How to Become Mother-Friendly

Barbara A. Hotelling
Helen A. Gordon

Editors

Policies and Procedures for Hospitals, Birth Centers, and Home Birth Services
How to Become Mother-Friendly
Barbara A. Hotelling, BSN, MSN, WHNP-BC, LCCE, IBCLC, has studied many aspects of women’s health, birth, and parenting over the past decades. First becoming a Lamaze childbirth educator, she continued to learn the art and skill of being a birth doula. During this time, Barbara served on the boards of DONA International, the Coalition for Improving Maternity Services, and Lamaze International, later becoming the president of each. She received her MSN as a women’s health nurse practitioner in 2006. She received certifications in lactation (IBCLC) and in helping families understand their newborns as a HUG Your Baby instructor and trainer. She is currently working on certification for infant massage.

Barbara continues to train birth doulas, Lamaze educators, and HUG teachers. Being a birth doula and a full-time clinical nurse educator at Duke University School of Nursing (DUSON) has been challenging, although Barbara manages to enjoy welcoming a new little person to the planet every so often.

Helen A. Gordon, DNP, CNM, CNE, received her BSN from the University of Arkansas College of Nursing, her MS in parent–child nursing and nurse-midwifery from the University of Utah, and her DNP from Case Western Reserve University in 2012. Dr. Gordon is an assistant professor at DUSON, teaching in the accelerated BSN program since 2005.

She has spent her entire career (40 years) in birth and women’s health. Before coming to Duke in 2003, she managed a grant for the American College of Nurse-Midwives in Washington, DC. For 5 years she was the state’s first technical specialist in nurse-midwifery care for the North Carolina Office of Rural Health, assisting in the implementation of certified nurse midwife and physician practices in rural North Carolina. She was the first nursing director in the United States to implement labor, delivery, recovery, and postpartum care in a tertiary setting. Dr. Gordon also has extensive experience in the development of market-driven, competitive women’s care services. She co-teaches the maternity nursing course and teaches senior seminar courses in the accelerated bachelor of science in nursing program. She has also served as lead faculty in community health, is currently chairman of membership for the North Carolina chapter of the Association of Woman’s Health, Obstetric and Neonatal Nurses (AWHONN), and was part of the submission team for the National League for Nusing designation to Duke as a School of Excellence.

Dr. Gordon was selected by the DUSON faculty to receive its Distinguished Teaching Award, and she received the Outstanding BSN Faculty Award from ABSN students. Dr. Gordon’s scholarly interests include the impact of nursing care on normal birth and adult learning principles.

Dr. Gordon currently serves as faculty-in-residence in Randolph dorm on Duke’s East Campus, where she resides with 182 freshman coeds. She is the first DUSON nurse to participate in this highly sought-after and uniquely rewarding Duke program. It is her mission to expose freshman students to a different perspective on nursing.
How to Become Mother-Friendly
Policies and Procedures for Hospitals, Birth Centers, and Home Birth Services

Barbara A. Hotelling, BSN, MSN, WHNP-BC, LCCE, IBCLC
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EDITORS
To all women who have had or will have optimal births, and to the wise caregivers who support them. This includes my children and their families; Harold, George, James, Claire, and Charles. In memory of my husband, Harold, with whom I had love and support for our births, our family, and this book.

—Barbara A. Hotelling

To my students in the Duke maternity course, N220, a big thanks for your enthusiasm and the care you provide to mothers and babies. You are an inspiration and my hope for the future of nursing. To my adorable sons, Aaron and Elliot, you made me a mother, a role that I wanted all my life. I love you both.

—Helen A. Gordon
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A very special thanks goes to the Duke University School of Nursing students and their instructor, Dr. Helen A. Gordon, for their original work that was reviewed, updated, and edited by the chapter authors.
I have been waiting anxiously for the completion of Hotelling and Gordon’s indispensable book, *How To Become Mother-Friendly: Policies and Procedures for Hospitals, Birth Centers, and Home Birth Services*. Indeed, it has been a long gestation, but now seeing the fruits of their hard labor it was well worth the wait.

As the editor of the *Journal of Perinatal Education* and co-author of two books published by Springer Publishing Company, I know first-hand what a monumental job it is to deliver, or should I say “birth,” the finished product. What Hotelling and Gordon have provided in this timely book is a valuable guide for health care providers caring for women and their newborns. As the first publication to provide well-researched, comprehensive, evidence-based policies and procedures for perinatal care, this book gives readers much needed justification for providing optimal, safe care to mothers, babies, and families.

