CHAPTER 15

We bring to childbirth our histories, our relationships, our rituals, our needs and values that relate to intimacy, our sexuality, the quality and style of family life and community, and our deepest beliefs about life, birth, and death.[1]

Pregnancy and birth are as ordinary and extraordinary as breathing, thinking, or loving. Whether you are having your first baby or are already a parent, each pregnancy calls on all your capacities for creativity, flexibility, determination, intuition, endurance, and humor. Similarly, each pregnancy should be accompanied by high-quality prenatal care, accurate information about pregnancy and birth, access to the full range of safe and healthy care options, and enough time for maternity

leave. You deserve encouragement, love, and support from those close to you; a safe work and home environment; nourishing food; and time for rest and exercise.

Ideally, you will experience your pregnancy and birth within what childbirth advocates call "a climate of confidence" that reinforces your strength and innate abilities and minimizes fear. Some of the factors that contribute to such a climate can be achieved only through collective efforts to fix major problems in our maternity care system; others are more likely to be within your personal control. This chapter focuses on how to prepare for a safe and healthy birth and how to understand and navigate the U.S. maternity care system. It provides guidance for choosing caregivers who listen to you and respect you as an active participant in your pregnancy and birth and selecting a birthing environment in which you feel comfortable and safe.

Because of space restraints, this chapter doesn't address the physical changes of pregnancy, normal fetal development, ways to cope with pregnancy discomforts, or the symptoms and treatments of pregnancy complications. Many excellent books cover these topics in depth, including *Our Bodies, Ourselves: Pregnancy and Birth; Pregnancy, Childbirth, and the Newborn;* and *The Working Woman's Pregnancy Book* (see Recommended Resources). There are also many organizations whose websites feature trustworthy information, including Childbirth Connection (childbirthconnection.org).

NINE MONTHS OF CHANGE AND GROWTH: PHYSICAL AND EMOTIONAL CHANGES

Pregnancy is a natural process. A new life develops inside you without any conscious work on your part. Cells divide, brain synapses develop, a new heart starts to beat.

The nine months of pregnancy are a full-body experience that can bring major emotional changes as well. Every organ system adapts. Your heart literally grows as it pumps extra blood throughout your body. Digestion patterns change as your body delivers nutrients from the food you eat to your growing fetus. Hormonal changes that support the pregnancy cause changes to your skin and hair. Your ligaments soften to allow your pelvis to enlarge to accommodate your baby as he or she is born. Your breasts grow, and you begin to produce colostrum, the earliest milk that will deliver nutrition and immune factors to your baby soon after birth when you breastfeed.

When it is time for your baby to be born, a remarkable cascade of hormonal signals between you and your baby trigger labor and allow it to progress. After birth, your body continues to offer your baby safety and comfort. Skin to skin, your baby will stay warm and quickly adapt to the many demands of life outside the womb. You and your baby will together experience hormonal shifts and physical sensations that set the stage for healthy attachment and breastfeeding. These same stimuli assist your body to recover from birth and minimize bleeding.

These remarkable changes assist with an even greater transformation: becoming a mother. Being pregnant transforms your identity and calls on your emotional strengths and resources. You may gain confidence in your own abilities as your body accommodates to the new life growing within you. Learning to trust ourselves and our bodies during the changes of pregnancy, birth, and parenthood may help us as we face other challenges throughout life.

As a woman who struggled with so many body image issues and an eating disorder as a younger woman, my first pregnancy was an exercise in

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body acceptance. Watching my stomach and hips grow and change in ways I could not control, I felt an alternating sense of disgust and amazement. When I began to look obviously pregnant, something changed. I was able to inhabit my body proudly, touching my hands to my belly knowing that my child needed this body to grow, develop, and give him life—never did I feel such love and pride about my physical body, and it was pure magic!

Many women report heightened perceptions, increased energy, and feelings of being in love, special, fertile, potent, and creative while pregnant. You may also have surprisingly strong negative emotions or feel ambivalent about this baby growing in you. These thoughts and feelings are common, even in planned and desired pregnancies.*

Sometimes it seemed like I had gotten pregnantion a whim—and it was a hell of a responsibility to take on a whim. Sometimes I was overwhelmed by what I had done. A lot of that came from realizing that I had chosen to have the baby without the support of a man. I was scared up until the third trimester that I wasn't going to make it.

You may have questions: How will my pregnancy change me and my life? How do I feel about my body changing shape? What supports do I have? How long can I keep working? Will I get laid off? Can I physically handle labor and birth? Do we have enough money? Will my baby be healthy? Will I be a good parent?

It is common to have fears and anxieties while standing on the threshold of the enormous and permanent change of becoming a mother. Many of us find it helpful to talk with other women who are navigating the changes that pregnancy and new parenthood bring. You may be able to find support in childbirth classes, exercise classes, and peer support groups designed for pregnant women, as well as on online social networking sites used by expectant and new parents.

Pregnancy and childbirth raise perfectly natural fears of pain and the unknown, and we can never be completely sure of the outcome, no matter how we care for ourselves in pregnancy, where or how we give birth, or how much we've

*If your pregnancy was not planned, or if you are deeply ambivalent about whether you want to raise a child, see Chapter 12, "Unexpected Pregnancy."

Courtesy of the Mariposa Ministry

planned or prepared for it. Yet pregnancy and birth are intrinsically healthy processes, successful in the great majority of instances when understood, respected, and supported. Our own confidence can be enhanced when our providers offer intelligent guidance and support, so that, when possible, labor unfolds on its own. Used in conjunction with appropriate medical interventions for managing complications, these practices help ensure that we experience pregnancy and birth safely in a true climate of confidence.

CHOOSING A PRACTITIONER AND A PLACE FOR YOUR BIRTH

Although our maternity care system as a whole has major limitations, there are many providers who consistently offer high quality, woman-centered care as well as birth settings where staff share a commitment to supporting safe, healthy, and satisfying birth experiences. Take time before becoming pregnant or early in your pregnancy to learn about your options.

An optimal provider and birth setting will offer you:

- Care that is consistent with the best available research on safety and effectiveness
- An environment and treatments that support or enhance, rather than interfere with, the natural process of pregnancy and birth
- Individualized care that takes into account your health needs and those of your baby, as well as your personal preferences and values
- Abundant support, comfort, and information
- Access, either directly or through an efficient referral mechanism, to treatments for complications, should the need arise

Identifying your priorities, learning about the differences among various approaches to childbirth, and finding out which options are available to you can help you make decisions that fit your circumstances and preferences.

CHOOSING A PROVIDER

Most providers are part of group practices, which means that you will be attended at birth by whichever provider is on call at that time. In addition, the provider on call will respond if you have any concerns during pregnancy that come up outside regular office hours. This can be frustrating if you have a good relationship with a particular provider but are offered care by another whom you do not know as well. On the positive side, working in such teams can give midwives and doctors more predictable, limited work hours; this entails less fatigue and can reduce medical errors. Some groups have you see one doctor or midwife for the whole pregnancy, while others rotate you through the group so you get to meet everyone. If you will be working with a group practice and have a choice, look for one in which all members have comparable philosophies of care that are well matched to your needs and preferences. Some practices host public events to introduce all the providers.

TYPES OF PROVIDERS

Midwives

Midwives have been attending and supporting women during pregnancy and childbirth, and teaching other women to do so, for centuries. All midwives are trained to provide women with prenatal care, care during labor and birth, and follow-up care after the baby is born. In the United States today, midwives attend approximately one in ten vaginal births, primarily in hospitals.

MODELS OF MATERNITY CARE

Before choosing a care provider and place of birth (the two usually go hand in hand), it is helpful to understand the two main paradigms in maternity care education and practice, described as the midwifery model and the medical model.*

The classic midwifery model is based on the assumption that most pregnancies, labors, and births are normal biological processes that result in healthy outcomes for both mothers and babies. It focuses on maximizing the health and wellness of a woman and her baby, identifying and managing medical problems early on, and attending to the emotional, social, and spiritual aspects of pregnancy and birth. Midwifery care seeks to protect, support, and avoid interfering with the unique rhythm, character, and timing of each woman's labor. Midwives are trained to be vigilant in identifying women with serious complications. Medical expertise and interventions are sought when necessary but are not used routinely.

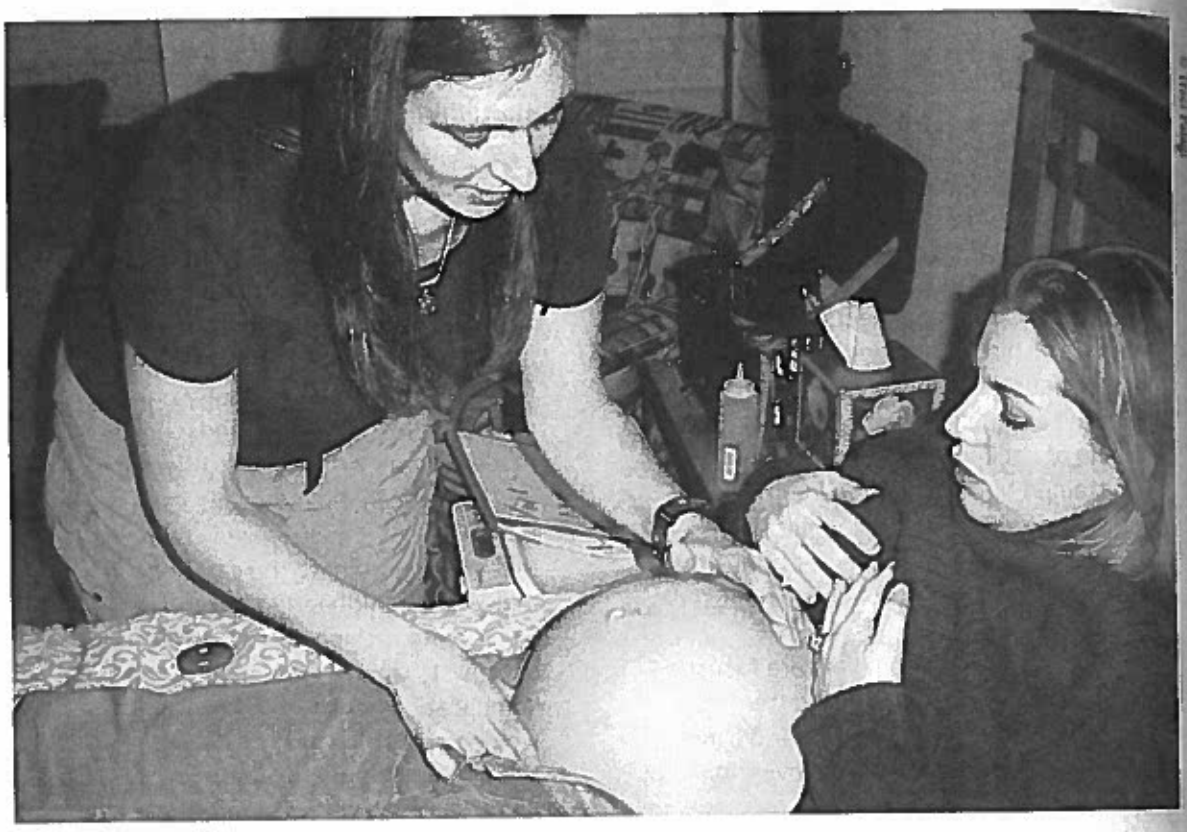
A strict medical model of care focuses on preventing, diagnosing, and treating the complications that can occur during pregnancy, labor, and birth. Prevention strategies tend to emphasize the use of testing, coupled with the use of medical or surgical interventions to avert a poor outcome. Medical expertise and interventions are vital for women and babies with complications. However, routine interventions on women at low risk of problems can actually lead to problems. Training in the medical model does not typically focus on developing skills to support the natural progression of an uncomplicated birth.

Although it is crucial to understand the differing philosophies and training among practitioners, it is also important to note that the letters after someone's name do not tell you much about her or him as an individual. Some doctors have attitudes, styles, and approaches that fit the midwifery model, and some midwives incorporate the medical model that is more common for doctors.

The midwifery model and medical model also give rise to two different ways of organizing maternity care systems. In most industrialized countries, midwives coordinate the care for the majority of childbearing women and collaborate with obstetricians or other specialists when a woman has medical complications or risk factors. Healthy women often give birth in midwife-led hospital units or birth centers or at home. In contrast, in the medical model prevalent in the United States, doctors manage the care of most women, almost all of whom give birth in hospitals. When midwives do provide the care, they are usually supervised by doctors and working under medical rather than midwifery protocols.

