplished its goal.

The report presented in this publication confirms that substantial support exists for the *Ten Steps of Mother-Friendly Care*. The CIMS Expert Work Group’s systematic review of the research published in the decade since the *Ten Steps of Mother-Friendly Care* was developed and launched

provides compelling evidence for each of the *Ten Steps*. The systematic review of out-of-hospital birth is a significant contribution to the literature. The transparency of the group’s methods (see pp. 5S–9S of this issue) and its willingness to evaluate evidence related to “no evidence of benefit” or “no evidence of harm” have resulted in a more all-encompassing and meaningful review of the evidence than many systematic reviews.

The CIMS Expert Work Group’s findings confirm the relevance and continued importance of the *Ten Steps of Mother-Friendly Care*, as well as the larger *Mother-Friendly Childbirth Initiative* (CIMS, 1996), and suggest future direction for researchers, maternity caregivers, and childbearing women. It also

For more information on the Coalition for Improving Maternity Services (CIMS) and copies of the *Mother-Friendly Childbirth Initiative* and accompanying *Ten Steps of Mother-Friendly Care*, log on to the organization’s Web site (www.motherfriendly.org) or call CIMS toll-free at 888-282-2467.

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For a copy of the *Listening to Mothers II* survey, call Childbirth Connection (formerly Maternity Center Association) at 212-777-5000 or visit the organization's Web site (www.childbirthconnection.org).

raises the issue: Why, with this much support, has birth become more, rather than less, mother-friendly?

RESULTS OF THE LISTENING TO MOTHERS II SURVEY

The completion of the research presented here coincided with the publication of *Listening to Mothers II: Report of the Second National U.S. Survey of Women's Childbearing Experience* (Declercq, Sakala, Corry, & Applebaum, 2006). *Listening to Mothers II* was carried out by Childbirth Connection (formerly Maternity Center Association), in collaboration with Lamaze International, and was conducted by Harris Interactive, a market research company. The sample included a total of 1,573 women between the ages of 18 and 44 with a singleton birth in a United States hospital in 2005. There were 1,373 online participants and 200 telephone participants. The findings of *Listening to Mothers II* confirm that birth is increasingly "intervention intensive" and less mother-friendly (Declercq et al., 2006).

Of the surveyed women who had vaginal births, 80% had intravenous lines, and 55% had their labors augmented with pitocin. Ninety-four percent of the women had electronic fetal monitoring (93% of those women were monitored continuously). Only 15% of the women reported eating anything in labor, and only 40% reported that they had anything to drink.

The cesarean rate among the surveyed women was 33%, with half primary and half repeat surgeries. Most repeat cesareans were planned. The vaginal birth after cesarean (VBAC) rate was 11%. Eighty-nine percent of the women who have had a previous cesarean had a repeat cesarean. Although 45% of the women who have had a previous cesarean were interested in VBAC, 57% of them were denied that option. The unwillingness of the caregiver (47%) or hospital (26%) was the main reason reported as the basis for the denial. Forty-one percent of the respondents reported that their caregiver tried to induce labor; 84% of the time, this was successful. Only 1% of the women gave birth outside the hospital; less than 10% received care provided by midwives, and 3% were attended by a doula or professional labor attendant.

A significant proportion (86%) of the respondents used pain medication. Among the women having a vaginal birth, 71% received an epidural. Less than half of the women used nonpharmacological pain relief in labor: 49%, breathing; 42%, position

change or movement; 25%, mental strategies such as relaxation, visualization, or hypnosis; and 29%, hands-on techniques such as massage, touch, or acupuncture. Only 6% of the women reported using immersion in a tub during labor, and only 4% used showers. A quarter of the women reported walking after they were admitted to the hospital in labor, and 57% reported they were on their backs during pushing, with another 35% pushing in a semisitting position.

The women reported they wanted full, complete information about their choices. Eighty-one percent said they thought it necessary to know "every complication associated with an intervention," and another 19% thought it important to know "most complications." Most women were "unsure" of the adverse effects of interventions. Even those who actually experienced the intervention were unable to identify adverse effects of cesarean and induction. Only 11% of the women refused to accept care that was offered to them.