I can remember when the Coalition for Improving Maternity Services (CIMS) was first born and was in its infancy. I attended the meeting in 1994, in which Lamaze International invited sister organizations and stakeholders in the birth and breastfeeding communities to a summit in Chicago, with the goal of fostering collaboration in a national effort to promote, protect, and support normal birth and breastfeeding. The commitment of that group to work together resulted in the establishment of the CIMS and 2 years later the launch of the Mother-Friendly Childbirth Initiative and the Ten Steps of the Mother-Friendly Childbirth Initiative for Mother-Friendly Hospitals, Birth Centers, and Home Birth Services. What wonderful important work this group of passionate, inspiring individuals and national organizations with concern for the care and well-being of mothers, babies, and families has accomplished. CIMS’s “Evidence Basis for the Ten Steps of Mother-Friendly Care,” first published as a supplement in the *Journal of Perinatal Education* in 2007, was a landmark contribution to the literature on mother-friendly care and set the stage for ongoing updates to the research that are supported by CIMS’s
Evidence and Action Committee and the CIMS U.S. Birth Practices Advisory Council. CIMS’s mission, to promote a wellness model of maternity care that will improve birth outcomes and substantially reduce costs, focuses on prevention and wellness as the alternatives to high-cost screening, diagnosis, and treatment programs. These 10 steps are the cornerstones of practice needed to support, protect, and promote mother-friendly maternity services. However, the recommended 10 steps alone are not enough to change practice. Health care providers need to base their practice on evidence-based guidelines and procedures.

Special kudos go to Helen A. Gordon and her nursing students at Duke School of Nursing for initiating the task of translating each of the Ten Steps of the Mother-Friendly Childbirth Initiative into policy and procedures. This work also could not have been accomplished without the careful review and contribution of a cadre of perinatal experts who are also to be commended.

*How to Become Mother-Friendly* offers something for all who are interested in the care of childbearing women and their families. The information is invaluable to novice as well as to seasoned providers working in hospitals, birth centers, or home birth settings. This book is an indispensable guide for anyone who is concerned about and wants to implement changes to the current maternity care system. The easy-to-read format provides readers with a comprehensive review of the best available evidence to support best practices consistent with the mother-friendly philosophy. In today’s costly health care climate, promoting strategies that support cost-effective safe care is warranted. The straightforward writing style and excellent examples make this an important work for the profession. The guidelines and procedures outlined in this invaluable book for safe, evidence-based, mother-friendly care are now ready for implementation by practitioners in hospitals, birth centers, and home birth practices.

Wendy C. Budin, PhD, RN-BC, FAAN

*Director of Nursing Research, New York University Langone Medical Center*

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*Editor-in-Chief, Journal of Perinatal Education*
Written for maternal–child caregivers, *How to Become Mother-Friendly* is the first publication to provide evidence-based policies and procedures for perinatal care. Publications exist offering policies and procedures to promote optimal care in medical practice, yet *How to Become Mother-Friendly* is the first to provide evidence-based policies and procedures that support optimal, physiologic perinatal care for mothers, babies, and families in home birth practices and birth centers. The foundation for this book is the Mother-Friendly Childbirth Initiative—the first consensus statement of the Coalition for Improving Maternity Services (CIMS). CIMS is:

... a coalition of individuals and national organizations with concern for the care and well-being of mothers, babies, and families. Our mission is to promote a wellness model of maternity care that will improve birth outcomes and substantially reduce costs. This evidence-based mother-, baby-, and family-friendly model focuses on prevention and wellness as the alternatives to high-cost screening, diagnosis, and treatment programs. (Mother-Friendly Childbirth Initiative [MFCI], 1996)

The evidence-based MFCI evolved from the collaborative effort of many individuals and more than 26 organizations focused on pregnancy, birth, and breastfeeding during meetings in the 1990s spanning nearly 3 years. The MFCI—the cornerstone of our mission—is the first and only consensus document on U.S. maternity care. The MFCI is recognized as a significant instrument for change both in this country and abroad. Acknowledging the need to ensure the ongoing education and promotion of the Mother-Friendly Childbirth model of care defined in the MFCI, CIMS was established as a nonprofit corporation in 1997 (www.motherfriendly.org). CIMS continues to promote this model of care with its publications, forums, and dogged determination to highlight programs that work and to debunk medical information that lacks evidence.
We are extremely fortunate to have the support of Dr. Helen A. Gordon, Duke University nursing professor, who assigned her students the project of writing policy and procedure for each of the 10 steps of the MFCI. After Dr. Gordon’s careful editing, she donated these policies and procedures to CIMS. They have once again been reviewed by experts in the field and are now ready for implementation by practitioners in hospitals, birth centers, and home birth practices.