* These terms derive from the kinds of care physicians and midwives have historically provided. However, their use is not meant to imply that all midwives follow a midwifery model or that all physicians follow a medical model. Some people believe it is more accurate to refer to the different models of care as a physiologic model (that is, care in accord with the normal functioning of a woman's body) versus an interventionist or pathology-driven model.

Most communities in the United States fail to promote a midwifery model of care despite powerful evidence in numerous studies that underscore the benefits of midwifery care and the heightened satisfaction of women who use midwives. A 2008 Cochrane systematic review comparing midwife-led to physician-led models of care concluded, "Midwife-led care confers benefits and shows no adverse outcomes. It should be the norm for women classified at low and high risk of complications."[2]



Certified Nurse-Midwives and Certified Midwives

Certified nurse-midwives (CNMs) are educated in nursing and midwifery. Certified midwives (CMs) are educated only in midwifery. Both CNMs and CMs are specialists in the care of healthy women in pregnancy and childbirth. They also provide well-woman care, which includes gynecological checkups, pelvic and breast exams, Pap tests, and family planning services. CNMs and CMs are certified by the American Midwifery Certification Board.

CNMs and CMs are able to attend births in hospitals, birth centers, or homes, and they typi-

cally have established relationships with doctors with whom they can consult as needed and who will assume care during pregnancy or labor if certain complications develop. Their services are usually covered by health care insurance policies. Depending on their style of practice, a CNM or GM might be with you for your whole labor or might function more as physicians do, coming in periodically to check on you and then being present when you give birth.

Because I had conceived through in vitro fertilization and had previously had a miscarriage, I was worried about my pregnancy. The reproductive endocrinologist I worked with frowned on any birth setting but a hospital. In addition, I had a serious gastroesophageal complication and wanted my providers to be on equal footing with each other. All this led me to choose an obstetrician. But when she announced she was leaving the practice (in my sixth month), I took the opportunity to reexamine my situation.

Not only had my OB and my gastroenterologist never communicated with each other, they gave me contradictory advice. I met with the other members of the obstetric practice and was uncomfortable with how they discussed epidurals and C-sections. I realized that no matter how I had conceived, I now had a normal pregnancy. Well into my third trimester, I switched to a midwifery practice and was able to have a natural childbirth like I wanted.

Certified Professional Midwives

Certified professional midwives (CPMs) specialize in healthy pregnancy and natural childbirth. They attend births at home and, in some states, birth centers. They learn their profession by attending freestanding midwifery schools or through apprenticeship to other midwives, combined with reading and study. CPMs have nationally recognized credentials through the North American Registry of Midwives. The licensing of CPMs varies from state to state, and in some states this type of midwifery is illegal or unregulated.

Recommended Reading: To learn more about your state's rules concerning CPMs, check out Citizens for Midwifery (cfmidwifery.org/states). To find out about efforts to change legislation in states that do not yet regulate CPMs, visit The Big Push for Midwives (thebigpushformidwives.org).

CPMs may or may not have formal relationships with individual physicians and/or hospitals. It is important to carefully explore the issues of medical backup and emergency care with your provider, because you may need to arrange for physician or hospital backup yourself. (For information on who is a good candidate for home birth, see "Birth Places," page 367.)

Insurance coverage of CPMs differs from state to state and insurer to insurer. It is more common where home birth midwives are licensed.

Other Midwives

Some midwives are not certified and consider themselves "traditional," "independent," or "direct entry" midwives. Although many such midwives are experienced and practice safely, the lack of a national credential and, in most cases, a license to practice makes it difficult to evaluate their skill and safety record. If you are considering a midwife who is not certified, ask careful questions about the midwife's training and experience and her arrangements for referral and transport if complications develop.

Physicians

In the United States, physicians attend 90 percent of all births. Here's a look at the different type of physicians who commonly provide care to pregnant women.

Family Physicians

A family physician is a medical doctor who is trained to provide basic, comprehensive care to people of all ages. Some family physicians provide maternity care and have hospital delivery room privileges. A few are trained to perform cesarean sections. These doctors often know the whole family, which can enhance planning for a woman's care as well as the care of the baby after birth. Studies have shown that family physicians' use of common interventions such as episiotomy, cesarean, and labor induction tends to fall between that of midwives and that of obstetrician-gynecologists.[3]

Obstetrician-Gynecologists

Increasingly over the last several decades, obstetrician-gynecologists (ob-gyns) have replaced family practice doctors in providing maternity care. Ob-gyns have completed a four-year medical and surgical residency program in obstetrics and gynecology after completing medical school. Because ob-gyns are trained to diagnose and manage complications of pregnancy and birth, they are appropriate providers for women or babies who have serious medical conditions. (For examples of these conditions, see "Hospital," p. 369.) Women with such health problems may benefit from shared care with a midwife. Ob-gyns also provide care for childbearing women without specific medical concerns who either prefer to work with an obstetrician-gynecologist or must do so because of limited options.

Ob-gyns commonly provide prenatal checkups and oversee labor but rarely stay with you throughout labor and may be present only at the time of birth. (During labor, your hands-on care is generally provided by labor and delivery nurses.) Because obstetrics is a surgical specialty, OB care typically involves much higher rates of intervention than midwifery or family practice–based care.

Maternal-Fetal Medicine Physicians

Maternal-fetal medicine physicians (MFMs) are subspecialists in the obstetrics field who have additional training in complicated obstetrics. They often assume care of women with serious conditions such as diabetes or heart disease. These doctors usually practice in large academic medical centers or urban areas and see women only on referral from a physician or midwife. Many perform prenatal and genetic testing procedures and have expertise in the field of genetics. Frequently, they devise a plan of care in collaboration with a pregnant woman's midwife or physician in her home community. If you are referred to a maternal-fetal medicine specialist, find out whether she or he actually attends births; many no longer do.

FINDING A PROVIDER

The vast majority of us enter pregnancy as healthy women, with no major medical problems. If this is true for you, you can choose from the full range of providers and birth settings available in your area. If you have a serious medical condition or are at risk of developing such a condition, an obstetrician or maternal-fetal medicine specialist should be on your team and you should plan to give birth in a hospital, but you still may have midwives involved in your care. Choosing a clinician and birth setting that fit with your beliefs and preferences will be more effective than writing a birth plan and hoping to influence routine practices in medical settings.

To get names of practitioners, ask your family and friends for recommendations and, if

you have insurance, find out which providers and services your health care insurance covers. Doulas and childbirth educators can provide excellent guidance about caregivers in the community. Interview the people who you think are most likely to be a good fit for you. (Some insurers will cover an interview visit, and some practices will not charge for the interview; this varies.) For a list of questions to ask, see p. 368.

Setting up a counseling visit before you become pregnant is one way to get to know a doctor or midwife you might consider for your pregnancy care. You can also choose your birth setting first and select a provider from those who attend births in that location. If you are not happy with the care you receive, you have the right to change providers at any time, but be aware that some care providers have a cutoff point for accepting new clients.

BIRTH PLACES

The environment, culture, and routine practices used in different birth settings can affect the process of labor and birth. If you are healthy and have not experienced complications in your pregnancy, you can choose from any of the options in your community, which may include giving birth at home, in a birth center, or in a hospital. Some communities have several hospitals that provide maternity services, so if you are planning a hospital birth you may want to evaluate each one.

Home

Home birth is a good option for healthy women who have healthy pregnancies, a safe and supportive home environment, and easy access to backup medical care. Two critical characteristics of home birth are that you rely on your body's natural abilities (not technology or drugs) to get you through labor and that you can receive continuous support from attendants of your own choosing. Home birth is associated with a very low likelihood of having a cesarean, episiotomy, medications to speed up labor, and pharmacologic pain relief and with high rates of satisfaction.

Midwives are specifically trained to monitor mother and baby's well-being during labor and to handle complications that may arise. Sometimes complications or a desire to use pain medication may require transport to a hospital.

ONLINE HOSPITAL AND CARE PROVIDER RATING SITES

Many websites allow health care consumers to rate and provide feedback on care providers and facilities. Other sites provide safety and performance data for hospitals. These sites, in turn, help consumers looking for health care evaluate the choices in their communities.

The Birth Survey is a grassroots project that aims to increase transparency in maternity care. The site invites women who have given birth to provide feedback about care providers and birth settings. Survey questions are designed to assess whether care is evidence-based and mother-friendly, as defined by the nonprofit Coalition for Improving Maternity Services. In addition, project volunteers have been working with state health departments to obtain and publish facility data such as rates of cesarean section, induction, and episiotomy. You can view consumer feedback and intervention rates for the providers and facilities in your area at thebirthsurvey.com.

QUESTIONS TO CONSIDER ASKING MIDWIVES AND DOCTORS

- What is your philosophy of childbirth?
- How long have you been practicing? How many births have you attended as the primary attendant?
- Do you practice alone or with others? If with others, what is their experience? Do they share your beliefs and manner of practice?
- Who attends births for you when you are away?
- Where do you attend births, and can I take a tour?
- How can I reach you?
- How often will I see you during these next months?
- What kind of childbirth preparation do you recommend?
- What tests do you recommend for pregnant women? Why?
- How do you define and handle complications?
- Do you provide labor support and stay with women throughout labor? If not, do the nurses provide one-on-one care for women during labor?
- How do you feel about doulas, labor assistants, or family and friends being present?
- Do you support moving around during labor, changing positions, and eating and drinking?
- Will I see you after the birth takes place?
- If I want to hold my baby right after birth, breastfeed, and not be separated, will that be supported?
- If I plan to breastfeed and experience problems, what support will you offer?
- Under what circumstances do you recommend IVs, continuous electronic fetal monitoring, Pitocin, episiotomy, forceps or vacuum, cesarean section, or immediate clamping of the baby's umbilical cord? What is your cesarean rate? Episiotomy rate? Induction rate?
- What is your protocol for the birth of twins and breech births?
- Do you attend vaginal births after cesareans (VBACs)?
- How much do you charge? Are your services covered by my insurance?

Additional Questions for Care Providers Who Attend Home and Birth Center Births

- Are you licensed and certified?
- What are your requirements for accepting patients to give birth in this setting?
- What drugs and equipment do you have available?
- What are the qualifications of your birth assistant?
- Do you have a formal agreement with an obstetrician-gynecologist to provide care if complications occur?
- Do you recommend that I meet the physician who will assist me in case of a complication?
- What hospital will I be transported to if a complication occurs during labor? What about in an emergency?
- Under what conditions would we go to the hospital?
- Would you stay with me if we transfer?
- What percentage of your clients transfer to a hospital during labor?
- Are you trained in newborn resuscitation?
- What kind of postpartum care can I expect? Do you provide follow-up care for the baby as well?

Many home birth midwives carry equipment to help address these needs before and during a transfer. In most studies of planned home birth, 10 to 20 percent of women who begin labor at home will transfer to a hospital before birth, but most of these transfers are for nonurgent situations, such as exhaustion, slow labor progress, or need for pain relief.[4]

Birth Center

Freestanding Birth Centers

Birth centers provide comprehensive family-centered care for women during pregnancy, childbirth, and the time following birth. In the birth center philosophy, pregnancy and birth are normal and healthy processes that should be interfered with as little as possible.

Usually birth centers are homelike places, in contrast to the more institutional setting of hospitals, with added comforts such as birth tubs and birthing balls for relaxation and to relieve pain. Midwives provide personalized, continuous care to laboring women. Birth centers have systems in place to deal with complications during labor and birth and to transfer you to a hospital if necessary.

As with home birth, at a birth center you can expect greater reliance on your own physiology rather than on technology, a focus on individualized care, and staff available to give you continuous support.

Birth centers vary in their rates of using tests and procedures, in their policies and restrictions, and in their medical backup arrangements. There are certain situations in which you may be required to switch to hospital care before or during labor—or even after giving birth—either as a precaution due to complications or in the rare event of an emergency.

Not all women are eligible to give birth at a birth center, and each has its own screening guidelines. Most commonly, this affects women seeking vaginal births after cesarean sections (VBACs). (For more information on VBACs, see p. 388.) You can find out if there is a birth center in your area through the American Association of Birth Centers (birthcenters.org).