Only one third of babies were in their mothers' arms immediately after birth. Although 61% said they wanted to breastfeed exclusively, at one week only 52% were doing so. Babies of nearly half the mothers who intended to breastfeed were given formula or water "supplements" and a pacifier, and most of the mothers received formula samples or offers. Sixty-six percent of the women reported suffering some degree of depressive symptoms that would suggest a need for follow-up measures, but only 20% of these women consulted a health-care or mental health professional.

The *Listening to Mothers II* survey results confirm that standard maternity care in the United States is far from mother-friendly and provides further support that each of the steps of the *Ten Steps of Mother-Friendly Care* continue to be relevant.

ONGOING NEED FOR RESEARCH AND ADVOCACY

Why has the substantial body of research support for the *Ten Steps of Mother-Friendly Care* failed to create change in maternity care? Where do we go from here? Our suggestions fall into two, broad, equally important categories: research and advocacy.

Research

There are two underlying issues of concern related to research: factors that influence what does and

does not get studied, and the failure to change practice based on best evidence. Both issues have implications for mother-friendly care.

The dominant medical model of care exerts a powerful influence on what gets studied and what does not. The result is a scarcity of evidence to establish the benefit of many nonmedical measures that facilitate normal, physiological labor and birth and help women manage their labors. The systematic review points out the gaps in these areas.

A further problem is that the current standard demands conclusive proof of benefit before implementing change in practice related to nonmedical issues; however, no such demands are made for changing practices that show no benefit but are consistent with medical values. Two examples illustrate this point. First, no evidence shows any benefit for continued routine use of either intravenous fluids or continuous electronic fetal monitoring, although harm has been demonstrated for both. Second, in contrast, the freedom to walk during labor has not been shown to have a major effect on labor progress, but when given the choice women prefer it. In spite of the preferred choice, women continue to be confined to bed in labor. A critical need exists for an in-depth analysis of why this is so and for a more complete understanding of the barriers to change.

What is the most appropriate way to evaluate maternity care practices? In 2001, Murphy and Fullerton proposed using an optimality model to evaluate midwifery care and, then, suggested its value in evaluating maternity care. Optimality looks for the desired, best possible outcome rather than the occurrence of undesired, adverse (and often rare) events. Optimality replaces the focus on risk and adverse outcomes with a focus on measuring the frequency of “optimal” (good, desired) outcomes. This approach allows for the incorporation of a “noninterventive” philosophy in the model. The optimality model provides an appropriate framework for designing a study of mother-friendly care. We think it is time for a large-scale study of mother-friendly care compared to standard maternity care measuring optimal outcomes rather than just adverse effects.

Advocacy

Advocates can use this systematic review to advance the principles of the *Mother-Friendly Childbirth Initiative* and the *Ten Steps of Mother-Friendly Care*.

For women, the birth environment and caregiver exert powerful influences on how their childbearing experience unfolds. The *Ten Steps of Mother-Friendly Care*—along with *Having a Baby? Ten Questions to Ask* (CIMS, 2000), which is based on the *Ten Steps*—provide guidelines for women as they attempt to untangle the web of modern obstetrics and make important decisions about their care and the birth of their babies.

The *Ten Steps of Mother-Friendly Care* provides guidelines for caregivers, hospitals, birth centers, and home birth services that are committed to ensuring their services are mother-friendly. But these guidelines are only a first step. Ultimately, informed decision making must include the ability and the power to either consent or refuse specific care practices. Women need a deeper understanding of their right to informed refusal, especially in areas whereby disagreement occurs over what constitutes “best practice.” Informed refusal has the potential to exert pressure on a maternity care system that is resistant to change.

The CIMS is developing criteria for the designation of birth sites as mother-friendly. Additionally, grassroots organizations are working with CIMS to rate how mother-friendly individual care providers and hospitals actually are and, then, making this information widely available. The Institute of Medicine (2001) has this to say in its publication, *Crossing the Quality Chasm*:

Care must be delivered by systems that are carefully and consciously designed to provide care that is safe, effective, patient-centered, timely, efficient and equitable. Such systems must be designed to serve the needs of patients, and to ensure that they are fully informed, retain control and participate in care delivery whenever possible, and receive care that is respectful of their values and preferences. (p. 36)

The evidence-based *Ten Steps of Mother-Friendly Care* is an important resource in helping that happen and in ultimately improving maternity care in the United States and globally.

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