Maternal–child caregivers have a difficult time remaining current on all new research. Even after reading the research, they then must decide its validity and determine if the outcomes warrant practice changes. How to Become Mother-Friendly provides guidelines by which caregivers may practice safe, evidence-based care that improves outcomes for mothers, babies, and families. Duke nursing students conducted literature searches and used the findings from the Journal of Perinatal Education supplement (CIMS, 2007) to create evidence-based policies and procedures for the many hospitals, birth centers, and home birth practices that want to provide mother-friendly care. Some time elapsed since receiving their work and expert research nurses who had experience on perinatal units were asked to update information and research citations where needed. Everyone volunteered their services and the royalties go directly to the CIMS.

CIMS has received many requests over the years to designate a facility as mother-friendly. Included in the appendices are several self-evaluation tools that can be used to rate current practices. How to Become Mother-Friendly provides readers with policies and procedures they can use to increase the rate of vaginal birth, vaginal birth after cesarean, and breastfeeding, while averting preventable cesareans, unnecessary interventions, and traumatic births. Readers will save health care dollars and increase patient satisfaction at the same time.

Thank you to Helen Gordon and the Duke nursing students who discovered a need and met it. Thank you to the reviewers for lending their expertise and dedication to this project. Thank you Elizabeth Nieginski, Chris Teja, and all those working with us at Springer Publishing Company for the nurturing support that brought the students’ and reviewers’ work into its useful form.

Barbara A. Hotelling
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An idea I had, which became the basis of a fabulous team assignment, is now a book. My years of experience in the nursing management of inpatient births and women’s units gave me the insight I needed: The implications provided from standards of care and health care policies for establishing clinical boundaries for professional nurses is the basis of practice change. I wanted my students to have hands-on experience in the creation of nursing policy. So I used the Mother-Friendly Childbirth Initiative from the CIMS.
and coached students in using those steps as the framework for crafting nursing policies.

I had a group of students who had just completed the maternity nursing course. They had witnessed first-hand the rather unfriendly policies instated by most of the clinical sites in which their maternal–newborn experiences had occurred. Now these students were in the fourth and final semester of an accelerated bachelors of science nursing program. I was their faculty mentor as well as their clinical instructor. My objective was to give them experiences in leadership, writing policy and, in some way, interaction with a community organization. The offices of the CIMS are based in Raleigh, North Carolina, close enough to Durham to be one of “our communities.”

Students were weeks away from graduating and, like the majority of our students, I knew they would be promoted one day into leadership roles. I felt this was a key experience for them to have while in school. I was not going to lecture on the topic; what was required was for us to roll up our sleeves and get down to the nitty-gritty of writing policies. This seemed like the perfect project for these graduating seniors; it forced them to review the literature on each step, gave them writing experience, and required them to team up with defined deadlines in service of a not-for-profit organization.

What they returned to me was beyond my expectation, so typical of our second-degree students! The second draft needed only my minor tweaks to be complete. Like so many great ideas, if the final product is not disseminated the work, while educational, would not benefit anyone but these students. With the permission of the group, I gathered the binder of their work and took it to CIMS. The executive director at CIMS then turned to the Board of Directors, suggesting that this project might be a viable one that CIMS could further disseminate. Barbara Hotelling took on the project. The students’ work was updated to include the latest references, then was consistently formatted, and ultimately found a home with Springer Publishing Company.

I am proud of the work my students did. I thank Barbara and all the collaborators who put the final polish on this manuscript. I speak for myself and on behalf of my former students in saying that we hope these policies will be the impetus for significant and needed change in the inpatient birthing units of hospitals. Hospitals need to embrace the 10 steps. But until nurses are given guidelines on how to do that, are required to implement those guidelines by their job descriptions, and are rewarded annually in their performance reviews, those needed changes will remain a pipe dream. We need more than isolated and zealous nurses who believe in the 10 steps. What is required is for hospital and nursing leadership to incorporate this work into the fabric of nursing care delivery in every hospital that cares for mothers and babies. It is to this end that we offer you the collective work of many people who banded together to make this publication possible.

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BIBLIOGRAPHY

Share
How to Become Mother-Friendly: Policies and Procedures for Hospitals, Birth Centers, and Home Birth Services
STEP 1

MARILYN CURL

A mother-friendly hospital, birth center, or home birth service offers all birthing mothers unrestricted access to birth companions, labor support, and professional midwifery care.
**STEP 1A**

**POLICY TITLE:** Unrestricted Access to Birth Companions

**POLICY:** To ensure that birth takes place among caring, supportive individuals who have been chosen by the laboring woman to share this life-changing event. Those selected may include father, partner, children, and other family members.