Birth Centers in Hospitals

A birth center located within a hospital may have a philosophy and practice anywhere on a continuum between that of a typical freestanding center and that of a hospital. Though many hospitals call their traditional labor and birth units "birth centers" in marketing materials, an in-hospital birth center is separate from the general labor and birth unit and is designed for healthy women who desire midwifery-model, low-intervention care. In most cases, women who need medical interventions—such as intravenous Pitocin or electronic fetal monitoring—or women who desire epidural analgesia will move to the general labor and birth unit for these procedures.

One advantage of in-hospital birth centers is the close proximity to surgical and anesthesia facilities, should they be needed. However, in-hospital birth centers are more likely than freestanding birth centers to place restrictions on laboring women, such as requirements for a period of continuous fetal monitoring before admission or certain routines for newborns.

Hospital

A hospital is the standard setting for many women who prefer to be close to medical care while giving birth or who intend to use an epidural for pain relief. It is also the setting of choice for women and babies who have medical conditions that increase the chances of needing special care. Hospital care is considered safest for women with high blood pressure, diabetes, or seizure disorders; women carrying multiple babies; women who are delivering prematurely or who are more than two weeks beyond their due date; and women whose babies are not in a

IS IT SAFE TO GIVE BIRTH AT HOME?

The media tend to portray childbirth as a high-risk event where anything could go wrong at any time. It is therefore not surprising that most of us feel that the safest labor and birth setting is the hospital, where we can be constantly monitored for problems and an operating room and surgical staff are available in case anything goes wrong.

But the reality is that most complications that occur in labor and birth are predictable. They tend to occur in women with high-risk pregnancies, develop slowly, or are known side effects of labor interventions such as medications to strengthen contractions or reduce pain. Although urgent complications can occur without advance warning, these are the exception rather than the rule.

Still, many women wonder if home birth can be as safe as hospital birth. Researchers have been studying this question for decades. Until recently, virtually every study suffered from major flaws that resulted in promising data but no clear answer to the safety question. More recently, three studies have been published that meet the highest standard for home birth research.[5] One of these, a study from the Netherlands, where home birth is common, looked at the outcomes of more than a half-million planned home births. These studies show no difference in death or serious injury to babies and much better outcomes for mothers in planned home births.

Importantly, the three recent studies came from countries where only healthy women at term, with no risk factors for complications, may plan home births. In addition, midwives in these settings are highly skilled and regulated and have established relationships with consultant physicians and hospitals, so women or babies who need hospitalization can access it easily.

For these reasons, the outcomes of the studies cannot necessarily be applied to the United States, where there are no standard eligibility requirements for planned home birth. Laws regulating midwifery vary across the United States, and some midwives work without any formal arrangements for consultation and referral. Still, the largest study of planned home births in the United States showed excellent outcomes for both mothers and babies with low rates of obstetric complications, although the study did not meet the rigorous standards of other studies because hospital data on low-risk women in the United States are inadequate.[6]

In practice, the safety of home birth depends on the health of the woman and fetus, the skill of the home birth care provider, the distance to a hospital, and the ability to get safe, timely care at that hospital should a complication develop. Consider each of these carefully when exploring the option of planned home birth.

head-down position or have problems that have been identified during the pregnancy. If you have one of these conditions, you will want to be with practitioners and facilities with experience handling your situation.

For some women, there are disadvantages to giving birth in a hospital. Hospital routines, which are set up to promote efficiency and to facilitate emergency medical treatment, are sometimes not flexible enough to accommodate an individual woman's needs. Providers who work in hospitals, even if they believe in informed choice and supportive, low-intervention care, are often constrained by hospital protocols—such as policies forbidding vaginal birth after cesarean section or restricting what women can eat or drink in labor. Interventions such as cesarean surgery, vacuum- or forceps-assisted vaginal birth, and episiotomy are significantly more common in hospitals than in birth centers or the home birth setting.[7]

If you don't have a doula or other knowledgeable support person, assistance with nonmedical pain management will depend largely on the skill and availability of the labor and delivery nurses. You may be able to request a nurse with such experience when you arrive at the hospital, if that is important to you.

There is wide variation among hospitals. Some adhere to best practices, attending to the emotional and physical comfort of women and honoring informed choice, while others impose rigid routines and impersonal care. Likewise, rates of procedures such as cesarean surgery and outcomes such as infection vary across hospitals. If you live in an area with more than one hospital, it is best to ask knowledgeable people, such as childbirth educators or doulas, for their opinions of area hospitals and to check published quality reports if these are available. (Search online for "maternity care quality" and your state or region, or contact your state department of health.) The Birth Survey (thebirthsurvey.com), a nationwide grassroots project, offers intervention rates (where available) and consumer feedback on hospitals as well as birth centers.

I almost never hear of the totally natural, completely positive hospital birth experience, and that's why I'd like to share our story. . . . We chose the hospital we did because of the fact that there were many nurse-midwives on staff that I hoped would be supportive of my desire to have a natural birth. I . . . felt very supported by my husband's medical knowledge and he knew how strongly I wanted to do it drug free—he would be my advocate. He also shared a very empowering piece of advice with our birth class: that should you be in a hospital and not comfortable with the plan, you are entitled to say that you understand the risks and benefits of a procedure and [you] can refuse it. That is your right.

When my contractions had not kicked in . . . twelve hours after my water broke and the usual time they give before they start to induce, we said we wanted to wait a bit. We walked, delaying the Pitocin, but [later] . . . negotiated half the normal dosage. . . . By that time, my husband looked at the monitor and noticed the contractions were getting stronger and more frequent without being induced. Despite the suggestion to continue as planned, we decided to go natural, asserting our right. The doula arrived, and after four hours of intense labor. . . . I reached a point where I said that I couldn't go on. She said to me, "No, you are there. Let's get ready to start pushing!"

Like a set change in a play, there was a whole new team, the bed changed position, and we started to push. Our incredible nurse-midwife was on her knees for the entire two hours while I pushed, holding a warm compress to my perineum so I wouldn't tear—which I didn't. At 5:40 P.M., Sadie was born. It was the single most incredible moment of my life. We feel very blessed to have had the seemingly elusive wonderful, natural hospital birth.

MATERNITY CARE IN TODAY'S HEALTH CARE SYSTEM

For many of us, pregnancy is our first serious contact with the medical system. Whether you have a healthy pregnancy or experience complications, with excellent information, care, and support, you can emerge from your maternity care experiences as an empowered, savvy health care consumer, better prepared to take control of your own health and that of your children.

I started my pregnancy with so much fear and mistrust of doctors and hospitals and decided on a home birth to avoid even having to deal with them. Well, best laid plans . . . at thirty-three weeks, I developed severe preeclampsia and HELLP syndrome. I had to accept that we needed doctors and hospitals to do this safely, but I wanted to be involved in making decisions about my care and not just accept every medical intervention just because I had a complicated pregnancy.

I was induced at thirty-four weeks, and even though I was on magnesium sulfate, which made me feel woozy and sick, and Pitocin, which strengthens contractions, had electronic fetal monitors, couldn't eat, and had to stay in bed, I was able to labor on my terms—with my husband and doula by my side. Against what seemed like all odds, I delivered my healthy daughter vaginally with no pain medication and was able to hold her skin to skin after birth. She did end up going to the NICU for a couple of days, but I think the fact that I held her right away made breastfeeding easier and helped me cope with the separation. I thought I'd feel traumatized by a "medicalized" birth, but I felt ecstatic and like I could take on whatever life throws my way. I think the experience prepared me for the intensity of motherhood, and I would even say it strengthened my marriage.

Unfortunately, too often the opposite is true. The maternity care system frequently offers fragmented, impersonal care that does not reflect what research has shown for decades produces the best health outcomes for mothers and babies. Maternity care in the United States is characterized by several problems:

Too few women get adequate prenatal care. In the past decade or so, care options—such as testing for pregnancy complications or pain relief options in labor—have become much more complex. Fewer women are taking prenatal education classes and more women are experiencing high-risk or complicated pregnancies. Yet the time a woman spends in prenatal visits has been reduced. The typical woman may have as little as two hours of total interaction with her doctor or midwife during her entire pregnancy.[8] Many women also enter prenatal care late, especially low-income women who have Medicaid insurance.

Too many women are exposed to the risks of high-tech procedures, even when they are healthy and unlikely to benefit from them. The most visible example of this is the U.S. cesarean section rate: one in every three women gives birth by C-section. Cesarean sections can be lifesaving and health-enhancing in emergency situations, but unnecessary cesareans expose more mothers and babies to the risks of major surgery, without any clear gains for maternal and infant health overall.

Too many women are subjected to these potentially harmful procedures without giving informed consent. In Childbirth Connection's national survey of women who had given birth in U.S. hospitals, Listening to Mothers II, participants overwhelmingly agreed that women should know the potential harmful effects of procedures. Yet far fewer than half of women were able to correctly answer basic questions about the risks of labor induction or cesarean surgery, even if they had experienced these interventions themselves.[9]

U.S. MATERNITY CARE: ROADBLOCKS TO CHANGE

Why are some medical interventions still being overused in the United States today, despite the evidence against them? And why aren't approaches that are known to be helpful offered to all women? Advocates for improving maternity care point to the following roadblocks to change.

Obstetrical training and the medical system. Obstetricians provide care for the vast majority of pregnant women in the United States. Obstetricians' training emphasizes identifying and managing the complications of pregnancy and childbirth. They generally receive much less instruction in the natural progression of childbirth or in low-technology techniques that minimize problems. While doctors trained years ago learned to safely deliver breech and twin babies vaginally, newer doctors have not learned these skills, as the standard of care has shifted to require cesarean for such births.

Economic incentives. Surgical interventions can save doctors time and money. Many payment systems offer a single or fixed fee to doctors, regardless of whether a baby is born vaginally or by cesarean, and others offer a larger fee for a cesarean. Therefore, doctors who patiently support natural labor, which starts at unpredictable hours and generally requires more time, are penalized financially. Scheduled inductions and cesarean sections help hospitals make nursing staff schedules more predictable and shift more of health care providers' work to convenient weekday hours. Nondrug methods of pain relief and the one-on-one nursing care that enables natural labor are not billable to insurance, while epidurals and other anesthesia services are major sources of revenue for hospitals.

Fear of lawsuits. If something goes wrong, doctors may be blamed for not doing something, but rarely are they blamed for doing something that is not necessary. For example, malpractice lawsuits for not performing a cesarean section are much more common than lawsuits for doing one when it wasn't necessary. To avoid litigation, many doctors and some midwives report that they feel compelled to do "too much" rather than be accused of doing "too little."

A rushed, risk-averse society. The desire to eliminate pain and control outcomes may cause both health care providers and expectant parents to embrace unneeded and potentially harmful procedures. Healthy women with low-risk pregnancies receive treatments that were designed for use by women with high-risk pregnancies. The widespread use of epidurals also has transformed childbirth in the United States. Though epidurals are in most cases a very effective form of pain relief during labor, they sometimes have adverse effects and require the proactive use of other interventions to keep mothers and babies safe and labor progressing.

The language of "choice." Labor and birth approaches are sometimes presented as equivalent "choices" without full, accurate information about their potential consequences. Choices that are perceived as risky for the fetus are more likely to be restricted than choices that are clearly shown to be risky to women. For example, vaginal birth after cesarean (VBAC) and planned home birth, though both are supported by research, are seen as unreasonable and made inaccessible to many women, while elective cesareans (cesarean sections done without a medical need) are increasingly presented by the media and some doctors in a misleading fashion as a reasonable option for healthy pregnant women.

In addition, nearly three-quarters of women who had episiotomies (a surgical cut to make the vaginal opening bigger during birth—a painful procedure associated with known harms when used routinely) did not give consent.

Too few women have the benefit of low-tech supportive care practices that help them safely cope with the demands of pregnancy, labor, and birth. In the Listening to Mothers II survey, most women said they were not allowed to drink or eat food, were confined to bed once admitted to the hospital and in "active" labor, and gave birth lying on their backs (a position that is more painful than upright positions and poses challenges for giving birth). Only 2 percent of women experienced a set of five supportive care practices that research shows benefit mothers and babies.*

Too many women end up with physical and emotional health problems after giving birth. In a follow-up survey of Listening to Mothers participants, many women experienced pain, physical exhaustion, and sexual problems lasting months after birth, as well as shorter-term problems such as infection and rehospitalization. Most had some symptoms of postpartum depression in the two weeks prior to the survey, and 9 percent of mothers appeared to be suffering from childbirth-related post-traumatic stress disorder.[10]

* These practices are: labor begins on its own; the woman has the freedom to move and change positions; the woman has continuous labor support from a partner, family member, or doula; the woman does not give birth on her back; and the mother and baby are not separated after birth.

PRENATAL CARE

Prenatal care consists of three interrelated elements: regular visits with your midwife or doctor; the care you give yourself; and the care you receive from friends, family, and other support people. This section focuses on prenatal visits with a care provider.

WHAT TO EXPECT FROM PRENATAL VISITS

Prenatal care by your midwife or doctor will encompass regular health assessments, coordination of care with other providers or services, and establishing a plan of care for labor, birth, and your postpartum recovery and adjustment to motherhood.

RIGHTS OF WOMEN DURING PREGNANCY AND BIRTH

No matter what situations you face when you are pregnant and in labor, understanding your rights is key to making good decisions and being better able to act on them. The statement below is excerpted and adapted from Childbirth Connection (childbirthconnection.org), a nonprofit group that works to improve maternity care for all U.S. women and families.*

The statement outlines a set of basic rights for childbearing women, applying widely accepted human rights to the specific situation of maternity care. Most of these rights are granted to women in the United States by law, yet they are not always honored. In addition, the wider social, political, and economic organization of health care, parenting, and the workplace makes it difficult or impossible to consistently exercise these individual rights.

Every Woman Has the Right to:

Choose her birth setting from the full range of safe options available in her community, on the basis of complete, objective information about the benefits, harms, and costs of these options.

Receive information about the professional identity and qualifications of those involved in her care and know when any are trainees.

Communicate with caregivers and receive all care in privacy (which may involve excluding nonessential personnel) and have all personal information treated according to standards of confidentiality.

Receive maternity care that is appropriate to her cultural and religious background and receive information in a language she clearly understands.

Leave her maternity caregiver and select another if she becomes dissatisfied with the care.

Receive full advance information about harms and benefits of all reasonably available methods for relieving pain during labor and birth, including methods that do not require the use of drugs.

Accept or refuse procedures, drugs, tests, and treatments. She has the right to have her choices honored and to change her mind at any time.

Enjoy freedom of movement during labor, unencumbered by tubes, wires, or other apparatus. She also has the right to give birth in the position of her choice.

Be informed if her caregivers wish to enroll her or her infant in a research study. She should receive full information about all known and possible benefits and harms of participation, and she has the right to decide whether to participate, free from coercion and without negative consequences.

Have unrestricted access to all available records about her pregnancy, her labor, and her infant; obtain full copies of all records; and receive help in understanding them, if necessary.

*For the full text of this statement, see Childbirth Connection's "The Rights of Childbearing Women" at childbirthconnection.org/rights.

A woman who had planned a home birth but discovered late in pregnancy that her baby was breech describes how she exercised her rights in a hospital setting:

Through all our research, we found out that there were several doctors at this hospital who were experienced in delivering breech and that while hospital staff would try to pressure me into having a C-section, it was my right to decline a cesarean. We showed up at the hospital the next day to try a version [where doctors try to manually turn the baby] with a letter that specified that we were not giving consent to a C-section unless mine and/or the baby's lives were at risk. The version didn't work, and the doctors tried to convince us to have a C-section. The biggest reason they could give us was that it would be challenging to schedule staff who were experienced at delivering breech to be available when I went into labor. That did not seem like a good enough reason to cut me open.

Once the doctors realized that we were not going to consent to a C-section, a very nice female doctor offered to be on call for me. She spent over an hour talking with me, trying to get me comfortable with delivering in a hospital. As I became more comfortable, my labor kicked into high gear. My third daughter was born less than four hours later. It was the easiest and quickest labor I have had. We were back home less than three hours after giving birth.

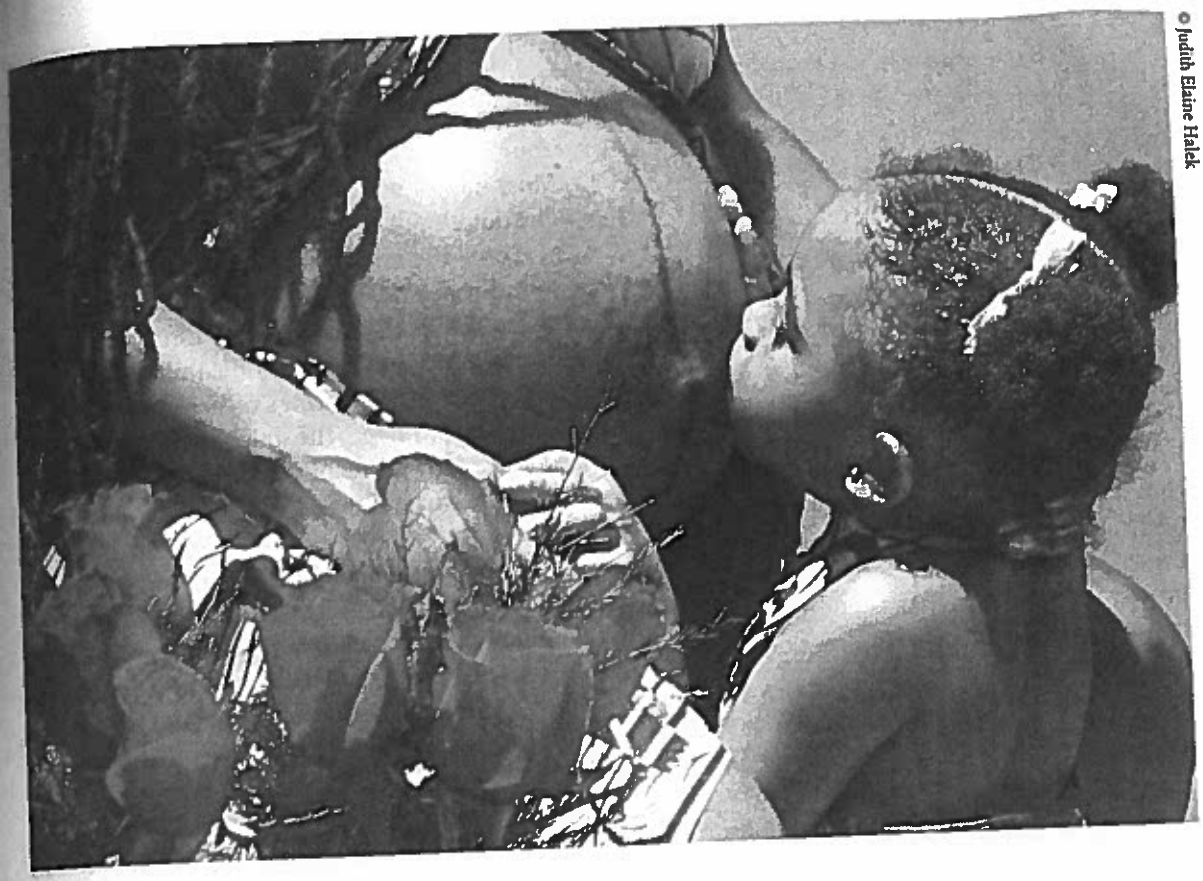
All prenatal care is not alike. Some prenatal care providers, especially midwives who practice in home and birth center settings, offer long visits with plenty of time to answer questions, address concerns, celebrate joys, and explore fears. We may be encouraged to participate in aspects of our visits, such as taking our own blood pressure or writing our weight in our own medical records.

My 6-year-old daughter, Lucia, often came to my appointments with me, and I think it was an important part of making her the great big sister that she is. Our midwife, Elizabeth, was really patient with all of Lucia's questions, let her try all of her tools, and always had a doll for her to hold that was the same size as our growing baby. After Savina was born, Lucia was really sad that we couldn't go visit Elizabeth anymore.

Some provider visits are brief and emphasize tests and procedures. While most of us have one-on-one appointments with a care provider, more women are participating in supportive group prenatal care with other women due around the same time. Be prepared to take a proactive role to get the most out of your visits. For more information, see Chapter 23, "Navigating the Health Care System."

PRENATAL VISITS

In the first trimester, prenatal visits to your health care provider are recommended every four to six weeks. The timing of your visits may vary depending on your individual needs. Visits will typically include measuring your weight and blood pressure, listening to the baby's heartbeat (after ten to twelve weeks), and measuring his or her growth by feeling the uterus or plac-



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ing a measuring tape on your abdomen. Ideally, you will have enough time to talk about any concerns, review test results if tests were done, and discuss future plans.

If you participate in group prenatal care with other women, your visits will also include time to learn together the information you will need to make informed choices about your care. If you have traditional one-on-one prenatal visits, you will likely benefit from childbirth education classes, including early pregnancy and breastfeeding or parenting classes, especially if your care provider offers relatively brief prenatal visits (less than thirty to sixty minutes with the midwife or doctor). For more information see "Childbirth Classes," p. 383.

YOUR FIRST VISIT

If your first prenatal visit is the first time you will meet your care provider, come with questions that will help you decide if she or he is a good fit for you. (See suggested questions on p. 368.) If possible, bring your partner, other family member, or a friend for support.

At the first visit, you will be asked about your health history and your family's history, your background, your occupation, and what support you have at home. You will talk about your diet, exercise, and drug and alcohol use. The purpose of this visit is to help you identify any problem areas, such as physical and psychological concerns. If you are experiencing physical or sexual abuse, consider telling your midwife or doctor.

CENTERING PREGNANCY: A MODEL OF GROUP PRENATAL CARE

Some doctors and midwives follow a model for group prenatal visits called Centering Pregnancy. At each prenatal visit, the provider facilitates learning and discussion among a group of pregnant women. In addition, the provider gives individualized private care to each woman at every meeting. Studies of Centering Pregnancy suggest that it lowers the likelihood of preterm birth and low-birth-weight infants, and increases breastfeeding rates and satisfaction with prenatal care experiences.[11] For more information, visit centeringhealthcare.org

He or she may be able to help by giving you referrals and scheduling more frequent visits if needed.

Another important goal of the first prenatal visit is to establish a reliable estimated due date (EDD). Your EDD is thirty-eight weeks from the day you conceived the pregnancy. If you don't know when you conceived, you can determine your EDD by reviewing your menstrual cycle. If you have regular, twenty-eight-day menstrual cycles, your EDD is forty weeks from the beginning of your last menstrual period. Many women, however, don't have regular menstrual cycles, or their cycles are longer or shorter than twenty-eight days. If this is true for you, tell your provider how long your menstrual cycles usually are, whether they are regular, and whether you have recently been on a hormonal birth control method or breastfeeding (these can both alter your menstrual cycle.)

Pregnancies usually last about thirty-seven to forty-two weeks, with most women giving birth between thirty-nine and forty-one weeks. Your EDD is merely the middle of that window. Most babies will not actually be born on their due date.

Some doctors' offices and clinics have ultrasound machines and use them at this first visit to see the fetal heartbeat and estimate how far along you are. However, office ultrasounds are not routine in all settings or necessary for most pregnant women. The quality of the pictures produced by ultrasound machines is unlikely to provide useful information about your baby's well-being.

At the first prenatal visit, your doctor or midwife may ask you to get undressed. The examination typically includes a pelvic exam to collect specimens for tests—which may include a Pap test and gonorrhea and chlamydia cultures—and to feel the size of your uterus. If you want to see your vagina and cervix, ask for a mirror. (For more information on pelvic exams, see "The Gynecological Exam" p. 35.) If it is ten to twelve weeks after your last period, you may be able to hear the baby's heartbeat with an electronic Doppler (ultrasound wave device). Later in pregnancy, the baby's heartbeat can be heard with a simple device called a fetoscope.

Before leaving, ask when to return, what to expect from future visits, and where and whom to call with problems and concerns. The practitioner should provide you with any other information you may need, such as written materials and referrals to classes and nearby resource centers. You should leave feeling listened to and well cared for—off to a good start. If you don't think this person is a good fit for you, seek a different provider, if possible.