**PURPOSE:** Birth stress has been shown to be reduced when women are surrounded by trusted family and friends. Such supportive care is a basic necessity identified by experts in maternity services, such as the World Health Organization (WHO), the Society of Obstetricians and Gynecologists of Canada (SOGC), and the Association of Women’s Health, Obstetric and Neonatal Nurses (AWHONN).

- There is no evidence of medical harm found for unrestricted access by mothers to birth companions of her choice—fathers, partners, children, family members, or friends—at birth.
- Family support seems to be more important for siblings attending the birth than actually witnessing the birth itself. There are some recommendations for the inclusion of children at birth to ensure a positive experience for everyone involved.
- Mothers reported less satisfaction with birth support when the support provider was a nurse or a doctor compared with a partner or doula.
- The perception of support during labor is a key ingredient in a woman’s ultimate satisfaction with her birth experience.
- A woman’s perception of support during labor is more important than her experience of pain or her satisfaction with pain relief methods in her overall satisfaction.

**PROCEDURE**

1. Laboring women will have the sole right to determine how many family members, friends, and others will be present to provide supportive care during labor, birth, and the immediate period following birth.
2. Children who attend a birth should have:
   a. Preparation, such as talking about the birth, reading books, watching videos, and answers to any questions they may have.
b. A caregiver assigned specifically to each child so each child can be given the opportunity to leave the room if he or she wishes.

c. The freedom not to witness the birth.

3. Care shall be provided in an environment that supports physical comfort.

4. Throughout the birth process, birth companions shall be free to move from public areas (waiting rooms) into the birthing suite at the direction of the laboring woman.

5. In the event of an unexpected surgical delivery, the woman shall be able to choose at least one person to accompany her to the operating suite. The infant, if healthy and stable, shall remain with the mother at all times.

6. Since there is no evidence to support policies that restrict support during labor, the woman has the right and responsibility to select who will be present during labor and birth. This allows limiting, if desired, the number of staff members including nursing and medical students, who are present in an observational role.

7. Fathers will participate in roles personally comfortable to them and the birthing women.
**POLICY TITLE:** Access to Continuous Emotional and Physical Support by a Skilled Woman

**POLICY:** Women giving birth should have unrestricted access to continuous emotional and physical support from a skilled woman; for example, a doula or labor-support professional.

**PURPOSE:** Skilled support (differentiated from support provided by family and friends) is the right of all laboring women and is supported by AWHONN (2011). The evidence is clear that:

- No evidence of harm has been identified when women have unrestricted access to continuous emotional and physical support from a trained caregiver.
- The perception of support during labor is more important in determining a woman’s satisfaction with her birth experience than her experience of pain or her satisfaction with methods of pain relief.
- Compared with a similar population receiving comparable clinical care, continuous labor support reduces the likelihood of utilizing pain medication or analgesia in labor, increases the likelihood of spontaneous birth without assistive devices (e.g., forceps, vacuum extractors), increases satisfaction with the birth experience, and reduces the likelihood of severe postpartum pain.
- Women receiving continuous labor support are more likely to have spontaneous vaginal birth (Goer & Romano, 2012, p. 436).
- Compared with a similar population receiving comparable but intermittent support, continuous labor support results in fewer newborn admissions to a neonatal intensive care unit.
- Continuous one-to-one female labor support by providers who are not hospital staff and in environments more likely to provide physiologic care provides more beneficial effects.
- Intrapartum nurses provide minimal supportive care due to systemic and cultural factors (Goer & Romano, 2012, pp. 438–441), for example, high nurse-to-patient ratio.
• Fathers may not be able to provide adequate labor support (Goer & Romano, 2012, p. 444).
• Recognizing that studies have shown that similar positive outcomes can be achieved when other experienced women who are not medically trained provide supportive care, the birthing family shall be free to choose attendants at will.

PROCEDURE

1. The circle of support during birth may include both professional nurses and nonprofessional caregivers whose only purpose will be to meet the physical and emotional needs of the laboring mother. This includes but is not limited to assistance with ambulation, sitting on the birthing ball, positioning in labor for comfort, assistance in the shower or Jacuzzi, positioning for pushing during the second stage, and assistance with breastfeeding or infant comfort during the fourth stage.
2. Doulas should be considered a part of the mother’s team of care reporting to and responding to other members of the team.
3. Preferably, doulas will not be members of the hospital staff.
4. Doulas will only perform continuous emotional and physical support. Doulas will not perform medical assessments or interventions even though they may know how to do these.
5. Doulas will involve the family and friends the mother has chosen to be with her in this support at their comfort level.
6. Providers attending birth (physicians, midwives, and nurses) should be offered training in nonpharmacologic care of women in labor.
STEP 1C

POLICY TITLE: Unrestricted Access to Midwifery Care in All Birth Settings

POLICY: To ensure that all women who have selected midwifery-based prenatal care have access to a midwife-attended birth regardless of the setting.