Your subsequent visits will generally be shorter than the first one. Your care provider will check your weight, blood pressure, and

CARE FOR PREGNANT WOMEN WITHOUT HEALTH INSURANCE

Finding appropriate medical care and services can be difficult if you do not have health care insurance. Some women who lack health care insurance become eligible for Medicaid coverage after becoming pregnant. Eligibility requirements in all states are expanded for pregnant women, and there is a special program called "presumptive eligibility" that pays for medical care for pregnant women whose Medicaid applications have not yet been approved. To find out if you are eligible for Medicaid, visit benefits.gov. To see if your state has a presumptive eligibility program, go to statehealthfacts.org and search for "presumptive eligibility."

In 2014, as a result of new health care legislation, many more of us will become eligible for federal subsidies to purchase health care insurance, and all plans will be required to cover maternity and childbirth services as part of an "essential health benefits" package defined by the federal government. Medicaid will also cover many younger adults who currently lack coverage, enabling women to have insurance before becoming pregnant. These insurers will not be allowed to charge women who are pregnant higher rates.

Your local medical assistance, welfare, social services, or public health office can help you find a clinic that will offer you care or refer you to an insurance program that is available to you.

One program available everywhere in the United States is the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). WIC provides milk, fruit, vegetables, whole grains, juice, cheese, and eggs and offers some prenatal and breastfeeding education. The program may be housed in the local health department, schools, or free clinics. It is available to everyone and is often the best place to start when you're looking for affordable prenatal care. People in the WIC office can refer you to health care providers and other programs and services that are available to you during pregnancy. The WIC website (fns.usda.gov/wic) lists toll-free phone numbers for WIC agencies in each state.

If you aren't able to find insurance coverage, you might consider working with a midwife at home or at a birthing center. These midwives often provide the most affordable care; your out-of-pocket costs will likely be lower than those at a hospital or ob-gyn office. For more information about finding low-cost care or accessing Medicaid, see Chapter 23, "Navigating the Health Care System."

urine; measure your belly to evaluate the baby's growth and position; and listen to the fetal heartbeat. You will occasionally have other tests or procedures, which your care provider should discuss with you ahead of time. All prenatal visits should include plenty of time to talk about your pregnancy, discuss plans for labor and birth, and get your questions answered.

TESTS DURING PREGNANCY

Some prenatal tests give information about the mother's health, while other tests provide information about the characteristics of the developing fetus. While some tests are routine and generally helpful, every test does not make sense for every woman. Ideally, tests will be selected based on your individual circumstances and personal preferences.

TESTS THAT GIVE INFORMATION ABOUT YOUR HEALTH

Prenatal tests that provide information about your health, such as blood testing to find out if you are anemic or are HIV-positive, are important because they detect conditions that often can be treated.

Your state health department may require certain tests, such as blood tests for syphilis or HIV. If you do not want certain tests, you may have options for refusing them in most states, although states differ in procedures for refusing such tests.

After your first prenatal visit, blood tests are not needed at each visit. In your sixth month, a blood test that measures the level of sugar in your blood is routine in many practices. The blood is drawn one hour after you drink a measured amount of sugar (glucose). If your blood sugar level is higher than normal after you've drunk the sugar solution, you will be asked to do a second, three-hour test to determine if you have gestational diabetes. Some women find that the testing makes them feel nauseous, lightheaded, or weak. Blood tests before and after a high-carbohydrate meal may be an appropriate alternative way to screen. Gestational diabetes occurs in about 4 to 7 percent of women and is associated with higher rates of cesarean section and larger babies. It also puts you at increased risk for developing diabetes later in life.

About a month before your estimated due date, your care provider will offer you a vaginal culture for group B streptococcus (GBS). GBS is not an infection; it is one of the bacteria that can be found normally in the vagina. Ten to 30 percent of pregnant women carry this bacterium. Because in rare cases a baby will become ill from GBS infection contracted during birth, your practitioner may test you for GBS and recommend treatment during labor to prevent your baby from becoming sick. Women with GBS are usually given intravenous penicillin during labor.

There is controversy in the obstetrical community about the value of recommending screening for GBS to all women. The test is not offered routinely in many other countries. That's because the downstream effects of the tests—such as the use of antibiotics and separation of mothers and babies after birth—can be harmful, and many women need to be screened and exposed to these interventions to prevent a single newborn illness or injury.

TESTS FOR FETAL IMPAIRMENTS

Ever since the 1970s, it has been possible to get some information during pregnancy about the characteristics of the developing baby. In recent years, the number of tests available to pregnant women has multiplied, allowing increased scrutiny of the fetus for specific disorders. Women may choose prenatal testing to learn about health problems, diseases, or disabilities that might occur. If you learn through prenatal testing that your baby will likely be born with a correctable, treatable, or lifelong impairment, you may want to make special plans before the child's birth. Or you may decide to end the pregnancy if you know that your future child would have a disabling condition or be unlikely to survive after birth.

Though prenatal tests may offer useful in-

CAN YOU REFUSE A TEST?

You have the right to refuse tests and procedures in pregnancy and on behalf of your baby after birth. However, many women feel intense pressure to agree to whatever interventions the provider recommends. Sometimes women are told that if they refuse certain tests (the gestational diabetes screening test or a GBS culture, for example) the baby will be subjected to painful tests and possibly separated from the mother after birth.

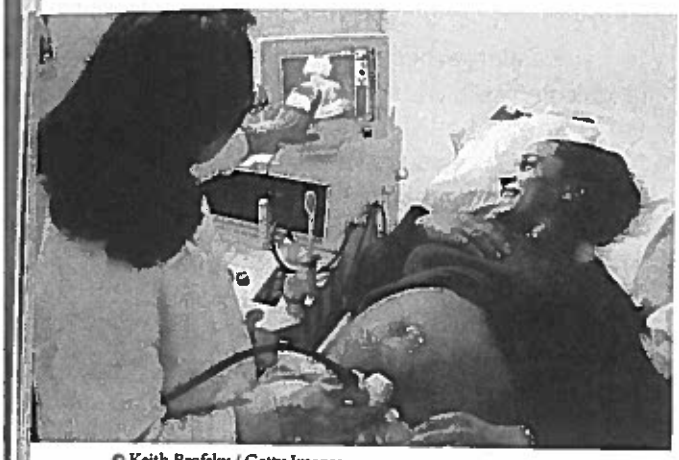
If you are facing scare tactics and have other care providers available to you, consider transferring your care. Seek out unbiased sources of information such as knowledgeable childbirth educators or reputable books and websites. You may decide that you do want to go ahead with the test and that you simply needed to feel fully informed before agreeing to it. Or you may discover alternative approaches to testing that feel more comfortable to you. If you decide to refuse a test given around the time of birth, make sure you have excellent labor support from companions or a doula with whom you have shared your choice. They may be able to help you stand up for yourself and avoid extra tests and procedures the hospital wants to impose.

I decided against getting the test to see if I carried group B strep. If you have GBS, they give you antibiotics, which need to be started four hours before birth. My entire first labor was less than four hours, so it seemed really unlikely that I would even be able to have the treatment. (I was right—I barely got to the birth center in time.) I figured—why do the test if you can't do anything about the results? Knowing I was colonized with GBS and that I wouldn't be able to do anything about it was not the kind of stress I wanted at the end of pregnancy.

formation, they also raise concerns if the report is false-positive. Most of the noninvasive tests (blood tests and ultrasounds) are screening exams that are not perfect, and they can indicate a problem that with further testing will turn out not to be there. Invasive tests such as amniocentesis or chorionic villus sampling (CVS) can give you a 100 percent true answer about some genetic conditions, but these tests involve drawing fluid out of the amniotic sac by inserting a needle through the abdomen or vagina. These tests carry a small risk of miscarriage. Even when they do not cause medical problems, tests can create anxiety and expense and add to the medicalization of pregnancy and birth.

I had a CVS [chorionic villus sampling] done, which was both physically and emotionally painful. We found out there were some irregularities, so I ended up needing an amnio as well. It turned out the irregularity was some fluke in the test, and we finally got a clean bill of health [for the fetus]—six months into the pregnancy. The waiting was excruciating. To be pregnant but not be able to let yourself feel the joy and hope of it was truly horrible.

Tests for fetal impairments give us both the opportunity and the responsibility to decide whether we want to become parents of a child with a particular set of characteristics. Some



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of us may decide that we don't want this information. Others of us will be extremely eager to know all we can about our developing baby. Your doctor or midwife may strongly recommend testing, but it should not be automatic; decisions about testing are up to you.

Types of Tests

Three types of tests screen for or diagnose disorders in the fetus:

- **Genetic carrier testing** is blood tests that can be performed before you get pregnant or in early pregnancy. The tests determine if you or your partner is a carrier of diseases that can be inherited by your children. Examples of genetic carrier tests are blood tests for sickle-cell anemia or cystic fibrosis.
- **Screening tests** measure the likelihood that your fetus has a particular condition but cannot tell for certain whether the fetus has the condition. Examples of screening tests are ultrasounds and "maternal marker" blood tests. Screening tests are typically used to determine if a diagnostic test is necessary.
- **Diagnostic tests** give a yes-or-no answer, identifying whether the fetus does or does not have a particular condition. Examples of diagnostic tests are amniocentesis and chorionic villus sampling.

It is important to note that none of the tests guarantees that the baby will be healthy; instead, they are designed to ask, and answer, one specific question, such as: "Does my baby have cystic fibrosis?"

For more information about specific tests for fetal anatomy and well-being, visit the March of Dimes (marchofdimes.com) and see the chapter on prenatal testing in *Our Bodies, Ourselves: Pregnancy and Birth.*

QUESTIONS TO CONSIDER ABOUT TESTING

Before choosing whether or not to have any test, find out what information the test is capable of providing and its advantages and disadvantages. Ask your health care provider, and do your own research, to find out the following:

- Does the test pose any risk to you and/or your developing baby?
- Why is this test recommended for you? Are you in a group that makes you or your baby more likely to have this condition?
- When can you expect the results to come back?
- How reliable is this test? What is the incidence of false-positive results? If you get a result described as abnormal or unusual, what kind of follow-up testing or counseling will be offered?
- What are your options after receiving the result? Are there any treatments available for you or for the fetus if the result is abnormal?
- How much will this test cost? Will your health care insurance cover part or all of the cost of this test? If not, can you get any financial assistance?

Additional questions for tests that give you information about the baby's characteristics:

- Would knowing that my baby will have a particular condition make a difference in my decision to continue my pregnancy? If so, how?
- What do I know about life with these conditions?
- Would knowing any other characteristics detectable by prenatal testing, such as the sex of my baby or the identity of the father, affect my decision about continuing my pregnancy? If so, how?

CHILDBIRTH CLASSES

Prenatal visits rarely provide enough time to discuss preparation for labor, birth, breastfeeding, and early parenting in detail. Childbirth classes can help fill this gap. In the past thirty years, childbirth education has evolved. Today, women can choose from Lamaze, Bradley Method, ICEA, Birth Works, HypnoBirthing, Birthing from Within, and mindfulness-based childbirth preparation methods, among others. Childbirth classes teach you about the process of labor and birth and offer techniques to help you relax and cope with it.

Techniques that improve confidence can help you prepare to cope with labor sensations. Meditation, visualization, movement, and rhythmic techniques are tools you might use to help ride the waves of labor.

Hospital-sponsored classes tend to focus upon medical interventions and are less likely to give you details about all of their risks and benefits or your rights. Seek out an independent childbirth educator to get unbiased information and help with making decisions and having a childbirth experience that meets your needs. A doula may also provide you with one-on-one education and preparation classes. If these options aren't available or are unaffordable, arrange a get-together with pregnant friends to explore childbirth information and stories together. Many large cities have independent childbirth educator or doula organizations that can provide a list of alternative class options. Childbirth education organizations can often direct you to educators in your community, and some of their websites include directories.

SPECIAL CONSIDERATIONS

WHAT IS A HIGH-RISK PREGNANCY?

Some women have preexisting medical conditions such as diabetes, high blood pressure, epilepsy, autoimmune disorders, HIV, or heart or kidney disease that increase the risk of problems during pregnancy. Others begin pregnancy healthy but develop a complication that needs closer monitoring, such as placenta previa, preterm labor, gestational diabetes, or preeclampsia.

When I first became pregnant, I envisioned having a healthy pregnancy and a natural birth with midwives—I'd already done that once before. But after experiencing serious bleeding in my seventh month of pregnancy, I was diagnosed with placenta previa. I spent the rest of my pregnancy on bed rest, hospitalized for most of that time, and eventually gave birth by emergency C-section when the bleeding started again. I never wanted to have hospitals, high-risk specialists, and surgeons so involved in my pregnancy, but I am eternally grateful that they were there when I needed them.

If you have a high-risk pregnancy, you may need to be seen by or consult with an obstetrician, maternal-fetal medicine physician, or relevant specialists and have more frequent prenatal

visits or adjust your daily activities. But even though your risk of complications during pregnancy is higher, you may not actually develop any worrisome complications.

Some of us are labeled "high risk" but are actually healthy, and with good supportive care we can expect to remain healthy and give birth safely to healthy babies. Being considered high risk can affect our confidence and expose us to extra testing and procedures that we may not need. If you don't think you are high risk, talk to your care provider about what that means for your care. If you believe a high-risk label will limit your choices unnecessarily or lead to overuse of interventions, consider switching care providers.

If your pregnancy requires attention from a specialist, a midwife or family practice doctor may still be able to provide the general care you need.

PREGNANT AND PARENTING TEENS

Becoming pregnant as a teenager can present many challenges. Younger teens (thirteen to fifteen years old) have a higher rate of complicated births, but you can help prevent problems by taking good care of yourself and getting support.

It will be especially important that you gain enough weight, so don't diet while you are pregnant. If getting enough food is difficult for you, contact the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) in your community or call your local food bank. (For more information, see p. 379.)

You may have many plans to make as you prepare to give birth. You will need to know where you and the baby will live, and you may need to figure out how to stay in school or at your job, arrange for health insurance, and ensure that you will have enough money. It can seem overwhelming. The more helpful people (family, friends, the baby's father, school counselor, public health nurse, social worker, midwife, or nurse-practitioner) you can surround yourself with, the better. They can encourage you to be and to stay healthy, to feel positive about pregnancy and birth, and to plan for and make decisions about your and your baby's future.

I'm 15, and when I got pregnant, it was really hard for me in school to do gym. You know, the running and all. The gym teacher was kind of mean, so I talked to my counselor, and she got me into this school that is just for girls who are pregnant. It is better for me, 'cause we just walk for exercise and everybody helps you.

Just because you are having a baby does not mean you have to leave school. Ask your school guidance counselor or health care provider if there are schools in your community especially for pregnant or parenting students. Many communities have such schools. They may offer classes in parenting as well as day care for your baby so that you can attend classes.

I'm 16, and this is my first baby. My mom had me when she was 16, too. When I went into labor, I told my mom I wanted my little sister to be with me. She's 12. After my baby was born, I told my sister, "You are smart and pretty. Don't do this. Don't do what me and mom did. You can be anything you want." I love my baby, but I want my sister to have a better life. Later, my midwife told me I was smart and pretty, too, and that I could do anything I want. She said I could still go to college. I hope I can. I know it will be a lot of work, but I would like to be a lawyer.

PREGNANCY IN YOUR LATE THIRTIES OR FORTIES

Many of us become pregnant for the first time in our late thirties and early forties, and, rarely, even in our middle or late forties. If you are over age thirty-five, medical providers may label you as an "elderly primigravida"—a woman of "advanced maternal age"—and consider you high risk. Most of this increased risk is not related to your age itself but to the fact that older women are more likely to have health problems such as high blood pressure or diabetes, which can affect pregnancy outcomes. In addition, the risk of some fetal impairments, such as Down syndrome, increases as a woman ages. However, the vast majority of women thirty-five and older have healthy pregnancies and births.

Because you are over age thirty-five, your health care provider will offer you blood testing, ultrasounds, and/or an amniocentesis to help determine if there are any chromosome problems in your baby. For more information about these tests, see "Tests for Fetal Impairments," p. 380.

Some of us find our age and experience a benefit as we progress through our pregnancies and motherhood:

For much of my life, I had been convinced that I didn't want kids. Then I settled into my career and found myself in a really great relationship. We talked about kids and realized that we really wanted them. We got married when I was 38, and I got pregnant three days later. . . .

As an older mom I think—no, I know—I'm a better mom than I would have been at a younger age. I'm healthy, so I'm still able to do all the active things with the kids—biking, snowboarding. And I am much more patient than I used to be. We do struggle a bit with balancing preparing for retirement with trying to save for the kids' college, but in the grand scheme of things, that's a pretty good challenge to have.

WEIGHT AND PREGNANCY

Women considered overweight or obese are at increased risk for certain complications, including gestational diabetes, high blood pressure, a larger-than-average baby, and cesarean sections. Of most concern is the sky-high rates of cesarean sections. Many providers work under the assumption that being fat interferes with a woman's ability to give birth vaginally and that cesareans are necessary when women are obese. But other providers and activists question whether the high rate is medically necessary and believe that it is caused in part by misguided assumptions about obesity and by unneeded interventions and protocols commonly used with big women.

Cesareans involve major abdominal surgery and thus pose risks for women of any size. They are even more risky for big women. Obese women who have surgical births have higher rates of anesthesia problems, severe bleeding, and infections than non-obese women who have surgical births.[12] If you are considered overweight or obese, there are things you can do to lower your chances of having a cesarean section. These include being proactive about your health habits, choosing a provider who is size-friendly, avoiding routine medical interventions during labor unless clearly needed, and not intervening when a big baby is suspected. (The fear of big babies is one of the strongest factors driving the high rate of cesareans in heavy women; however, having a big baby is not in and of itself a valid medical reason for having a cesarean.) For more detailed information, see "Women of Size and Cesarean Sections: Tips for Avoiding Unnecessary Surgery" at the Our Bodies Ourselves website, ourbodiesourselves.org.

IF YOU ARE EXPERIENCING ABUSE OR VIOLENCE

Some studies find that one in six women is battered during pregnancy. Unfortunately, this figure may be misleadingly low, because many women do not report abuse—or even recognize that they are being abused.

Many women experience abuse for the first time during pregnancy. The stress of a pregnancy and jealousy over the baby may trigger violent or controlling behavior in a partner who hasn't behaved violently in the past. Abuse can involve any type of physical violence (slapping, hitting, shoving, squeezing, choking), sexual violence (forcing you to have sex when you don't want to or making you have sex in ways that are painful or make you feel bad about yourself), or emotional abuse (keeping you away from friends or relatives or saying things that make you feel bad about yourself).

Many health care providers do not notice or recognize the signs of abuse (bruises, depression, drinking to cope) and therefore fail to address it. But if you tell your care provider about the abuse, she or he can direct you to community resources that can help. You can always get help by calling the National Domestic Violence Hotline (thehotline.org) at 1-800-799-7233. This free, confidential service is available twenty-four hours a day, and translators are available for those who don't speak English. Hotline advocates can provide crisis intervention, safety planning, and information on and referrals to local domestic violence agencies in all fifty states.

For more information about partner abuse and getting help, see "Intimate Partner Violence," p. 709.

IF YOU HAVE EXPERIENCED SEXUAL ABUSE

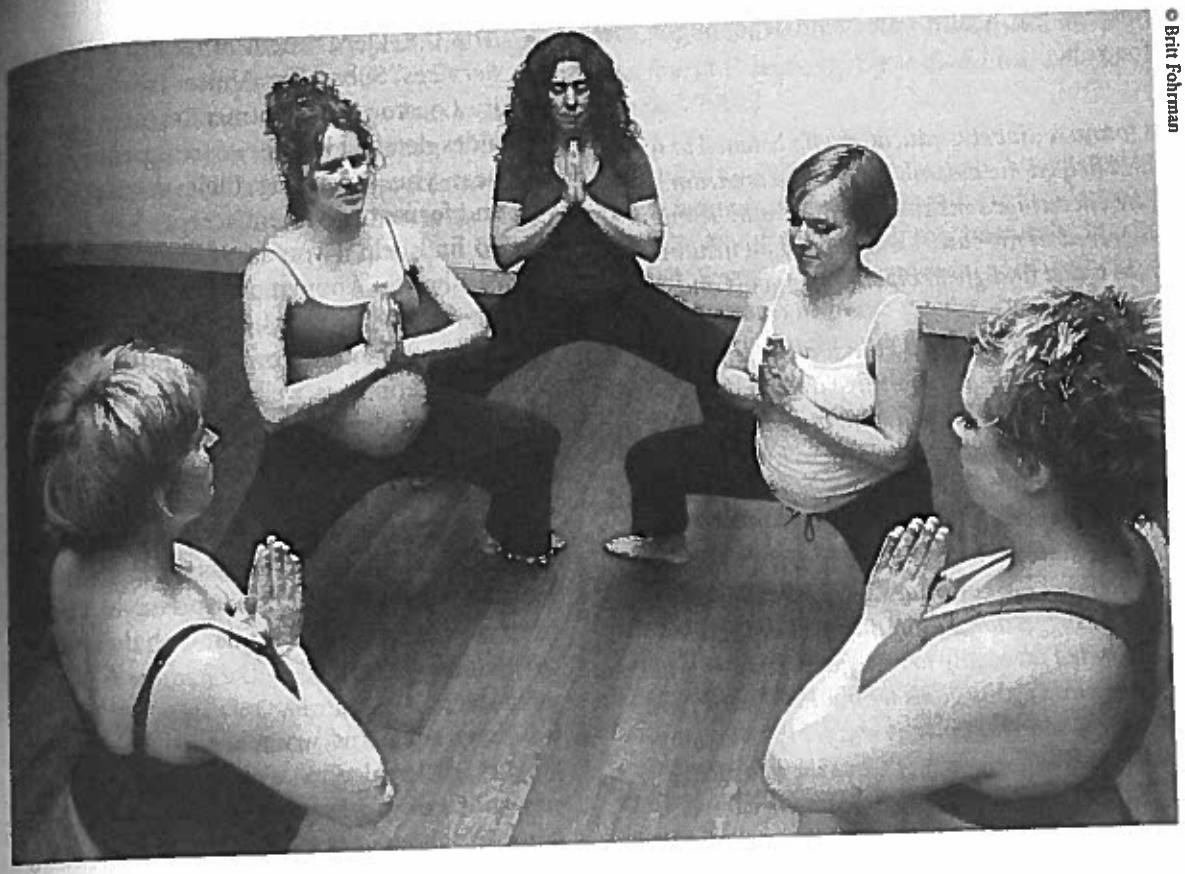
The effects of previous sexual abuse may resurface during pregnancy and labor and after the baby is born. For example, you may feel invaded or violated during prenatal checkups, feel extraordinarily vulnerable in the midst of labor, or have unsettling flashbacks while nursing or bathing your baby. Try to find a health care practitioner who listens carefully to you—and with whom you feel comfortable enough to tell at least part of your story. Find a family member or friend to talk with, or a therapist if possible. Though having a history of sexual abuse may be emotionally difficult, with good support, pregnancy, birth, and motherhood can be empowering and healing, both physically and emotionally.[13]

IF YOU HAVE A DISABILITY

Women with physical, intellectual, or psychiatric disabilities have the right to the same choices as women without disabilities.

However, you may encounter inaccessible facilities, insensitive practitioners, ignorance, or discrimination when attempting to get care. There have been limited research, data, and training about disability and pregnancy. Be prepared to advocate for yourself and to educate your health practitioner, or to find someone who can help.

People may try to talk you out of having a baby, unable to imagine how you could cope. Don't let their ignorance affect your decision. Asking yourself questions beforehand can help clarify your thoughts and wishes: Will pregnancy and birth put my health at risk? If so, how? Are there ways to lessen the risk? If my disability is genetic, how do I feel about the possibility of passing my disability on to the baby? Contact organizations that deal with your specific concerns.



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Being in the hospital and experiencing the intense physical changes of labor may trigger feelings of vulnerability or helplessness. Remember that you are the expert about your own needs. Trust yourself to handle difficult situations and people, and ask for help. Make sure someone accompanies you to act as your advocate. You may want to tour the hospital or birth center in advance. You also may want to write a brief statement about yourself and include a paragraph describing how you want to be treated (for example, "Don't talk to me through my attendant/interpreter; talk to me directly"). Hand out copies to everyone so that you won't have to answer the same questions over and over.

IF YOU HAVE A CHRONIC ILLNESS

If you have a chronic illness, you may wonder both how the pregnancy will affect the illness and how the illness will affect the pregnancy. Some chronic illnesses are unaffected by pregnancy, some may be made worse, and others may actually improve. If possible, arrange for a preconception consultation with a maternal-fetal medicine specialist or a physician with expertise in your particular condition.