PURPOSE: In order to choose what best suits their needs, circumstances, and preferences, women must have access to all types of practitioners who are qualified to take sole responsibility for the care of childbearing women during the prenatal, intrapartum, and postpartum periods. While any individual practitioner may practice a model of care conforming with the philosophy of the Ten Steps of Mother-Friendly Care, research shows that such practitioners are more likely to be midwives.

A professional midwife is defined as a skilled attendant who has achieved official recognition as a midwife through licensure, registration, or certification. “Access to professional midwifery care” is defined as access to a professional midwife who is authorized to provide care independently throughout the childbearing period to women who are at low or moderate risk of complications. Professional midwives may attend births within hospitals, freestanding clinics or birthing centers, the family’s home, or some combination of these locations.

According to the definition endorsed by the International Confederation of Midwives:

The midwife is recognized as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife’s own responsibility and to provide care for the newborn and the infant. This care includes preventive measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical or other appropriate assistance and the carrying out of emergency measures. (International Confederation of Midwives, 2005; Goer & Romano, 2012, p. 451)

In comparison to physician care for similar populations, care by professional midwives is likely to result in the following maternal outcomes that support physiological birth:

- Women are likely to report longer and more frequent antepartum visits that resulted in increased education and counseling.
• There appeared to be a decreased incidence of antepartum and/or intrapartum hypertension that resulted in fewer antepartum admissions and fewer inductions of labor.

• Women reported increased access to food and drink in labor and limited use of intravenous fluids in labor.

• Midwives were more likely to encourage ambulation in labor and to use nonsupine positions for birth.

• Amniotomy was performed less frequently and there were fewer episodes of abnormal fetal heart rate in labor.

• Continuous electronic fetal monitoring, external and internal, was used less frequently.

• Women who preferred nonpharmacologic pain relief were more likely to achieve their goals and reported effective pain management in labor. They also had reduced need for analgesia including epidural anesthesia.

• Surgical intervention were less likely and women were as likely or more likely to experience spontaneous vaginal births with fewer or equivalent instrument-assisted births.

• Midwifery care in labor and birth reduces the likelihood of genital tract trauma (Goer & Romano, 2012, pp. 467–468).

• Midwives rely less on restrictive or invasive intrapartum procedures including:
  • Pharmacologic induction
  • Oxytocin augmentation
  • Any type of induction or augmentation
  • Amniotomy
  • Continuous electronic fetal monitoring
  • Prohibition of eating and drinking in labor
  • Routine intravenous fluids
  • Mobility in labor
  • Position for birth (Goer & Romano, 2012, pp. 471–472)

• With one exception, which may be explained by systemic factors, midwifery care results in equivalent or superior newborn outcomes compared with physician management (Goer & Romano, 2012, pp. 472–474).

• Midwife-led care produces equally good or better maternal and infant outcomes as physician-led or shared care, with lower procedure and medication rates (Goer & Romano, 2012, pp. 476–477).

• Both midwifery care and midwife-led models of care appear to be safe and beneficial for medically and sociodemographically moderate-risk and high-risk women and their infants (Goer & Romano, 2012, pp. 478–481).
PROCEDURE

1. Laboring women will choose who will support them in labor.
2. Laboring women will choose who will provide professional care during labor and birth.
3. Mother-friendly birth settings have policies in place that provide for full staff privileges for all licensed birth attendants including midwives.
4. In the event of a surgical birth, the midwife will attend in a supportive role and will remain with the family if desired through the initiation of breastfeeding.
5. Midwives will be integrated into the health system including hospital privileges, consultants, technology (e.g., resuscitation expertise, lab tests, medication), and collaborative relationships with physicians (Goer & Romano, 2012, pp. 474–475).
6. Midwives will be received warmly by the medical team when their clients are transferred to hospitals.
7. All low-risk women should have the option of booking midwifery-led care (Walsh, 2007, p. 28).
8. Free-standing birth centers should be established in metropolitan and rural areas (Walsh, 2007, p. 28).
9. Integrated birth centers should be established in all medium to large consultant units (Walsh, 2007, p. 28).
10. Labor-support staff need training in noninstitutional birth skills (Walsh, 2007, p. 28).

BIBLIOGRAPHY