Carefully choose the people who know you and your needs best to help you decide where you want to have your baby and who you want to be with you during childbirth. If your health care insurance plan doesn't allow you to make these decisions, try to meet all of the mem-

bers of the health care team who might care for you.

I found a diabetes educator who listened to me and helped me assemble a health care team. She encouraged me to learn more and be more involved in my care. I was started on insulin and a diet and given blood sugar goals and supplies.

It was not easy, but I did it all—testing eight times a day, insulin shots five times a day, and the diet. I didn't have a baby yet, but I lugged a large insulated diaper bag everywhere I went. It was filled with my needles, insulin, log, meter, snacks, ice, and other supplies.

I became an active member of the team who had a good idea of what was going on and even offered suggestions. I am thankful my body responded favorably to my efforts and I was able to keep hitting my goals without complications. After my son was born, it was scary to no longer have such intense support, but the knowledge I gained will allow me to continue to care for myself in order to care for him.

IF YOU ARE DEALING WITH ADDICTION

If you are struggling with addiction to tobacco, drugs, or alcohol, it's important to get help. Some of us find added motivation to quit in knowing that our babies will be affected by our use. Finding treatment may also be easier, as federal laws require that Medicaid and most private insurance plans cover smoking cessation counseling and drug therapy for pregnant women.

The following resources can help you find the care you need:

- To find a smoking cessation program, call 1-800-QUITNOW, or go to smokefree.gov or quitnet.com.
- The U.S. Department of Health and Human Services' Substance Abuse Treatment Facility Locator (findtreatment.samhsa.gov) provides detailed listings of treatment programs near you, including their particular focus and forms of payment accepted.
- To find help if you are abusing alcohol, visit Alcoholics Anonymous (aa.org), Narcotics Anonymous (na.org), or Women for Sobriety (womenforsobriety.org) to find local groups and meetings as well as online support. All are free and guarantee anonymity. Volunteers can answer questions and help you get connected with support people, meetings, treatment centers, and other help. Even if alcohol is not the drug you are using, AA can connect you with a counselor or support person in your area who is familiar with the drug you are using.

Many pregnant women are afraid to seek treatment for alcohol or drug addiction. You may not know whom to trust or if by telling someone about your use you could get into legal trouble. Women with addictions deserve support and access to safe, affordable treatments—not punishment.

IF YOU HAVE HAD A PREVIOUS CESAREAN SECTION

Most women who have given birth by cesarean section in the past can safely give birth vaginally in a following pregnancy, thus avoiding the complications associated with cesarean surgery. These complications include infection, excess bleeding, and problems associated with blood clots. Vaginal birth is also associated with an easier and shorter recovery than cesarean surgery. The risks of pregnancy and likelihood of problems during cesarean section increase the more C-sections a woman has had, so women who intend to have future pregnancies can re-

duce the chance of problems by planning vaginal birth.

However, about one out of every four women who plans a vaginal birth after cesarean (VBAC) will have a cesarean because of problems that arise during labor. Cesareans that take place during labor are somewhat riskier than cesareans occurring before labor. In addition, a small number of women who plan VBAC—about 1 in 200—will experience uterine rupture during labor. Uterine rupture—a tear through the complete thickness of the uterus, usually at the site of a previous C-section incision—requires immediate delivery of the baby and surgical repair of the uterus to control bleeding. Although most women and babies who experience uterine rupture recover fully, studies show that for every 100 uterine ruptures, about 6 babies will die and 25 women will have hysterectomies (removal of the uterus). Overall, death of the baby during labor or soon after birth is very rare but slightly more common with planned VBAC versus planned cesarean.

Not every woman faces the same chances of experiencing harms and benefits. For instance, if you have given birth vaginally in the past, you are more likely to give birth vaginally and less likely to have a uterine rupture than women who have not. If your cesarean section was for slow progress in labor, your chance of giving birth vaginally is lower than if your C-section was for a problem such as fetal distress. You need accurate, unbiased information about *your* likelihood of various outcomes to make an informed choice. In addition, you must consider the risks and benefits of different choices within the context of your own life and priorities.

I hated the idea of recovering from surgery with a toddler in the apartment and a new baby to take care of, especially since my partner could only take a few days off of work. I also wasn't sure we were done having kids, and I was afraid of some of the complications you hear about with third and fourth C-sections. I'm so glad I was able to have a VBAC.

Unfortunately, in the United States today, most women are discouraged from planning VBAC. As of 2009, half of hospitals in the United States *required* women with prior cesareans to consent to cesarean surgery in order to give birth there, and a large proportion of maternity caregivers are unwilling to attend VBACs, a clear violation of the right of informed refusal.[14] In 2010, the National Institutes of Health convened a Consensus Conference to review all of the scientific evidence on planned VBAC and planned repeat cesarean and affirmed that both options have important risks and benefits and that VBAC is a reasonable and safe choice for most women.[15] Several months later, the American Congress of Obstetricians and Gynecologists (ACOG) released a practice guideline encouraging greater access to VBAC and reaffirming women's right to autonomy and choice.[16] Based on strong evidence, the guidelines recommend that most women with one or two previous cesareans receive counseling and be offered the choice of VBAC. These developments have paved the way for consumer advocacy to improve access to the full range of safe birth options for women with prior cesareans.

For more information about the advantages and risks of both VBAC and repeat cesarean section and how to advocate for the best care for either choice, visit Childbirth Connection (childbirthconnection.org) or the International Cesarean Awareness Network (ican-online.org).

DEPRESSION AND OTHER MENTAL HEALTH CHALLENGES DURING PREGNANCY

Despite the stereotype that all pregnant women are glowing, for some women pregnancy is a dif-

ficult time. Symptoms of depression include loss of pleasure in activities that you used to enjoy; persistent feelings of worthlessness, sadness, or hopelessness; prolonged periods of appetite change or fatigue; uncharacteristic tearfulness; or suicidal thoughts. It is possible to be depressed without actually having feelings of sadness. Though depression can affect any pregnant woman, it is more common in women who have experienced depression in the past.

It can sometimes be hard to differentiate between feelings of sadness that are part of the normal range of response to challenging life experiences and serious depression that calls for more than basic support and help with problem solving. The medical definition of depression typically ignores the cause(s) of a woman's distress, and thus often fails to address specific issues such as poverty, discrimination, sexual assault, abusive relationships, or the end of a relationship that contribute to feelings of sadness, poor self-image, and despair.

Too often women experiencing reasonable responses to difficult life situations are treated by health care professionals with mood-altering medications that can have unwanted side effects. These medications—whose popularity is fueled by simplistic and unrealistically optimistic advertising—are often prescribed before women are offered more holistic approaches that have been demonstrated to be equally or more effective. However, when social support systems are not readily available or talk therapy is not helpful, some women do find that medications can provide relief, especially by helping them return to normal function in the short term.

Currently, in North America, pregnancy is treated as though it is an at-risk situation for depression, and routine prenatal care includes screening for depression. Nonetheless, evidence shows that pregnant women experience no more depression than women who are not pregnant. According to one large systematic review, about one in every thirteen pregnant women experiences some depression.[17] In a survey of U.S. women of reproductive age, there was not a significant difference in rates of depression between pregnant and nonpregnant women, and the trend was actually toward pregnant women experiencing less depression.[18]

Why is there potential harm with screening? Screening large, generally healthy groups of people inevitably produces false positives that may result in healthy people being labeled as having a mental health disorder and exposing them to the unnecessary risks of treatment. Furthermore, although many believe that detection and treatment of depression in pregnancy have been shown to prevent depression after birth, there is little scientific evidence to support this view.

Symptoms of serious depression may develop in the context of challenging life circumstances, or they may arise with no apparent cause.

Ever since my eighteenth week of this pregnancy, I have been feeling depressed. I feel flat/unhappy all the time, I cry a lot, I can't sleep, I can't concentrate, I'm impatient with everyone, and not even playing with my toddler makes me happy anymore. This is a much-wanted pregnancy, and there is nothing going on in my life that should be making me so unhappy.[19]

If you are pregnant and experiencing feelings of mild to moderate sadness, the first things to do are to try to get enough sleep and exercise, eat well, and reach out to friends, family, religious counselors, and/or specialized support groups for practical and emotional support. If these strategies do not ease the depression, seek help from a health professional, such as your primary care provider or ob-gyn, or a psychotherapist, social worker, or psychologist with experience treating depression during pregnancy. Depression is treatable, and a good therapist can provide support and guidance as well as help as-

sess whether additional treatment may be helpful. If you have concerns about hurting yourself or others, or an acute sense of hopelessness or inability to function, seek medical attention immediately.

Antidepressants are commonly prescribed during pregnancy. Although these medications are widely believed to be very effective, a recent review of *all* the clinical trials submitted to the FDA—including negative studies pharmaceutical companies chose not to publish—found that antidepressant medications are only slightly more effective than placebos.[20]* For people experiencing mild to moderate depression, they were no more effective than a placebo. Among people who were suffering from major depression, only one of ten people treated with antidepressant medication significantly improved as a result of taking the medication. Among people whose depression was categorized as "very severe," one out of four responded to antidepressant medication.

Furthermore, antidepressants have not been shown to be more effective for mild to moderate depression than nondrug options such as psychotherapy, cognitive behavioral therapy, and exercise. The clinical trial evidence strongly supports a model of symptomatic treatment focusing on life situation, rather than a model of an imbalance in brain chemistry that is "fixed" by antidepressant medication. Most depression is episodic, generally resolving (even without treatment) in about four to six months.

Although some clinicians believe that antidepressants are more effective than shown in clinical trials, the only scientifically valid way to determine whether and by what margin medication is superior to treatment with a placebo is from the results of randomized, double-blind, controlled trials.

In addition to the question of effectiveness, there is some concern about the possible risks of taking antidepressants during pregnancy. For example, can they cause birth impairments? Do they increase the risk of miscarriage? Several studies suggest that there is an increased risk of heart defects in infants whose mothers take antidepressant medications, especially paroxetine (Paxil and generic equivalents),[21]† and some evidence that women taking certain antidepressant medications have an increased risk of miscarriage.

There have also been reports of some harmful effects on infants of women who took antidepressants in the last trimester of pregnancy, including effects such as jitteriness, crying, and feeding problems that may be withdrawal effects, and very rarely, a serious disorder called persistent pulmonary hypertension.[22] There has been controversy surrounding all of these risks and the medical evidence is being hotly contested in legal cases. More research is needed to answer questions about potential risks, including risks that may be due to underlying differences (unrelated to drug use) between women who do and don't take antidepressants.

For women who become pregnant while taking antidepressant medication, these concerns must be weighed against the risk that stopping antidepressant medication during pregnancy will lead to worsening of depression or the symp-

* Estimates of higher efficacy are possible when one selects a subset of clinical trials that omits studies showing less efficacy or when an analysis puts a positive spin on negative results. It is also true that many studies show a considerable response rate to a placebo. Moreover, most depression episodes are temporary and resolve on their own, and in many cases it is hard to distinguish between the effects of drugs and those of other forms of social support and care.

† The FDA has classified paroxetine as class "D" in pregnancy. This means that the FDA has determined good evidence of human fetal risk and thus recommends "do not use" during pregnancy. The other SSRIs are classified as "C," indicating that there is only animal evidence and/or lack of human studies. Therefore, the FDA recommends their use with caution. Drugs classified as "A" or "B" are generally considered appropriate for use in pregnancy; "D" and especially "X" drugs should be avoided if possible.

toms of drug withdrawal. One study showed a high rate of depression relapse when pregnant women were taken off their antidepressant medication, but the study did not gradually taper the dose of medication and failed to distinguish between symptoms of drug withdrawal and recurrence of depression.[23]

Depression in pregnant women is associated with low weight gain, alcohol and substance abuse, and sexually transmitted infections, all of which can harm mothers and babies. Although there is no evidence that taking medications will prevent any of these problems, women with severe depression clearly need professional help.

In the United Kingdom, the National Institute for Health and Clinical Excellence (NICE) recommends the use of older and less expensive tricyclic antidepressants rather than newer drugs such as Prozac, Paxil, and Zoloft because of the longer experience with their use and because of concerns that the newer antidepressants may be less safe overall during pregnancy.

Pregnant women who are struggling with other mental health problems, such as bipolar disorder, anxiety, or post-traumatic stress disorder may be offered medications other than antidepressants. If medication is recommended, make sure that you are fully informed about its benefits and adverse effects, as well as the full range of alternatives—both drug and non-drug. Also, check the FDA's assessment of the safety of each medication for use in pregnancy. (This information is included in the package insert of each prescription medication, which is available from your pharmacy.) You and your health care providers can also get free information on the possible risks of medication on your pregnancy from the Organization of Teratology Information Specialists* (otispregnancy.org).

*Teratology is the study of the causes and biological processes leading to abnormal fetal development and birth impairments.

PREPARING FOR LABOR AND BIRTH

As the weeks pass and you get closer to the day your baby will make his or her long-awaited arrival, it's a good time to ask yourself, "What do I want out of my birth experience?"

Every woman hopes for a safe birth and a healthy baby. Beyond that, you may prefer strongly to have a natural childbirth, or you might know you prefer an epidural. You may have cultural or religious customs you would like to integrate into your birth. If you have other children, you may be particularly motivated to have an easy recovery. If you have had a prior traumatic birth or other past trauma, you may wish to avoid certain triggers during this birth. These are just a few examples of the many hopes and expectations we bring with us to the birth-planning process. It is important to ask yourself questions to clarify your values and preferences and, if you have a partner, to discuss these and find out about his or her hopes as well.

As you learn more about pregnancy, childbirth, and early motherhood, you may find that your values and assumptions have changed since early pregnancy. As you begin to think about your upcoming birth and transition to motherhood, ask yourself if your midwife or doctor still seems like a good fit. It is common for women to switch care providers or birth settings in mid- or late pregnancy, and most women who do switch are happy they did.

The major labor and birth choices you will need to consider ahead of time are who you want to have with you for support, strategies for coping, and which labor interventions you will agree to under which circumstances.

IF YOUR CARE PROVIDER RECOMMENDS INDUCTION OF LABOR OR CESAREAN SECTION

In a survey of women who gave birth in U.S. hospitals in 2005, fully half of respondents had labor induced (34 percent) or underwent a planned cesarean before labor began (16 percent). Though some of those were necessary procedures, experts agree that both interventions are overused.

Every week of pregnancy matters for proper development of the fetal heart, lungs, and other organs, and women who have inductions who are first-time mothers and/or have an unready cervix are vulnerable to ending up with unneeded cesarean.

With exceptions such as placenta previa, severe high blood pressure, or a baby whose growth is significantly restricted, letting labor begin on its own is generally safer than induction or planned cesarean. If your care provider suggests inducing labor or scheduling a C-section, take time to carefully consider the recommendation and ask plenty of questions, such as:

- Why are you recommending an induction or cesarean?
- What are the risks to my baby and me if I wait for labor to begin naturally?
- Can you provide me with a high-quality research study that shows that induction/cesarean in this situation is safe and will reduce my risk of an unhealthy outcome?
- Is induction likely to be successful for me? If not, how much time will you wait for labor to start, or will you expect me to have a cesarean?
- What other aspects of my care are affected by the choice to have an induction/cesarean (e.g., restrictions on food and drink or movement in induced labor, separation from the baby after birth)? How can my birth team support me in making sure my baby and I get the supportive care we need?

DOULAS

Having continuous, high-quality supportive care from others during labor and birth is one of the best ways you can ensure a safe and satisfying experience. Studies demonstrate that women who receive continuous labor support while giving birth need less medication, have lower cesarean section and assisted vaginal birth (vacuum extraction, forceps) rates, and are more satisfied with their birth experiences.[24]

Many of us count on and receive excellent support from our partners or our health care providers. Yet our partners are probably inexperienced at attending births and need their own support, especially in long labors. Midwives, doctors, and nurses in hospitals may not be able to provide continuous care because of the many different demands on their time. (Midwives who attend women at home or in a birth center typically do provide continuous support.) For these reasons, some women choose to be accompanied by a doula (a trained labor support person) or a relative or friend who is knowledgeable about and comfortable around birth and who can stay through the whole process.

Birth doulas provide continuous emotional support, comfort techniques, and encouragement throughout labor and birth. Doulas complement midwifery and medical care, offering a wide range of services, sometimes including home visits after the baby is born. To find a doula in your area, try doulamatch.net or the websites of any of the doula-certifying organizations.

Doulas usually make an initial visit during pregnancy and then arrange to be with you during labor. Some doulas specialize in certain situations, such as teen mothers, women whose native language is not English, women who have experienced a prior loss, VBAC mothers, women whose partners are deployed overseas, or women who cannot afford traditional doula services.

PLANNING FOR PAIN MANAGEMENT

During pregnancy, most of us wonder how we will cope with the intensity and pain of labor and birth. You and those who will support you during labor can learn relaxation routines and other strategies from classes, books, or audio or video resources and practice them before you go into labor. These strategies range from comfort measures such as changing positions, using touch, or relaxing in water to mental strategies such as focused breathing or hypnosis to medication such as opioids (narcotics) or epidurals.

The pain relief methods you choose to use can affect your experience and memories of labor. Learning about the potential advantages and disadvantages of different methods, thinking about your preferences with regard to pain control, and talking with your provider and support people about what you want before you go into labor will help you make sound decisions.

While preparing is important, labor itself is unpredictable. You can't know in advance what you will experience or what you will want or need. Your labor may be easier or more complicated than you imagine. You might plan to give birth without medication and then find yourself needing greater relief, or you might plan on having an epidural but then find you don't need one.

I was determined to have a total "medical buffet" during my delivery. I'd start with Nubain and then move to an epidural and be blissfully pain free. However, when I arrived at the hospital, my OB told me that it was too late for any medical intervention and it was time to push. In fact, I had been lucky not to have had him in the car on the way. I had to throw my "imagined delivery" out of the window and have this baby. I labored for sixty-four minutes in the hospital, and he was born. I was swearing like a sailor and yelled at everyone within a two-foot radius, including my husband. (I swore at my OB so atrociously that when I returned to the same hospital three years later for baby number two, the nurses remembered me.) At one point my OB nonchalantly said, "If you focused that energy on pushing instead of yelling at us, you'd have a baby by now." I got all huffed up at her and my husband, and then my son crowned. She smiled and said, "I told you." It was the most powerful moment of my life; I delivered him, cut the cord, and held him in my arms . . . all before breakfast.

Because it is often challenging to make specific decisions about pain relief before labor, and because all pain-relieving medications can have adverse effects, it is generally best to approach normal labor with the idea of using no-risk or very-low-risk strategies first and then proceeding to the next higher level of intervention if needed. It's also helpful to rest as much as possible during early labor and conserve your energy, as exhaustion can diminish your capacity to tolerate pain and thus increase the need for pain medication. The "Pain Medications Preference Scale" on pp. 396–397 can help you clarify

your feelings about pain and pain management during labor.

Your choice of birth setting and provider can affect your options for pain management; for more information, see "Choosing a Provider," p. 362, and "Birth Places," p. 367. For more information on specific coping strategies and pain relief methods, see "Coping with Pain," p. 410.

PLANNING WITH CONFIDENCE, KNOWLEDGE, AND FLEXIBILITY

Learning about our options for coping with labor and working with a knowledgeable support team can help us feel less anxious as we anticipate labor and birth. We can arrive at informed decisions about the approaches we prefer, recognizing that we may need to make changes based on how our labor unfolds.

I was scared of the pain. I wanted to avoid interventions if possible, but I also wanted my limits to be respected. I wanted to see a midwife because I believed that her philosophy of birth, practical techniques, and continuous support would help me have the kind of birth I wanted. But I needed to know that if my labor was really hard or lasting forever, or if I was totally exhausted, she would support me in getting an epidural.

The first midwife I interviewed when I was pregnant didn't seem to hear my fears; she just said that women's bodies were designed to give birth and that my body would do so also. The second midwife, the one I chose, was more reassuring: she said she knew lots of nondrug techniques to help me cope and manage with the pain but that she was committed to helping me have a good birth, whatever that meant to me. She said that there were times when epidurals were extremely helpful. In the end, I didn't have an epidural, but knowing that it was an option—and knowing that my midwife wouldn't see me as a failure if I had one—may have been part of what helped me avoid one!

PREPARING FOR BREASTFEEDING

Breast milk is the best food for babies; it provides all the nutrients your baby needs to grow, as well as antibodies that protect against infection. Nursing also provides numerous health benefits to you. Whether you are undecided about breastfeeding or committed to it, take time to talk with midwives, childbirth educators, and other mothers and to read available books during your pregnancy. Having good support and plans in place before you give birth can help smooth the way. (To read more about breastfeeding, including how to get off to a good start, see "Breastfeeding Your Baby," p. 436.)

YOU ARE READY FOR BIRTH!

The transition to motherhood can be challenging, both physically and emotionally. Learning as much as you can and listening to other women's stories will give you information and inspiration to face the challenges of pregnancy and childbirth with greater confidence.

A woman planning a home birth said:

My mother gave birth to me at home. Her mother had given birth to five children and had considered her labors her finest, strongest moments. I know I can give birth and it is hard work, but I trust my body. At night I sit still, close my eyes, breathe deeply, and picture myself opening up. . . . My birth will be unique.

PAIN MEDICATIONS PREFERENCE SCALE

This table, created by the childbirth educator Penny Simkin, can help you clarify your feelings about pain and pain management during labor.*

NUMBER	WHAT IT MEANS	YOUR PARTNER, DOULA, NURSE, OR CAREGIVER CAN HELP YOU BY
+10	I want to be numb, to get anesthesia before labor begins. (An impossible extreme.)	• Explaining that you will have some pain even with anesthesia. • Discussing your wishes and fears with you. • Promising to help you get medication as soon as possible in labor
+9	I have a great fear of labor pain and I believe I cannot cope. I have to depend on the staff to take away my pain.	• Doing the same as for +10 above. • Teaching you some simple comfort techniques for early labor. • Reassuring you that someone will always be there to help you.
+7	I want anesthesia as soon in labor as the doctor will allow or before labor becomes painful.	• Doing the same as for +9 above. • Making sure the staff knows that you want early anesthesia. • Making sure you know the procedures and the potential risks.
+5	I want epidural anesthesia in active labor (4-5 cm). I am willing to try to cope until then, perhaps with narcotic medications.	• Encouraging you in your breathing and relaxation. • Knowing and using other comfort measures. • Suggesting medication when you are in active labor.
+3	I want to use some medication but as little as possible. I plan to use self-help comfort measures for part of labor.	• Doing the same as for +5 above. • Committing herself or himself to helping you reduce medication use. • Helping you get medications when you decide you want them. • Suggesting half doses of narcotics or a "light and late" epidural.
0	I have no opinion or preference. I will wait and see. (A rare attitude among pregnant women.)	• Helping you become informed about labor pain, comfort measures, and medications. • Following your wishes during labor.

-3	I would like to avoid pain medications if I can, but if coping becomes difficult, I'd feel like a "martyr" if I did not get them.	• Emphasizing coping techniques. • Not suggesting that you take pain medication. • Not trying to talk you out of pain medications if you request them.
-5	I have a strong desire to avoid pain medications, mainly to avoid the side effects on me, my labor, or my baby. I will accept medications for a difficult or long labor.	• Preparing for a very active support role. • Practicing comfort measures with you in class and at home. • Not suggesting medications. If you ask, suggesting different comfort measures and more intense emotional support first. • Helping you accept pain medications if you become exhausted or cannot benefit from support techniques and comfort measures.
-7	I have a very strong desire for a natural birth, for personal gratification along with the benefits to my baby and my labor. I will be disappointed if I use medication.	• Doing the same as for -5 above. • Encouraging you to enlist the support of your caregiver. • Requesting a supportive nurse who can help with natural birth. • Planning and rehearsing ways to get through painful or discouraging periods in labor. • Prearranging a plan (e.g., a "last resort" code word) for letting her or him know if you have had enough and want medication.
-9	I want medication to be denied by my support team and the staff, even if I beg for it.	• Exploring the reasons for your feelings. • Helping you see that they cannot deny you medication. • Promising to help all they can but leaving the final decision to you.
-10	I want no medication, even for a cesarean delivery. (An impossible extreme.)	• Doing the same as for -9 above. • Helping you gain a realistic understanding of risks and benefits of pain medications.

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